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Update

ISO study cites 3 tort provisions for escalating liability claim costs

NEW YORK—Tort laws allowing claimants to recover unlimited non-economic damages; sue for joint and several liability; and collect money from collateral sources without a reduction in their settlements or court awards greatly increase insurers' total claim costs, says a new study by the Insurance Services Office Inc.

As a result, settlements or court awards exceeding $25,000 were received by only about 9% of tort claimants, but

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Insurers plead 'don't lift stay' on Prop. 103

By GLENN HUNTLEY

SAN FRANCISCO—California's property/casualty insurance market will be seriously disrupted if the state Supreme Court lifts its temporary stay of the implementation of Proposition 103 while deliberating its constitutionality, insurers contend.

Graphic: Roger Schillerstrom

In court filings last week, insurers said the stay has stabilized the state's insurance market while giving the court time to consider legal challenges to the sweeping changes called for by the proposition.

The court issued the stay the day after California voters narrowly approved the proposition last month (*BI*, Nov. 14).

But, Standard & Poor's Insurance Rating Service last week said it assumes the court will uphold most of the new law and as a result placed four insurers on its CreditWatch list: Allstate Insurance Co., Farmers Insurance Group, Fireman's Fund Insurance Cos. and SAFECO Insurance Co.

Any potential downgrades, however, are unlikely to exceed one full rating category, S&P said.

In separate filings, associations representing health and life insurers also have asked the court to continue the stay and eventually

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Pension offset rules: Mission impossible?

By JERRY GEISEL

WASHINGTON—Pension experts are urging the Reagan administration to give them more time to comply with the Internal Revenue Service's sweeping pension integration rules.

The complex and voluminous new rules explain how employers are to comply with provisions in the 1986 tax law that placed new, more stringent limits on the ability of companies to coordinate or integrate their defined benefit and defined contribution pension plans with Social Security.

Those rules will force tens of thousands of companies to scrap integration formulas they have used for decades and to adopt new methods to calculate retirement benefits earned after Jan. 1, 1989.

For example, the most common type of pension integration formula—reducing or offsetting a pension benefit by a percentage of a retiree's Social Security benefit—appears doomed by the regulations (see story, page 45).

While the IRS rules give employers alternatives to current but soon to be obsolete integration formulas, benefit experts say there simply isn't time for employers to redesign their pension programs to fit the new formulas by a Jan. 1 deadline.

Redesigning a pension plan so that pension and Social Security benefits produce combined benefits that meet the retirement income needs of a diverse workforce takes months, experts say.

"Major employers with integrated plans cannot comply by the beginning of their 1989 plan years regardless of the amount of resources they might devote to plan design, because the process of consultation, decision making, drafting, approval, adoption and notification will consume substantial time," said the Washington-based Assn. of Private Pension & Welfare Plans in a letter sent last week to Assistant Treasury Secretary O. Donaldson Chapoton.

"Like a rocket launched into space, a pension plan is a long-range commitment that cannot be recalled and needs months of expert planning," said John Feldtmose, president of A. Foster Higgins & Co. Inc. in New York, in a letter sent last week to Treasury Secretary Nicholas Brady.

"Without time to design plans carefully, it's inevitable for some companies to set benefits too low, while other firms find they are over-committed to costly programs," Mr. Feldtmose added.

If the IRS had met congressional deadlines and issued integration rules on time, employers now would not be under such a tremendous crunch to amend their pension programs.

When Congress passed the Tax Reform Act of 1986, which called for changes in the way employers integrate pension benefits with Social Security, it told the IRS to publish final regulations on the integration provisions by Feb. 1, 1988. Presumably, that would have given employers sufficient time to amend their plans.

But, due to the diversion of IRS staff to other congressional projects, like technical changes to the 1986 tax law, proposed—not final—integration rules, were not published until Nov. 15, despite an effective date of Jan. 1 for most pension plans.

IRS officials were not available for comment last week.

At the same time, the IRS still has not published other regulations that employers will need to amend their pension plans.

For example, the IRS has not published rules required under Section 401(a)(4) of the 1986 tax law to implement new non-discrimination provisions for pension plans, as well as regulations relating to minimum participation standards and coverage requirements.

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Judge halts business at 10 Teale-led firms

By DOUGLAS McLEOD

ATLANTA—A state judge has ordered 10 corporations controlled by Alan Teale into temporary receivership following allegations by state regulators that Mr. Teale and the companies are operating illegally and represent a "threat to the insurance-buying public."

The order, issued Wednesday by DeKalb County Superior Court Judge James H. Weeks, also enjoins Mr. Teale and his companies—including TRT Associates Inc. and Fenmar International Insurance Services Ltd.—from transacting any business pending further order of the court.

Judge Weeks' order follows a Nov. 23 order by another state judge placing Victoria Insurance Co. Ltd. in temporary receivership.

The Georgia Insurance Department, which suspended Victoria's license in September after discovering that most of its assets were not in the state, asked that Victoria be placed in temporary receivership after finding that the insurer had only $41,815.17 in a bank account, and that its premium and claims records were inadequate (*BI*, Oct. 3).

TRT, Fenmar and Mr. Teale, a former Victoria executive vp, have acted as underwriting managers for Victoria despite their failure to obtain Insurance Department approval as required by state law, the Georgia department alleges (*BI*, Oct. 10).

Deputy Insurance Commissioner Hugh Edenfield says the Victoria receivership order—set to expire after 30 days—might still be lifted if the insurer's proposed new owner, Isle of Man-based Aram Investment Co. Ltd., follows through on its announced plan to transfer several million dollars in assets to a Georgia bank.

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Photo: AP/Wide World

Tornado damage

K mart will call on its coverage from Protection Mutual Insurance Co. to pay damages at its Raleigh, N.C., store, which was destroyed by a tornado last week. Raleigh officials said 10 businesses were destroyed and damage to all commercial and residential property is estimated at $75 million. See page 3.

Minet sues 102 E&O insurers to pay for PCW settlements
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Update

Liability awards skewed: ISO

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represent 76% of the total compensation paid by insurers, says the study released last week.

The study of 13,316 claims files of 24 major insurers, "Claims File Data Analysis," also found that:

- Claimants' awards or settlements for non-economic damages on average are more than three or four times their economic damages.
- About 40% of the time, a policyholder's percentage of settlement exceeds his percentage of fault. Government entities and municipalities are more likely than other policyholders to make settlement payments that exceed their percentage of fault.
- Less than 10% of claimants receive settlements or court awards reduced by collateral sources of recovery, such as workers compensation benefits. Reducing settlements or court awards by collateral sources of recovery reduces insurers' costs by 20% to 28%.
- Settlements of cases seeking punitive damages are 60% to 150% higher than settlements in cases not seeking punitive damages.

"Meaningful tort reform may reduce the number and dollar value of insurance losses," ISO Chairman Fred R. Marcon said.

A study conducted by ISO last year, which evaluated the impact of tort reforms on six specific but hypothetical claims files, reached a similar conclusion (*BI*, May 11, 1987).

Three Robins trustees removed

RICHMOND, Va.—Three of the five trustees administering a trust fund set up to pay women injured by the Dalkon Shield intrauterine device manufactured by A.H. Robins Co. were removed last week by U.S. District Court Judge Robert R. Merhige Jr.

The judge said trustees Barbara Blum, Gene Locks and Ann Samani resisted court supervision of the trust fund and failed to organize a plan for distributing the $2.4 million in the fund.

The trust fund today began offering those women who suffered only minimal injury from the Dalkon Shield out-of-court settlements of $725 each. Claimants slightly injured by someone else's use of the Dalkon Shield, such as children of IUD-users or husbands who filed claims for emotional distress or physical injury, are eligible for $300 settlements. And, claimants whose records reflect conflicting evidence of Dalkon Shield use or injury can receive $125 settlements.

This is the first time Robins has offered these types of settlements since the company's reorganization plan was approved on July 26.

Robins filed for bankruptcy under Chapter 11 of the U.S. Bankruptcy Act in 1982 due to IUD claims.

Report accuses 20 in JAL crash

SEATTLE—Four unnamed Boeing Co. employees are among 20 people Japanese police say should be charged with criminal negligence in connection with the 1985 Japan Air Lines crash that killed 520 of 524 people aboard, press reports say.

A Boeing spokeswoman said the company was aware of the reports but could not provide any further information.

The Gumma Prefectorial Police also are targeting 16 Japanese citizens—12 JAL employees and four officials from the Japanese Ministry of Transport—"as being responsible for contributing to the cause of the accident," a JAL spokesman said. However, he had no information about specific charges.

The crash of the JAL Boeing 747 is the worst single aviation loss in history (*BI*, Aug. 19, 1985). Underwriters have estimated the final liability cost could exceed $345 million (*BI*, June 8, 1987).

The Japanese Ministry of Transport reported in June 1988 that the disaster was caused when the bulkhead gave way, causing pressurized air to blow off the airplane's tail. The ministry report also found that Boeing personnel had improperly repaired the plane, while JAL and ministry personnel inadequately inspected it.

Boeing and its aviation product liability underwriters have agreed to pay 82.5% of the compensation to survivors and relatives of those who died, while JAL's liability underwriters agreed to pay the other 17.5%.

Boeing's $1 billion in aviation product liability coverage is written by a group of London, U.S. and French underwriters. JAL's hull and liability coverage is underwritten by Tokio Fire & Marine Insurance Co. Ltd. on behalf of the Japanese Aviation Pool.

Travelers must pay on surety

NEW YORK—Travelers Indemnity Co. plans to appeal a U.S. District Court finding that Travelers must pay a contractor more than $3 million in compensatory and punitive damages because the insurer breached the terms of a surety bond and acted in bad faith by refusing to pay the contractor's claim.

The Nov. 28 award to Granite Computer Leasing Corp. involves Travelers' 1973 surety contract with National Modular Systems, a subcontractor for Community Science Technology Inc. The surety bond named Community—a predecessor firm to Granite—as an obligee.

Community, which had a government contract to manufacture and install modular housing units at several Air Force bases, subcontracted to National Modular Systems, which encountered financial difficulties. Travelers refused to provide the relief to National Modular and Community provided the funding and then filed suit against Travelers to recoup its outlay.

Travelers acted in bad faith by following a claims manual clause called the "do nothing" plan, according to Lauren Wachtler, an attorney with Shea & Gould in New York, who represented the plaintiff. The plan called for Travelers to deny legitimate claims when it deems the cost of litigation over the claim would be less costly than paying the claim itself, according to Ms. Wachtler.

Travelers argued that it denied the claim because Community was late in paying amounts it owed to National Modular Systems, causing the subcontractor's financial problems.

Jim Reidy, an attorney with the New York law firm of Greenberg, Cantor, Trager & Toplitz, which defended Travelers, said his firm would appeal the decision to the 2nd U.S. Circuit Court of Appeals.

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Minet sues E&O insurers over PCW-related losses

By STACY SHAPIRO

LONDON—Lloyd's of London brokerage group Minet Holdings P.L.C. is suing 102 of its professional liability insurers over losses at Lloyd's syndicates formerly managed by PCW Underwriting Agencies Ltd., a now-defunct Minet affiliate.

Minet is seeking to recover as much as 40 million pounds ($73.6 million) in PCW-related losses from the defendant insurers, which include syndicates managed by many leading figures in the London market, including Lloyd's Chairman Murray Lawrence.

The funds Minet seeks to recover represent money paid by the broker to PCW syndicate members to settle disputes between the members and Minet, Lloyd's and other parties.

More than 39 million pounds ($71.8 million) of PCW syndicate assets allegedly were funneled to reinsurers controlled by PCW officials. In addition, syndicate members faced an estimated 235 million pounds ($432.4 million) of underwriting losses on business written by PCW before the members agreed to a 1987 settlement with Lloyd's, Minet and 36 other organizations.

The one-page lawsuit—not including eight pages listing the defendants—asks the British High Court to confirm that a May 1982 professional liability insurance agreement made with the defendants is "valid and in full force." Minet and subsidiary J.H. Minet & Co. Ltd. also seek damages for breach of the insurance agreement.

The suit does not mention PCW by name, but Minet Chairman Ray Pettitt confirmed that the litigation results from Minet's long-running dispute with its professional liability insurers over coverage for Minet's share of the PCW-related losses.

While Mr. Pettitt will not comment on the amount that Minet seeks to recover from the insurers, which is not disclosed in the suit, he has said in past interviews that the company's total cost from the PCW affair is between 30 million pounds and 40 million pounds (between $55.2 million and $73.6 million) (*BI*, June 20).

The lawsuit, which was filed Oct. 28, was prepared as a "protective" measure because the statute of limitations will soon expire, Mr. Pettitt explained. The suit so far has not been served to any of the defendants.

"We can't get into the detail of the negotiations (because) they are confidential and delicate," he said.

Mr. Lawrence said last week he was aware of the litigation but did not know the details of the dispute.

However, Lloyd's Junior Deputy Chairman Alan Parry said that Minet had informed him of the litigation recently because it involved a legal dispute within the Lloyd's market. He said Minet told him that it was just a "protective" measure while negotiations continued.

"I can't believe they won't reach a settlement" be-

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Pollution exclusion bars cleanup recovery: Court

By STACY ADLER

MINEOLA, N.Y.—The pollution exclusion bars a policyholder that purchased a polluted piece of land from recovering the costs of cleaning the site under its general liability policy, an intermediate New York appellate court has ruled.

The decision marks one of the first pollution exclusion rulings involving a policyholder not responsible for the pollution, according to attorneys.

And, the decision further intensifies the split among New York courts interpreting the pollution exclusion, they say.

Powers Chemco Inc. of Glen Cove, N.Y., says it will seek to appeal the ruling that it is not insured for a multimillion-dollar cleanup of a hazardous waste site at its headquarters.

Powers Chemco, a photographic supplies manufacturer, purchased property in Glen Cove, N.Y., on Dec. 1, 1978, unaware that it had hazardous wastes buried in it.

After discovering the buried wastes, Powers Chemco entered into an interim consent decree with the New York State Department of Environmental Conservation under which Powers Chemco agreed to clean the site.

Powers Chemco then filed a claim in 1984 with Federal Insurance Co. of Warren, N.J., its comprehensive general liability insurer since 1977, to recover the costs of the cleanup. The cleanup costs are expected to exceed $1 million.

But on Feb. 22, 1985, Federal Insurance denied the Powers Chemco claim on the basis of the pollution exclusion, which bars coverage for all types of pollution unless it is "sudden and accidental."

Powers Chemco then sued Federal Insurance in Nassau County Supreme Court arguing that the exclusion did not apply because it was not the actual polluter of the site.

Trial court Judge James J. Brucia ruled that Powers Chemco was entitled to coverage for the hazardous waste cleanup because the pollution exclusion only applies to actual polluters.

However, the appellate court, overturning the lower court ruling, said: "The clear and unambiguous language of the pollution exclusion makes no exception for pollution caused by someone other than the insured where that pollution is not 'sudden and accidental.' "

To make an exception for policyholders not responsible for the pollution would distort the meaning of the insurance policy, according to the five-member panel of New York's 2nd Judicial Department, an intermediate appellate court.

Powers Chemco attorney Judith Roth said the court's ruling was "extreme" because the policyholder was neither a generator, transporter nor the owner of a hazardous waste treatment plant.

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Don't delay liquidations, regulators told

By DEBORAH SHALOWITZ

WASHINGTON—State insurance regulators need to pull failing insurers from the marketplace more promptly to minimize the harm insurer insolvencies cause and to stabilize the market, says a report by an insurance consultant.

But regulators—acting like doctors trying to heal the sick rather than like police officers looking after the public good—delay liquidations, which compounds the insurer insolvency problem, one of the report's authors asserted.

However, regulators counter that caution is necessary when declaring a company insolvent and, when circumstances warrant, their actions indeed are quick.

The report, "Managing Insurer Insolvency," was prepared by New York-based insurance consultant Stewart Economics Inc. for the National Assn. of Insurance Brokers. It was released at a press conference in Washington last week.

The report recommends several ways to improve regulation of the property/casualty insurance industry, including: giving regulators more information about insurers; improving financial information and analysis of insurers; and increasing the power of state regulators.

However, the most important goal is for state regulators to change their attitudes about insurer insolvencies, said Richard E. Stewart, chairman of Stewart Economics and a former New York insurance superintendent.

'The regulator feels that an insolvency is a failure of regulation,' but that is not true, Mr. Stewart says. 'It is no matter of shame or embarrassment' to take failing companies out of the market.

"The regulator feels that an insolvency is a failure of regulation," but that is not true, Mr. Stewart said. "It is no matter of shame or embarrassment" to take failing companies out of the market.

"Because the regulatory agencies have inherited the idea that their main duty is to keep insolvencies from happening, they see rescue as the preferred course of action or inaction when a company gets in trouble," the report states.

However, when regulators delay action, the situation worsens, Mr. Stewart said. Furthermore, "now we're in the world of the potential billion-dollar insolvency," he warned.

"The usual effect is to let the company continue selling policies to the unsuspecting, paying claims in preferential order and digging itself deeper into the hole," the report explains. "Delaying insolvency by looking away or helping or just failing to take action is thus likely to make the loss—when eventually it has to be faced—worse than it would have been if acted upon earlier."

However, John Washburn, director of the Illinois Insurance Department and president of the National Assn. of Insurance Commissioners, said moving more quickly to close foundering insurance companies "may be theoretically better but may not be possible."

"An insurance company is a complex financial entity" and discerning its true financial state is a lengthy process, he said. Usually "it's not a clear-cut case" of a company being completely out of cash, he explained.

Furthermore, regulators know that if they do declare an insurer insolvent, "that's the end" for the company, he continued. The finality of that decision "makes you more cautious."

Kevin Foley, deputy superintendent of the New York Insurance Department, agreed.

"These are often judgment calls," Mr. Foley said. When a foundering insurance company "shows a rational plan to recover, then I think we have an obligation to entertain that."

However, "if we find that a company can't meet its obliga-

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Reinsurers look with trepidation toward new year

By JUDY GREENWALD

While reinsurers expect their underwriting results to decline only slightly during the remainder of this year, most are looking ahead to 1989 with apprehension.

Reinsurers will see a "little bit of deterioration" in the fourth quarter because of rate erosion among primary insurers, said James M. Dwane, president of Prudential Reinsurance Corp. in Newark, N.J.

However, "I look at '89 as a very competitive and mediocre year from an earnings standpoint," he said.

"I think the fourth quarter is probably going to be pretty much the same as the first nine months of the year, but I think '89 is going to have a continuing fall-off in the volume and that we're going to see results that are considerably worse in terms of composite ratios," summed up William G. Clark, president and chief executive officer of Stamford, Conn.-based Transamerica Reinsurance Co.

Reinsurance company executives say that while competition among reinsurers may have increased this year, it still is not the major impetus behind the softening primary property/casualty market.

"The reinsurers, I think, are still competing on a pretty responsible basis," said Paul Inderbitzen, senior vp for American Re-Insurance Co. in Princeton, N.J. "The biggest impact as far as reinsurer volume is concerned is increased retentions and underlying pricing by primary companies."

"I think most people feel that the primary companies are still the root cause of the problem," said Steve Bensinger, senior vp and chief financial officer of Skandia America Reinsurance Corp. in New York.

"Certainly whatever deterioration is going on in the marketplace is not being led by reinsurers," agreed N. David Thompson, presi-

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Defunct reinsurance pool triggers flurry of litigation

By STACY SHAPIRO

LONDON—A defunct reinsurance underwriting pool formerly managed by Accolade Underwriting Agency Ltd. is the focus of scores of lawsuits filed by pool members and ceding companies in Britain's High Court of Justice.

The former members of the Accolade pool are suing the pool's retrocessionaires to recover a portion of the retrocessional claims the members claim they are owed.

Between March and October, the eight reinsurance pool members led by Overseas Union Insurance Co. Ltd. of Singapore filed 27 lawsuits in British High Court seeking more than $6 million from the pool's retrocessionaires.

Altogether, through litigation and negotiations, the reinsurance pool members are trying to recover $30 million in unpaid claims from retrocessionaires, according to Tim Oliver, chairman of Market Run-Off Services Ltd., which is managing the runoff of the Accolade pool.

Overseas Union also has asked the court to declare that Overseas Union is not liable to pay claims under certain reinsurance contracts ceded to the pool because Accolade had no authority to bind the pool members to those contracts (see story, page 39).

Meanwhile, at least 60 ceding companies have filed suit in the High Court demanding that Accolade pool members, particularly Overseas Union, honor unpaid claims. The ceding insurers, which did not specify the amount of claims they believe they are owed, cite scores of policies on which Overseas Union, as a member of Accolade, has not paid claims.

The flurry of legal activity revolving around the Accolade pool comes about six years after Accolade allegedly stopped writing on behalf of the pool members. It

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Stores' twister losses insured

By MICHAEL BRADFORD

RALEIGH, N.C.—Insurance will cover the bulk of the damage sustained by two retail businesses devastated by tornadoes last week.

Twisters that tore through the Town Ridge Shopping Center in Raleigh destroyed a K mart department store and inflicted heavy damage to a Radio Shack Computer Center, according to Carolyn Carter, assistant city manager for the northern North Carolina city.

The storms killed four people in North Carolina and injured about 150 others.

Ms. Carter estimated damages to commercial property in Raleigh at $6 million and residential property damages at about $69 million.

An official for American Insurance Services Group Inc. in New York said an official estimate of insured damage would not be available until this week.

Ms. Carter could not provide specific figures on the K mart loss, but she said it was the largest business to be destroyed or damaged by the tornadoes that swept through the area. In all, 10 businesses were destroyed and 11 others were heavily damaged, she reported.

Jack Berry, risk manager for K mart Corp. in Troy, Mich., said last week that damage to the store was fully insured.

Park Ridge, Ill.-based Protection Mutual Insurance Co., a member of the Factory Mutual System, insured the building and contents and provided business interruption coverage, said a Protection Mutual spokesman. He could not give details of the coverage or an estimate of the damage, but said "it was

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HMO membership growth slows: Study

By ALISON KITTRELL

Growth in health maintenance organization membership has slowed as HMOs seek to improve their financial health and employers increasingly turn to more flexible managed care and self-insurance plans, according to a recent survey.

Total HMO membership grew 1.4% to 32.5 million members nationwide in the second quarter of 1988 from 32 million members in the first quarter, according to a report released by InterStudy, an Excelsior, Minn.-based HMO research organization.

Traditional, or pure, HMOs added only 350,606 members during the second quarter of 1988, a growth of only 1.1% from the first quarter.

However, InterStudy notes that, "Enrollment tends to surge during the first quarter, when most employers have open enrollment periods. Historically, enrollment growth during the remainder of the year has been much smaller.

"However, second quarter growth in 1988 was much smaller than the same period last year, when HMOs added 800,000 members," or a 3% increase from the first quarter of 1987, the authors said.

Pure HMOs now have 31.4 million members nationwide.

Growth in open-ended HMOs also has slowed, despite the surge seen in previous Interstudy surveys (*BI*, Oct. 10; June 13).

In open-ended HMOs, members have two or sometimes three choices of providers from whom they can receive services, although usually coverage for care received from other providers is less comprehensive than care received from providers within the HMO.

Open-ended HMOs added 5,570 members in the second quarter of 1988 to bring total enrollment to 482,358 people.

"The growth of 1.2% was slower than expected," the survey authors note.

The one bright spot for HMO growth was in Prudential Plus, an HMO product virtually identical to an open-ended HMO that was introduced in 1987 by Prudential Health

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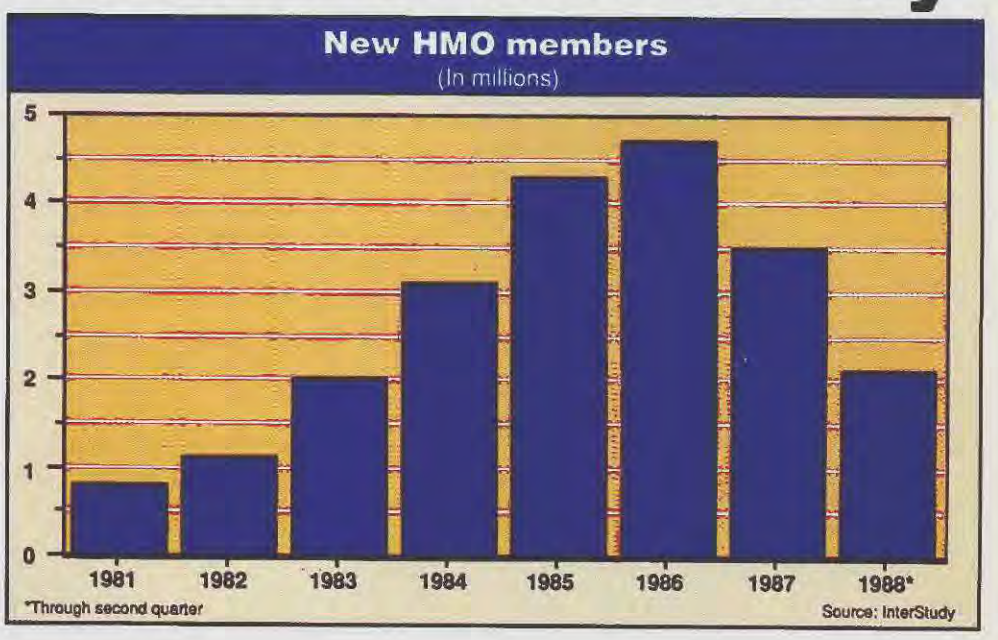

Proposition 103

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strike down Proposition 103 as unconstitutional because of a provision permitting premium tax rate increases.

And, in a letter to the court last week, state Insurance Commissioner Roxani Gillespie and Gov. George Deukmejian urged the court to continue the stay and the justices to rule promptly on the law's constitutionality, though the letter did not take sides on the constitutionality issue.

State Attorney General John Van de Kamp—who has asked the court to lift the stay and has said he would "vigorously defend" Proposition 103 against challenges—last week expanded his attack on the insurance industry. Mr. Van de Kamp said he would prosecute insurers and company executives under the state's antitrust laws if he finds evidence they conspired to deny coverage after the voters' approval of the new law.

Proposition 103's backers, meanwhile, also are urging the court to lift the stay and uphold the proposition, saying insurers are "inventing" problems with the law.

The court has not announced any further ruling about the stay or whether it will rule on the constitutionality of Proposition 103.

Proposition 103, approved Nov. 8 by 51.1% of the electorate, requires insurers to roll back most property/casualty insurance "charges" to 20% lower than in November 1987 and mandates "good driver" discounts on auto policies after Nov. 8, 1989. The rollback would be effective for one year. Workers compensation, marine insurance and reinsurance are exempt from the new law.

After Nov. 8, 1989, insurers would have to provide financial justification for future rate increases and receive prior approval from the Insurance Department for rate hikes.

The new law also requires that the insurance commissioner be elected instead of appointed and subjects insurers in the state to all state antitrust laws. As a result, the Insurance Services Office Inc. has suspended some services in California (*BI,* Oct. 31). The law also allows state-chartered banks to sell insurance.

A group of insurers, as well as the Assn. of California Insurance Cos. and ISO, which jointly filed suit to block Proposition 103, urged in court filings quick court action in the public's best interests.

The group—which includes Fireman's Fund, Allstate, Farmers, State Farm Insurance Cos. and CalFarm Insurance Co.—also argued in their response that:

- Many insurers have issued new policies or have renewed auto policies that may become "perpetual" under the initiative.

If the court lifts the stay against provisions of the proposition that prohibit insurers from canceling or failing to renew auto policies, insurers may have "no choice but to try to disengage from these policies," the group says.

- If the court lifts even part of the stay while it reviews the proposition and then strikes down the law, the court may "unfairly whipsaw all Californians, insurers and insureds alike."
- If the court decides not to rule on the constitutionality of Proposition 103, the approximately 700 property/casualty insurers in California would be forced to file separate actions in various superior courts or seek rate relief from the insurance commissioner.
- Proposition 103's proponents are trying to re-define a provision of the law that allows insurers to seek relief from the new law's insurance "charge" rollback provisions if insurers can show that compliance would substantially threaten their solvency.

Proposition 103 supporters now say insurers are entitled to "a just and reasonable return" on investment, without dealing with the insolvency issue raised by their own initiative, the insurers say.

- If the court upholds the law, the Insurance Department could not provide rate relief to insurers threatened by insolvency quickly enough to prevent the insurers from becoming insolvent.

In a separate action, the Health Insurance Assn. of America and the American Council of Life Insurance also have urged the state Supreme Court to strike down Proposition 103.

In a brief filed last month, the HIAA and ACLI argue that a provision of the new law that allows the state Board of Equalization to levy a higher premium tax rate to recover revenue lost by lower property/casualty premiums would penalize health and life insurers in the state, said Terry Sorota, HIAA counsel.

The property/casualty insurers and ISO argued in a lawsuit jointly filed shortly after the election to block enactment of the law that this provision is unconstitutional because only the Legislature is permitted to set and raise taxes (*BI,* Nov. 21).

The HIAA and ACLI also charge that Proposition 103 violates state law by dealing with more than one subject in the same initiative.

In their letter to the court last week, Ms. Gillespie and Gov. Deukmejian urged the court not to lift the stay on the new law while it considers the constitutionality of the law.

"Such a brief delay in implementing Proposition 103 should not be injurious to consumers," said the letter, which was signed by Vance Raye, the governor's legal affairs secretary and presented in the names of Gov. Deukmejian and Ms. Gillespie.

However, Attorney General Van de Kamp argues that the stay should be lifted. And, noting last week that as many as 67 insurers announced immediately after the election that they would withdraw entirely or stop writing some property/casualty insurance in the state as a result of the new law, he threatened to prosecute insurers under the state's antitrust statutes if it is found the insurers are conspiring in these actions.

"The timing and the circumstances of these actions suggest the possibility of a concerted effort to force the courts or the Legislature to repeal Proposition 103," Mr. Van de Kamp said.

Meanwhile, Proposition 103 proponents—including the Voter Revolt to Cut Insurance Rates, the group that sponsored the proposition; Harvey Rosenfield, group chairman; and consumer advocate Ralph Nader—urged the court in their filings to put Proposition 103 in full force.

"The people have spoken. Now, predictably, those who lost the election are looking for and, where necessary, inventing potential problems with Proposition 103 in an effort to persuade this court that they are being persecuted by Proposition 103," the proponents' response says.

At the least, the stay on the insurance "charge" rollback provisions should be lifted, the supporters argue. "Any company whose capital is threatened by the 20% rollback is permitted to avoid that result by the exemption," they say.

Proposition 103 proponents say in their briefs, filed Nov. 22, that:

- The insurance commissioner can provide adequate and quick relief for insurers threatened with insolvency because of the law.
- The other provisions of the proposition do not present "a threat of irreparable injury" to insurers. Thus, the court should lift the stay on those provisions at once. ■

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At issue

Do you favor federal regulation of the insurance industry?

Michael Zuckerman
Director-risk management/ insurance
Thomas Jefferson University, Philadelphia

No. I don't believe in substituting one bureaucracy for another. But I think the states could do a better job, especially in the area of analyzing financial conditions of companies.

George Blackall
Manager-risk management/ brokerage
G.E. Capital Corp., Stamford, Conn.

Yes, provided it is a complete and total substitution for all state regulations. Although using the words federal government and simplicity in the same sentence is an oxymoron, I think it would simplify the regulatory situation.

Lucille Gallagher
Vp-risk management
Monfort Inc., Greeley, Colo.

It's a Catch-22 situation, but I would still say no. The states should maintain the right to regulate insurance companies. However, it is difficult to regulate foreign insurers in any setting, federal or state.

Compiled by Christine Woolsey

Benefit beat

Health clinic grows into 'family doctor' for airline employees

By GLENN HUNTLEY

A health clinic that began as a small, off-site center for pre-employment physicals and on-the-job injury care is now open to treat minor illnesses and provide wellness programs for employees at Tempe, Ariz.-based America West Airlines Inc.

Employees pay $8 per visit, and America West, which self-insures its employee health care benefits, pays the balance.

"In addition to a complete benefits program, the new medical facility enables us to offer our employees the added comfort that comes with accessible and affordable health care," said Michael J. Conway, president and chief operating officer of the airline.

The company's health plan, which includes a $100 deductible for individual and $300 for family coverage, is administered by Bloomfield, Conn.-based Connecticut General Life Insurance Co.

The facility even is capable of serving as the "family doctor" for employees, Mr. Conway said.

The center is owned jointly by America West and PMH Health Resources Inc., the parent company of Phoenix Memorial Hospital.

Among the health services available to employees at the facility are stop-smoking and flu shot programs, gynecologic care, an in-house pharmacy and referrals to other medical providers.

While the program was not intended to replace care covered by the airline's indemnity health care plan, it has already had "a positive effect" on costs, according to Alan R. Koehler, senior director of health resources.

For example, when the airline referred its pre-employment screening and on-the-job injury cases to outside providers, it spent about $23,000 to $24,000 a month, he said. But the center already has nearly paid for itself by providing pre-employment drug testing, which can cost up to $40 for each positive result, and offering first response to on-the-job injuries.

"We're getting awfully close to a break-even amount," he said.

America West, which operates regionally out of the Phoenix Sky Harbor International Airport, had started a medical center in downtown Phoenix a year ago. The intent was to take care of on-the-job injuries and to process pre-employment drug tests and physicals.

The company outgrew the 1,000-square-foot medical center it opened in December 1987, and this November spent about $100,000 to remodel a building adjacent to the Phoenix airport so the center could be relocated near many of the airline's 6,000 employees, a spokesman explained.

The center now has 2,600 square feet of space and a staff of seven, including a full-time physician and two part-time doctors, who provide a variety of services.

The medical facility is open from 7:30 a.m. to 4 p.m. daily.

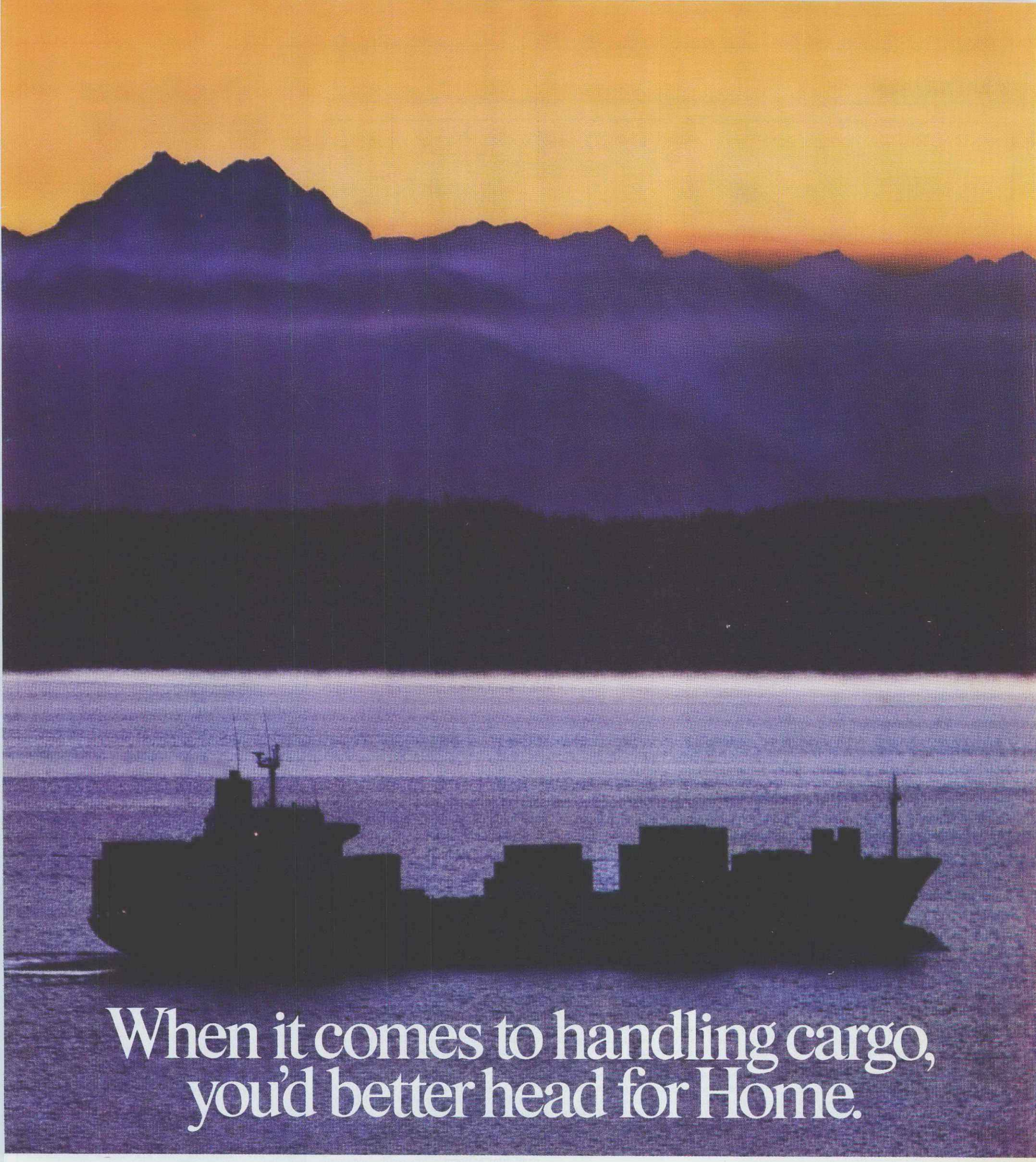
"The response has been excellent. We're already seeing over 40 employees each day," said Dr. Terry Lowry, the facility's medical director.

America West also is emphasizing preventive care, such as weight control programs, at the facility.

While the potential savings from the preventive care program cannot be calculated yet, the airline expects the program will help reduce future medical claims, Mr. Koehler said.

•

Benefit beat keeps insurance and employee benefit managers informed on what other companies are doing and of current developments in the employee benefit field. We'd like to know if you've made any changes. Write Glenn Huntley, Business Insurance, 6404 Wilshire Blvd., Los Angeles, Calif. 90048, 213-651-3710.



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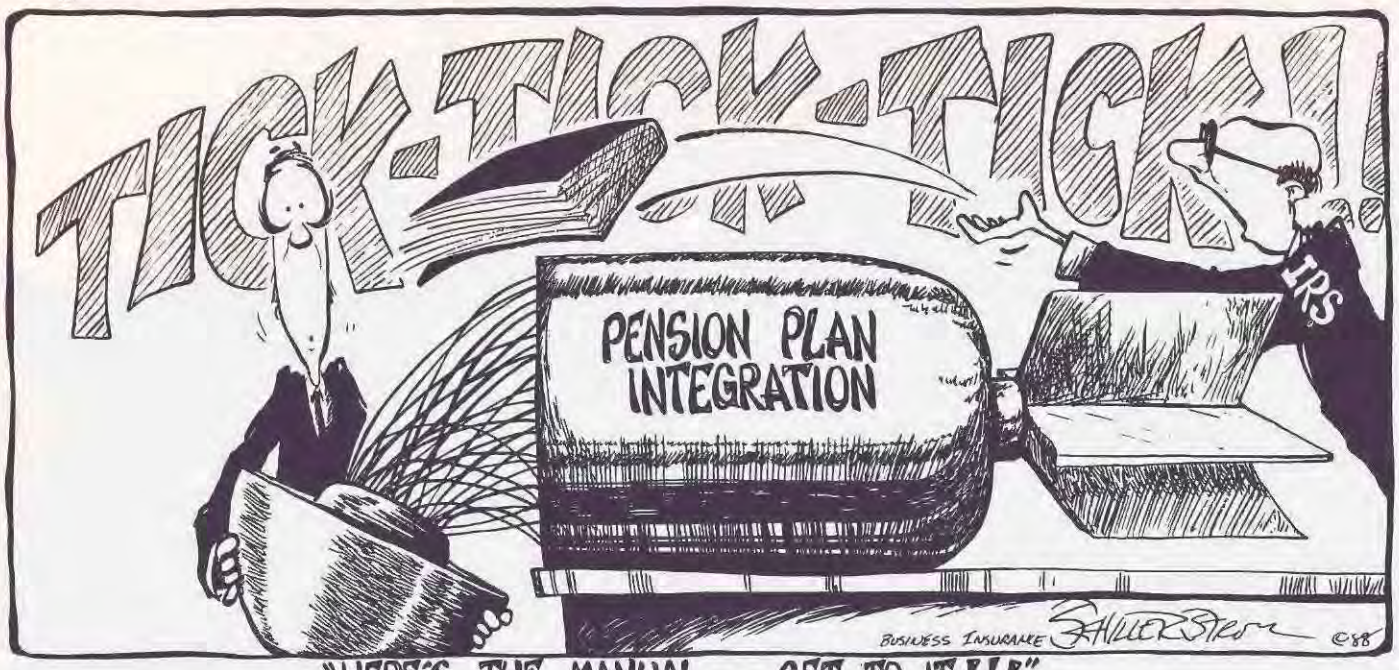

"HERE'S THE MANUAL....GET TO IT!!!"

Employers under the gun

IT ISN'T REASONABLE TO expect employers to completely redesign their pension plans in six weeks to comply with new, complex pension integration rules.

And, it borders on the outrageous to expect compliance when the complete set of rules has not yet been published.

Yet, that is what employers are being asked to do—unless the Internal Revenue Service grants some last-minute relief.

Under the Tax Reform Act of 1986, the IRS was ordered by Congress to develop regulations to aid employers in complying with the new, tougher integration provisions included in the 1986 tax law. Legislators overhauled integration—under which employers can reduce pension benefits by a portion of Social Security benefits received by a retiree—because they believed benefit cutbacks were hurting low-wage earners.

Congress recognized, though, that employers would need time to come up with new benefit formulas so that their pension plans would mesh smoothly with Social Security under the new integration provisions. As a result, Congress mandated that the IRS publish rules by Feb. 1, 1988.

That would have given companies 10 months to make the necessary changes to their pension plans before the provision was set to take effect on Jan. 1, 1989.

But it was only last month that the IRS published integration rules—and incomplete rules at that. Still to be published are IRS general pension nondiscrimination rules, which also could affect pension plan design.

Without relief from the IRS, employers will be in an untenable position. They must change their plan design, but lack enough information to make the proper changes.

While the IRS lacks the authority to change the Jan. 1 effective date of the integration provisions, it could—and should—allow employers to adopt temporary benefit accrual formulas with the right to make retroactive changes once the complete set of pension regulations are published.

Letters

Burlington Industries succeeded in appeal

To the editor: With respect to the Legal Brief article, "Samaritan's Death Compensable" (*BI*, Nov. 14), perhaps readers would like to know that Burlington Industries Inc. appealed this decision to award workers compensation benefits and won.

Gerald F. McCabe
Property/Casualty Manager
Corporate Risk Management
Burlington Industries Inc.
Greensboro, N.C.

■ *The case involved a Burlington Industries employee who was killed when he stopped his car to assist at the scene of an accident. The employee at the time was returning from a business trip.*

As reported in the Nov. 14 issue, the widow of the employee filed for workers compensation benefits, which were denied.

But, the Court of Appeals of North Carolina in June 1977 awarded death benefits, concluding that the employee's humanitarian efforts while driving home from work benefited his employer by increasing Burlington's "goodwill."

However, the North Carolina Supreme Court in February 1988 reversed the lower court opinion and again denied benefits. The court stated: "The record here contains no evidence that anyone other than the decedent invoked in the events surrounding his accidental death had any connection to Burlington.

"So far as this record reveals, decedent acted solely for the benefit of a third party. We thus hold that his death did not arise out of the employment," the court stated.

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

Policy form changes adopted too quickly

To the editor: In following the various *Business Insurance* articles regarding the Insurance Services Office Inc.'s proposed commercial general liability policy form modifications, I find that the really frightening aspect of the entire story is the fact that 31 state regulators have already caved-in and approved an "absolute" pollution exclusion and 22 regulators have also approved the three remaining exclusions.

It would seem to me that much like the National Assn. of Insurance Commissioners' "watch list," brokers and buyers should know which regulators routinely roll over for every ISO proposal. Why is it up to the Risk & Insurance Management Society Inc. and a handful of bright, well-informed attorneys to keep ISO in check?

It is absolutely astounding that any regulator would promptly approve an exclusion that strips away *all* pollution coverage, including that which is more properly a products/completed operations exposure.

For many firms, such an exclusion would render their product liability coverage illusory (vapor coverage).

I would be curious to know whether ISO has any supporting loss data to demonstrate just how onerous each of these particular exposures has really been and what type of credit a policyholder might expect in return for the reduced coverage.

It is interesting to note that the insurance industry was able to afford a $60 million-plus tab to protect its turf in the fight over Proposition 103 in California but has a problem with things like host liquor liability.

I believe that if we left the decisions up to ISO, they would emasculate the CGL form to the point that all that would be left is coverage for slips and falls—unless, of course, you just happened to slip on a pollutant.

James W. Capell
President
Capell Industrial Risk Management Inc.
Princeton, N.J.

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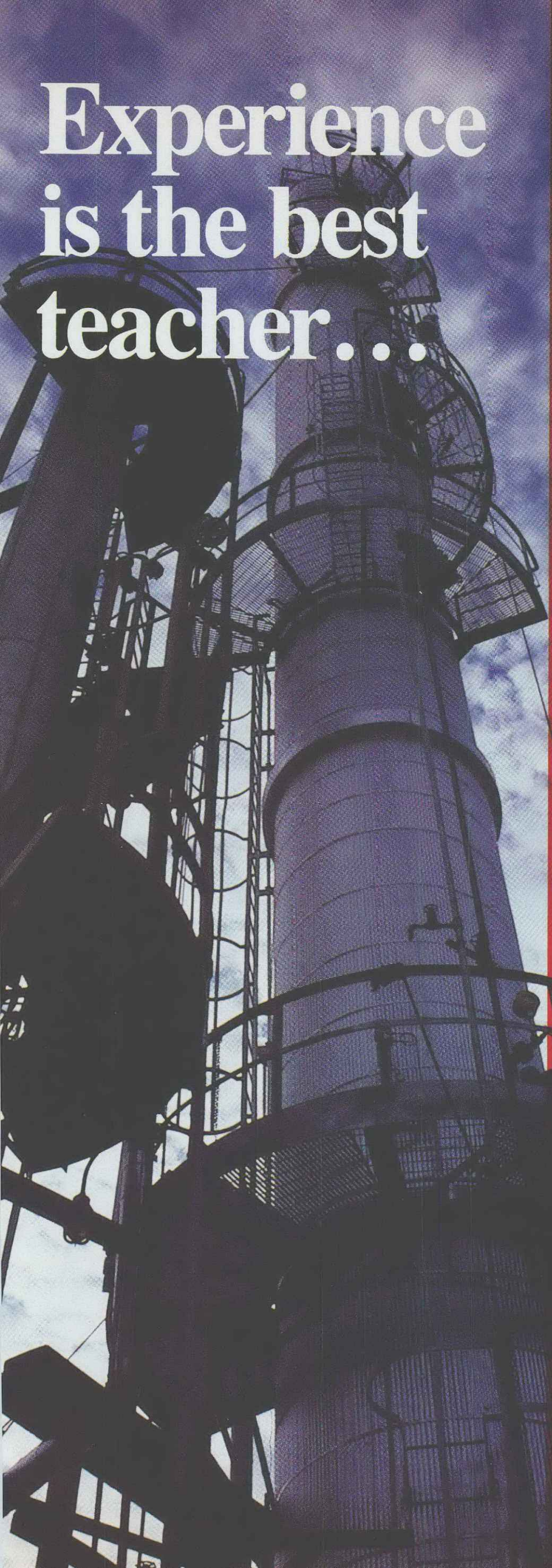

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Insolvencies

Continued from page 3

tions, we move fairly quickly," he stated.

"That decision is never made lightly," Mr. Foley added. Fewer "companies (in the marketplace) means less competition and that's never a good thing."

However, according to the report, too much competition is one of the reasons behind the growing problem of insurer insolvencies.

"The insolvency problem is worse now, and threatens to get even worse in the future, for two big reasons," the report states. "The first is the importance and difficulty of liability insurance. The second is chronic overcapacity and price competition."

Barbara Stewart, president of Stewart Economics, explained that it is standard economic theory that participants in an overcrowded marketplace will compete on price alone—driving prices down to levels that, in many cases, are lower than they should be.

Furthermore, liability insurance is particularly difficult to manage for several reasons, she said.

First, the time lag between the collection of premiums and the payment of losses makes pricing extremely difficult, she explained.

Second, costs are rising in liability insurance "due to changing tort law," she continued.

Third, liability insurance has a potential for catastrophic losses, such as asbestos, product liability and pollution incidents.

And fourth, buyers increasingly are self-insuring more predictable, easier risks and are buying commercial insurance for the more difficult ones, she said.

These problems with cutthroat competition and with liability insurance in general have contributed to the recent increase in insurer insolvencies, Ms. Stewart said.

If regulators would move more quickly to take failing insurers out of the market, "the better it is for the consumer," Ms. Stewart said.

"Eventually, it should bring more stability to insurance prices," she said. And, although in the short term prices might rise, in the long term they would decline because competition among healthy firms would resume and there would be a decrease in costs associated with insolvencies, such as guaranty fund assessments, she explained.

In addition to calling on regulators to change their attitudes about insolvencies and move more quickly, the report makes several recommendations to improve regulation of the industry, including:

- Giving regulators more information about the operations of insurance companies, including details about the delegation of key company functions, such as underwriting and claims, to outsiders, and the compensation involved; reinsurance terms; and the identity and compensation basis of those, both inside and outside the company, who set reserves.
- Improving financial information and analysis, such as lengthening the reported loss development periods and separating them by class and line; and improving analysis of the market value of fixed assets such as bonds, sinking fund preferred stocks and trade receivables like agents' balances.
- Requiring more discipline in preparing balance sheets, such as making explicit reserve discounting, reducing or disallowing credit for unrecoverable, doubtful or disputed reinsurance and showing contingent obligations, such as financial guarantees and investment commitments.
- Increasing the power of regulators to issue binding orders to cure capital impairments and to restore surplus to appropriate levels within fixed deadlines.
- Giving insurance regulators the responsibility for guaranty funds. Also, the report recommends that guaranty fund eligibility rules and coverage limits should be decided by state legislators and respected by courts.

Mr. Stewart noted that a move to national instead of state regulation of the insurance industry would not make a lot of difference. "The federal government would probably (regulate the industry) no better and no worse than the state regulators," he said.

The NAIB commissioned the report because of its concern about insurer insolvencies, according to an official of the trade group.

"We have viewed with concern the increasing number of insolvent insurers," said NAIB President Martin J. McFadden, a managing director in the Chicago office of Marsh & McLennan Inc.

According to a July 1987 report issued by the U.S. General Accounting Office, there were 142 insolvencies of property/casualty companies between 1969 and 1986 (*BI*, Aug. 3, 1987). Of these, 42% occurred since 1983, the GAO report stated.

'The insolvency problem. . .threatens to get even worse in the future,' the report states.

The NAIB plans to talk with regulators and others in the industry about the problem of insurer insolvencies and the study's recommended solutions.

"What's radical (in the report) is the solution to the problem" that is proposed—"asking insurance regulators to take companies out of the market sooner rather than later," said an NAIB spokeswoman.

According to the report, regulators delay terminating failing insurers for several reasons, among them:

- Regulators and the industry continue to look upon insolvency as a regulatory failure.
- The practice of delaying insolvencies began when the size of insolvencies rarely exceeded $1 million or $2 million, so the risk to the public and to the rest of the insurance business was small. However, this is no longer true.
- It is difficult to establish the true financial condition of an insurance company writing a lot of casualty business. A casualty company can be in much worse trouble than appears under routine scrutiny. Furthermore, if the problem is discovered much later than it should have been, it could be embarrassing to those who should have discovered the problem earlier.
- Insurance accounting fosters fuzzy decision-making by managements and regulators. For example, bonds may be carried at artificial values and yet the insurance commissioner may not be able to challenge those values for solvency valuation purposes.
- Since financial distress usually turns up at the end of price wars, there is a persistent thought that if the company is allowed to stay in business it can make enough profit in an imminent hard market to get well and bolster its reserves.
- The legal concept of insolvency is itself a problem. The statutory definitions are vague and unhelpful. The commissioner must go to court to take over a distressed company and court attitudes have not always been helpful or realistic.

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For a free copy of the study, "Managing Insurer Insolvency," contact the National Assn. of Insurance Brokers, 1401 New York Ave. N.W., Suite 720, Washington, D.C. 20005; 202-628-6700.

Louisiana tax loophole in jeopardy

By MICHAEL BRADFORD

BATON ROUGE, La.—The Louisiana Department of Economic Development is trying to close a loophole in state law that allows insurance companies to avoid paying premium taxes.

The law allows insurance companies doing business in Louisiana to take a 200% premium tax credit against amounts those companies invest in Louisiana venture capital companies, which loan money for the creation or expansion of businesses.

The 1984 law was introduced in order to boost the state's flagging economy by helping create jobs and businesses.

However, the Department of Economic Development, which must certify venture capital companies before they can accept insurance company investments, has stopped taking applications from such companies while it studies how to change or repeal the law.

'There are a great deal of insurance companies that have expressed an interest in taking advantage of this investment,' Louisiana's Mr. Lewis says. 'However, this administration is of the opinion that the law is too generous.'

Cornelius Lewis, assistant chief of staff of the Department of Economic Development in Baton Rouge, said: "We're looking at the ways and means we can use to change what we perceive as a flaw in state law."

Louisiana cannot afford to allow insurance companies such a generous tax credit, according to Mr. Lewis.

If every insurer took advantage of the ability to wipe out its tax liability, the state would lose about $120 million in premium taxes annually, according to the Insurance Department.

If the law is not removed or changed, "it would result in a substantial loss of revenue to the state fund and general fund," Mr. Lewis said.

"This law. . .is a problem we inherited," when Gov. Buddy Roemer took office earlier this year, Mr. Lewis remarked.

Although the law was passed in 1984, until this year no venture capital companies had qualified to receive insurance company investments.

Certified Capital Corp. and Louisiana Seed Capital Fund, both of Baton Rouge, were the only two venture capital companies certified to accept investments from insurers before the Department of Economic Development suspended the program last month.

"There are a great deal of insurance companies that have expressed an interest in taking advantage of this investment," Mr. Lewis noted.

"However, this administration is of the opinion that the law is too generous. Therefore, we will introduce remedial legislation to either repeal or amend the statute," he said.

Mr. Lewis did say he believes the concept of boosting venture capital in the state "has merit. . . .We will try and see if we can still provide some incentive for insurance companies to invest in venture capital companies."

Under the law, a venture capital company can receive up to $20 million from investors.

Mr. Lewis pointed out that while no single insurance company operating in the state is paying enough in premium taxes to make it worthwhile to invest that maximum, the 200% tax credit makes it possible for an insurer to wipe out its entire premium tax obligation by investing half its anticipated tax liability in a venture capital company.

Several dozen insurance companies have queried the Insurance Department about investing in the venture capital companies, said a spokesman for Insurance Commissioner Doug Green, but administration of the law is handled through the Economic Development Department and not the Insurance Department.

William Huff, senior vp and general counsel at Employers Casualty Co. in Dallas, said both of the venture capital companies certified to receive insurance company investments have approached his company.

"We still haven't sorted it out," said Mr. Huff. "We haven't invested yet, but we haven't decided anything."

Mr. Huff said Employers Casualty will continue to study the proposals and wait to see if Louisiana officials act to modify or repeal the law.

He added that the possibility of wiping out his company's premium tax liability in Louisiana is "pretty tempting."

Until the law can be changed or removed, insurance companies can legally invest in one of the two certified venture capital companies, Mr. Lewis pointed out.

"However," he added, "we would discourage an insurance company from doing this, in light of (the state's) current fiscal posture."

And, Mr. Lewis remarked, "At the same time, we discourage the (venture capital) companies that are certified from consummating any arrangements with insurance companies."

Robert Cunard Jr., president of Certified Capital Corp., said his company is continuing to talk with insurers about investing in the company.

Certified Capital is still in the process of capitalizing, he explained, and "we are negotiating investments with insurers." He would not say which insurers are interested in investing in his company.

"There are a lot of different ways to look at it," Mr. Cunard said. "We feel this program will spur the economy of the state."

He said the program has the ability to "double, if not triple, the tax base of the state by putting money back to work in the state's economy."

Kevin Couhig, president of Louisiana Seed Capital Fund, could not be reached to comment on his company's operation. ■

Asbestosis exclusion applies only to that disease: Court

By STACY ADLER

CHICAGO—An asbestosis exclusion in a liability insurance policy excludes coverage only for that disease and not for all types of asbestos-related diseases, a U.S. district court has ruled.

The court's ruling stems from a dispute between Chicago-based UNR Industries Inc. and its comprehensive general liability insurers over coverage for thousands of asbestos bodily injury claims filed against UNR.

In the earlier phase of the trial, the court found that UNR had no liability coverage prior to June 1958 to respond to the asbestos claims (*BI*, June 1, 1987).

In this most recent ruling, the court interpreted a 1977 comprehensive general liability policy written by Northbrook Insurance Co. of Northbrook, Ill., for UNR.

The Northbrook policy contains an asbestosis exclusion that stipulates: "In consideration of the premium charged it is agreed that coverage under this policy shall not apply in the case of any claims arising out of asbestosis."

Northbrook argued that the exclusion was meant to be construed broadly to exclude coverage for claims alleging all types of asbestos-related diseases.

UNR said the exclusion should be read plainly, to exclude coverage only for claims alleging asbestosis.

UNR, which filed for reorganization under Chapter 11 of the Federal Bankruptcy Act in 1982, stopped manufacturing asbestos-containing products in March 1970 (*BI*, Aug. 9, 1982).

Since then the company has been bombarded with thousands of asbestos bodily injury claims and, more recently, it has received hundreds of claims from the owners of buildings seeking to recover the costs of removing the asbestos (*BI*, April 25).

UNR says the exclusion should be read to exclude coverage only for asbestosis claims.

Some of the claimants who have filed bodily injury claims against UNR allege they have manifested asbestosis, which is a lung disease caused by the inhalation of asbestos.

Other claimants say they suffer from mesothelioma, a form of lung cancer resulting from exposure to asbestos.

The court ruled that the asbestosis exclusion contained in the Northbrook policy only excludes coverage for those claims filed against UNR where the claimants alleged asbestosis, but did not allege other asbestos-related diseases.

Judge William T. Hart of the U.S. District Court for the Northern District of Illinois Eastern Division said: "Before Northbrook issued its endorsement, the separate and distinct diseases associated with asbestos inhalation were recognized by judicial decisions, medical authorities and lay dictionaries.

"A sophisticated party such as an insurance company must be presumed to be aware of such distinction. Accordingly, the policy is clear on its face—only claims arising from asbestosis are excluded," Judge Hart added.

In addition, the court ruled that any excess insurers that follow the form of the Northbrook policy are bound by the court's ruling.

In its Nov. 8 ruling, the district court also made several other technical rulings interpreting UNR's excess liability policies, such as: Excess policy language precludes UNR from combining its payments under deductibles with insurance payments received from primary insurers to meet the amount of underlying insurance payments required to trigger an excess policy.

Attorneys for UNR and Northbrook could not be reached for comment.

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UNR Industries Inc. vs. Continental Insurance Co., et al.; U.S. District Court for the Northern District of Illinois Eastern Division, case number 85 C 3532.

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Reinsurance's role evolving: Center Re exec

By ROGER SCOTTON

HAMILTON, Bermuda—Reinsurance is becoming an "extremely sophisticated management tool," and reinsurance buyers must recognize and adjust to this change, a reinsurance executive says.

Reinsurance buying, "whether we like it or not," has permanently changed in purpose and complexity, said Steven M. Gluckstern, president and chief executive officer of Centre Reinsurance Holdings Ltd., a Bermuda-based company capitalized at $250 million earlier this year that specializes in writing "finite risk" reinsurance (*BI,* Oct. 31).

"No longer can a reinsurance buyer merely be concerned with transferring risk from his or her company to another,' Mr. Gluckstern told the second annual International Reinsurance Forum last month in Bermuda, co-sponsored by Hawksmere Ltd., a British conference and publishing company, and accountant Coopers & Lybrand.

'The financial analysis required goes far beyond listening to your broker as to which markets might be around in 10 years to pay claims and which won't,' warns Steven M. Gluckstern of Centre Re.

"Reinsurance rather must be viewed as an extremely sophisticated financial management tool, a tool which can and should accomplish many different ends," he continued. "I would contend that the transfer of risk is really a result and consequence of reinsurance, rather than its purpose."

Mr. Gluckstern said that although risk transfer is a component of any reinsurance transaction, the purpose of the transaction for a ceding company is to create economic and reporting stability.

"If a major insurance company. . .really could ignore the analysts and its shareholders would promise in advance to look at the company's results no sooner than 10 years from when they purchased the stock, I believe that the market for virtually all types of reinsurance—except that for extremely high-level catastrophes—would vanish completely," Mr. Gluckstern explained.

"It is this interaction of internal economic reality and the external perceptions of the capital markets that truly should motivate the reinsurance buyer of today," he said.

Reinsurance should be used both to protect the true economic position of a company and its reporting position in order to secure the company's relationship with capital markets, he said. "That is why the purchase of reinsurance must be viewed as a sophisticated tool in the management of financial position and not merely as a means of taking one's losses and moving them to someone else."

Mr. Gluckstern pointed out that the environment in which reinsurance buyers operate has changed since 1983.

One change involves the growth in the sheer volume of premium dollars flowing through the reinsurance system, which have more than doubled in the last five years, he pointed out.

Also, the economic position and financial sophistication of reinsurers has changed, with reinsurers becoming more profitable and writing very different business from five years ago.

Today, reinsurance buyers also need to consider the impact of taxes on their bottom lines, which Mr. Gluckstern said the industry once virtually could ignore. However, since the U.S. Tax Reform Act of 1986, "a reinsurance buyer who does not understand that his or her actions have a significant impact on a corporation's overall economic results after-tax is doing a serious disservice to his or her shareholders."

Mr. Gluckstern also noted "the increasing risk appetite of the ceding companies." The combination of higher net retentions and higher court awards "has never before been experienced by these companies and the burden for such risk management falls squarely on the reinsurance buyer."

Security also has emerged as a consideration for reinsurance buyers. Mr. Gluckstern said that this "new and well-founded concern" has added yet another required skill for reinsurance buyers. "The financial analysis required goes far beyond listening to your broker as to which markets might be around in 10 years to pay claims and which won't," he warned.

"And if organizations who make a business of analysis such as (A.M. Best Co.) make mistakes, how can one expect the reinsurance buyer to adequately assess the credit risks he or she takes every time they make a purchase decision?" he asked.

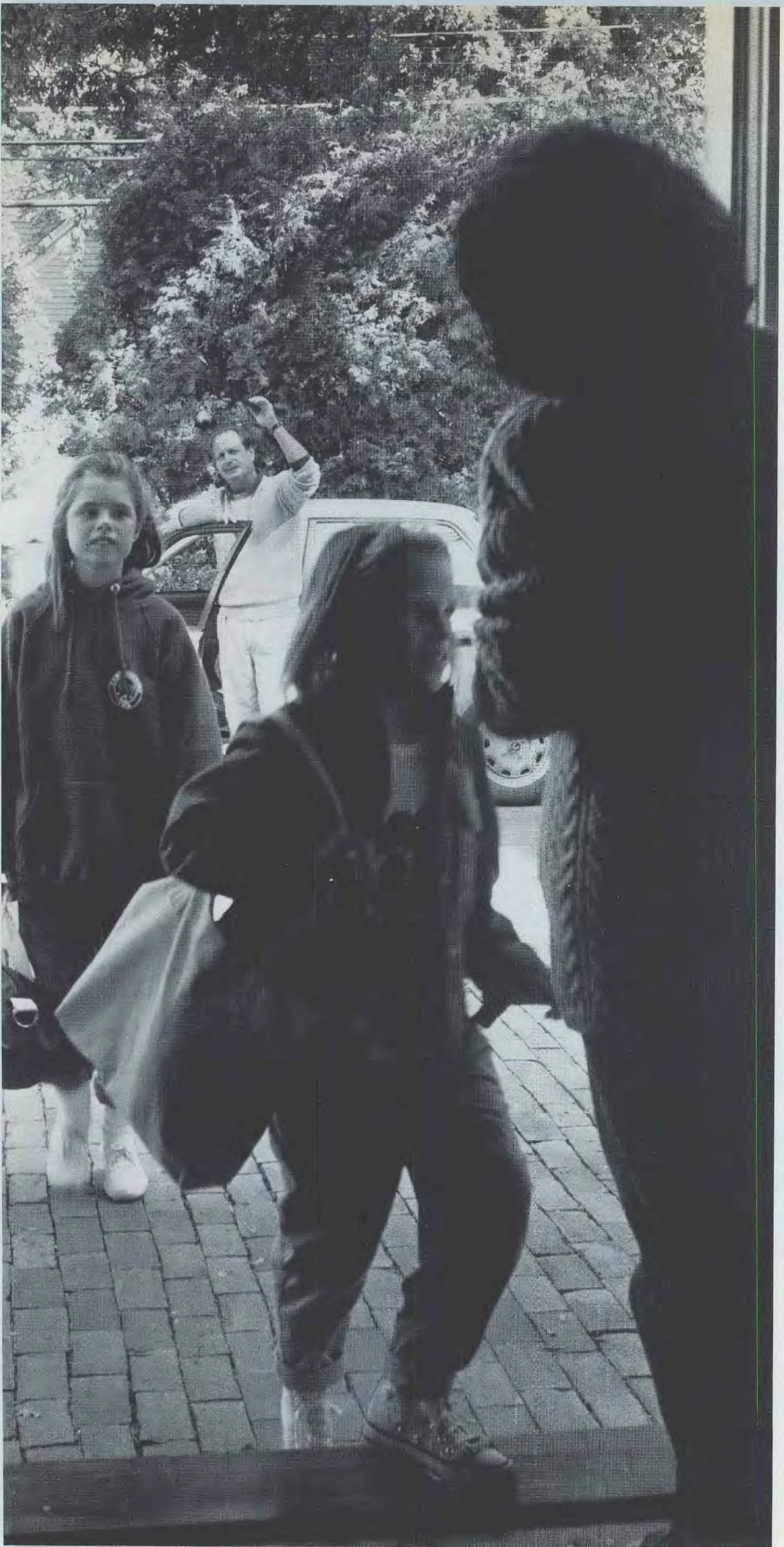
Lastly, Mr. Gluckstern said, reinsurance buyers have been forced to become more accounting-oriented, especially if they represent a publicly held insurer. "When all you needed to do was move a piece of risk from you to someone else, it wasn't so important to understand the accounting impact of such a transaction," he said.

As Centre Re's underwriter, Mr. Gluckstern said he has noticed "that the people across the table during a reinsurance negotiation are changing."

"Chief financial officers and treasurers—individuals who I would venture to say had little knowledge of the workings of the ceded reinsurance department—are now found frequently," he said. Many reinsurance buyers now are certified public accountants or have master of business administration degrees, he pointed out.

Reinsurance is becoming more readily recognized as a means by which a company manages its exposures—not only its exposure to natural catastrophe and similar risks—but also its exposure to volatility of financial distress, he said.

"Any buyer who fails to recognize this not only severely disadvantages his or her shareholders, but is likely to soon find himself or herself without gainful employment," Mr. Gluckstern said. ■



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Popularity of commutations grows: Insurer

By ROGER SCOTTON

HAMILTON, Bermuda—The decision to commute a reinsurance contract should be based on economic and strategic realities, not technical and scholarly analysis, a reinsurance executive says.

Andrew Kerstein, vice chairman of American Centennial Insurance Co. of Wilmington, Del., says that a decision to commute a contract should reflect evaluation of the reinsurer's or ceding company's financial health, regulatory reporting requirements, administrative expenses, incurred and projected loss ratios and "the elusive specter of adverse development."

"If you are an assuming reinsurer with heavy casualty exposure and real concerns about the sufficiency of both outstanding loss reserves and (incurred-but-not-reported losses), especially if you are in runoff, the commutation may be the only quick, inexpensive way to do something as simple as stay alive and solvent," he said.

Mr. Kerstein spoke at the second annual International Reinsurance Forum last month, sponsored by Hawksmere Ltd., a British publishing and conference company, and accountant Coopers & Lybrand.

"In many instances, the prohibitive draining cost of arbitrations or litigation over a questionable coverage issue makes the choice" to commute a reinsurance contract "one of necessity, not preference," Mr. Kerstein said.

"In my own experience I have found that my fellow companies recognize this fact and prefer to negotiate a resolution with words and numbers, not briefs and attorneys' fees," he said.

Since American Centennial's acquisition in May 1987 by First Delaware Holdings Inc., the insurer has commuted numerous reinsurance contracts.

Mr. Kerstein said that if a company is serious about commutations, it should assemble a team with responsibility for negotiating and executing commutations. The team should be given access to all the actuarial, legal, claims, underwriting and accounting information it needs, he added.

According to Mr. Kerstein, a commutation agreement is a simple contract to terminate two parties' reinsurance relationship under mutually acceptable terms. But, he said that "creative enhancements" are allowing commutations to be applied to a wide range of situations.

"This is particularly true where one of the major factors in the commutation decision has been the financial viability of the reinsurer," he said. "For example, we have already seen attempts at using surplus notes in conjunction with a commutation and assignment of retrocessional collections in conjunction with a commutation of the net-retained portion of assumed business.

"Other alternatives include a basic commutation of a portion of the business reinsured and an agreement to cap the losses on the remaining business, or a commutation with additional payments to the original cedant, depending on the financial condition of the reinsurer," he explained.

Mr. Kerstein said that if a prime factor in these considerations is business that is involved in arbitration or litigation, the parties to the dispute may want to think about agreeing to a minimum and maximum commutation price in advance, so that a court or arbitration panel simply picks a price based on its assessment of the issues.

"Given the uncertainty of a panel's or judge's decision and the possible risk to one or both parties of an all-or-nothing award or verdict, this type of approach may prove to be in everyone's best interest," he said.

Mr. Kerstein said the popularity of commutations is linked to the problems experienced by the insurance industry in the last soft market. With some insurers and reinsurers on the brink of insolvency, commutation became the mechanism for controlled, voluntary self-rehabilitation, he explained.

Inefficient liquidations and unpredictable arbitration awards also are contributing to the popularity of commutations, he said.

International Reinsurance Forum

Mr. Kerstein's remarks about commutations at the conference followed a comparative review of British, U.S. and Bermuda reinsurance arbitration law and practices by Bermuda-based attorney John Milligan-Whyte, who called for the development of a soundly reasoned and compatible framework to enforce the morality of utmost good faith in these three "intertwined" jurisdictions.

The decision whether to include an arbitration clause in a reinsurance contract, what provisions the clause should contain and under what circumstances it should be acted on once a dispute arises is a "complex and important one," said Mr. Milligan-Whyte.

Arguing that arbitration is not capable of fulfilling the "extravagant promises" that have been made for it, he pointed out that arbitration is not necessarily cheaper or quicker than litigation.

The popularity of arbitration, he explained, is based not on the illusory advantages of speed or economy, but upon the hope that the parties will be able to maintain control over the intensity of a dispute and the methods used to resolve it. They perceive such control to be impossible in the litigation process, he said.

"Arbitration is perhaps best resorted to under four circumstances," Mr. Milligan-Whyte said.

First, he said arbitration can be used "in connection with routine business under which the parties expect to have disputes, which, while substantial, will not interfere with the ongoing business relationship between them."

Mr. Milligan-Whyte said in such a situation, arbitration can be carried out in an atmosphere of civility and against the background of a continuing relationship.

A second type of case that lends itself well to arbitration is an international dispute "in which the decision maker will need a generally international viewpoint in order to fairly decide the merits of an argument."

He pointed out that parties in these disputes also may want to seek a neutral forum.

"A third type of situation which may benefit from a neutral territory arbitration clause is one for which the choice of a particular system of law is very important,"

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Commutations

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he said. "It may be possible, by use of an arbitration clause directing decision by an arbitration award not subject to appeal, to avoid expansive interpretations of law which frustrate the purpose of the contract."

Mr. Milligan-Whyte explained that British and Bermuda laws permit appeals from arbitration awards on points of law when standard forms are involved. Parties also are allowed to demand reasons for arbitration awards.

Arbitration cannot insulate a transaction from the effect of mandatory law in the forum having natural jurisdiction, he pointed out. However, claims under the Racketeer Influenced and Corrupt Organizations Act are likely to receive unsympathetic and unexpansive treatment by an arbitrator in a neutral forum, even though he might be required to apply U.S. or European Community laws.

The nature of reinsurance disputes makes them awkward to adjudicate, says Mr. Milligan-Whyte.

A final good reason to arbitrate, according to Mr. Milligan-Whyte, is the availability in the United States, England and Bermuda of the New York Convention, a 1958 international agreement for the enforcement of awards.

"There is no uniform or widely accepted mechanism for enforcing judgments and error is easy to commit. In the jurisdictions that have acceded to it, the New York Convention gives arbitration awards much enhanced authority and enforceability," he explained.

Mr. Milligan-Whyte predicted that judges and arbitrators on both sides of the Atlantic will increasingly face issues arising from the interaction of different markets and the "cumbersome character" of reinsurance disputes.

"The multifaceted nature of reinsurance disputes makes them extremely awkward to adjudicate," he said. But, Mr. Milligan-Whyte, like Mr. Kerstein, does not advocate shipping off contract files to attorneys when disputes arise.

Lawyers can be retained to "quietly advise on the strengths and weaknesses of the factual and legal position of a client," a step that Mr. Milligan-Whyte said could be taken either as an alternative or as a preliminary move toward arbitration or litigation.

"Why spend the time or money fighting either weak cases or strong cases that can be expeditiously settled?" he asked. "The preliminary steps taken are of crucial importance if you wish to forgo a starring role in an opera of fast-breeding arguments, passionate recrimination and bitter business relationships."

Mr. Milligan-Whyte said the decision to arbitrate or litigate depends on the nature of the dispute, its complexity and the prospects for enforcement of an arbitration award or judgment in other jurisdictions.

And, with the exception of alleged fraud, nearly any commercial dispute in the United States, England or Bermuda may be arbitrated, he added.

However, "the advantages of arbitration are apt to pale if it develops that the parties must fight not only the arbitration proceeding, but also simultaneous lawsuits arising out of the same issues. Recognizing that fact, the New York Convention calls for the issuance of a compulsory stay of litigation on the courts of contracting states when a qualifying arbitration proceeding is being or will be commenced," he said.

He pointed out that in all three jurisdictions, a party waives his rights to arbitrate if his actions do not show an intention to arbitrate. To forestall litigation over an arbitrable dispute in England and Bermuda, "a defendant must apply to the court for a stay at any time after appearance and before delivering any pleading or taking any steps in the proceedings."

U.S. courts, he continued, take a considerably more liberal view of arbitration rights.

"Rather than focusing on the demonstrated intention, they consider whether or not the opposing party suffered any prejudice or damage as a result of the delay in seeking arbitration," he said. "However, just as in England and Bermuda, what is involved here is a case-by-case analysis that makes strategic thinking somewhat difficult."

The views of Mr. Kerstein and Mr. Milligan-Whyte reflect the divided body of opinion on the value of arbitration.

Mr. Kerstein clearly favors commutation as the "graceful way" to resolve a dispute and avoid the unpredictability of bitter and protracted arbitration.

"Reinsurance used to enjoy the reputation of being a gentlemen's or handshake business," Mr. Kerstein said.

"About the best way to sum up the state of the industry today is contained in a comment made to me by one of the most prestigious former reinsurance CEOs, who said that he wouldn't bother to write a reinsurance treaty today with an arbitration clause.

"Although gentlemen can always choose to arbitrate if a dispute ever arose and would probably do so, unfortunately there aren't enough gentlemen left in the reinsurance business. You're better off dealing with non-gentlemen in the courts," Mr. Kerstein said. ■

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Brokers needed to prevent reinsurer failures: Crawley

By ROGER SCOTTON

HAMILTON, Bermuda—Reinsurance brokers should take a "new, strong, collective initiative" to help prevent or reduce reinsurer insolvencies, says a reinsurance company president.

Brokers have a watchdog role to play in the reinsurance security process and they should "collectively and openly acknowledge their responsibility to their markets," according to Jonathan Crawley, president of Bermuda-based Aneco Reinsurance Underwriting Ltd.

"Indeed, (the initiative) can only be taken by the brokers," Mr. Crawley told attendees of the second annual International Reinsurance Forum last month in Bermuda. The forum was co-sponsored by Hawksmere Ltd. and Coopers & Lybrand.

Brokers have a watchdog role to play in the reinsurance security process and they should 'collectively and openly acknowledge their responsibility to their markets,' says Jonathan Crawley of Aneco Reinsurance Underwriting Ltd.

"Underwriters only underwrite for their own companies. Brokers 'broke' to reinsurance underwriters all over the world. Underwriters only accept and decline business for their own companies. Brokers market business to underwriters all over the world," he explained.

Mr. Crawley said that the non-recoverable reinsurance "crisis" was a new malaise that must be stamped out.

"As to how (the brokers) choose to prevent it I am not so certain and I don't think that is important for us to consider today because I have every confidence that the brokers can easily work that out for themselves once they have come around to looking at each other in a non-competitive, responsibly collective manner and have determined that nobody else is able to do it."

International Reinsurance Forum

Brokers, Mr. Crawley said, have the most important role in the reinsurance security process.

Quick access to information is one of the greatest aids available in slowing the rate of reinsurer insolvencies, he said.

Brokers, "with their ears to the telegraph wire," should use this information and, in a spirit of intersupportiveness, "see that something is done to put a stop to potentially terminal situations," he suggested.

Mr. Crawley

Brokers "should collectively put in place mechanisms to stop the irresponsibility of the few amongst them outweighing the responsibility of the many," according to Mr. Crawley.

Mr. Crawley was particularly scathing about those brokers who, he said, viewed the recent era of "innocent capacity" as an opportunity to make hay while the sun shone.

The term "innocent capacity" was coined in the early 1980s to refer to insurers and reinsurers competing for business that did not have the underwriting talent to price it properly.

Two companies that could have both benefited from "collective broker responsibility" were Phillips Petroleum Co.'s Bermuda captive, Walton Insurance Ltd., and American Centennial Insurance Co.'s Bermuda affiliate, Beneficial International Insurance Co. Ltd., Mr. Crawley said.

Both Phillips and American Centennial later chose to run off non-related business written by their Bermuda operations (*BI*, April 25, 1983; March 9, 1987).

As chairman of a Bermuda market underwriting committee, Mr. Crawley said he was so concerned about Walton's underreserving that he prepared a private report on the company in 1981, a report that he

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Brokers

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said "somehow" found its way to London.

"Although many brokers from London who had seen my memorandum came to tell me that I was probably right, they nonetheless continued to pour business on Walton willy nilly," Mr. Crawley said.

"Beneficial International. . .had somehow been persuaded by different London brokers to take shares in no less than four London underwriting agencies, either up front or on a proportional reinsurance basis," Mr. Crawley said.

"These agencies were writing very overlapping books of business," he added.

The fact that all the underwriting agencies had lost huge sums of money by the mid-1980s and that several companies participating on their programs had failed was not the point, Mr. Crawley said.

'The tendency of many brokers to exploit innocent, naive, stupid, ignorant, greedy, suicidal underwriters has got to stop and it will only stop when brokers start acknowledging their collective responsibilities,' Mr. Crawley says.

"All I want to point to, is that brokers not only permitted Beneficial International to participate in these clashing agencies but that a whole slew of other London brokers were happy to show huge volumes of business to these agencies," Mr. Crawley said.

"The tendency of many brokers to exploit innocent, naive, stupid, ignorant, greedy, suicidal underwriters has got to stop and it will only stop when brokers start acknowledging their collective responsibilities," Mr. Crawley said.

International Reinsurance Forum

"It is not for me to suggest how their collective responsibility should be organized, and throughout the industry we are all of us aware that they cannot just sit down together one morning and decide that none of them will show business to any company located outside" the United Kingdom or the United States, Mr. Crawley said.

"But perhaps a start could be made by categorizing reinsurers according to the number of solvency tests which they pass and perhaps these solvency tests could be standardized by the information agencies," he continued.

Mr. Crawley went on to argue that if brokers are to look after their markets, underwriters must be "overtly ready" to allow such scrutiny.

"It is fatal," he said, "to adopt an antagonistic posture and to seem to mistrust all the business brought to you. Brokers must want to come and see you and they must know that you trust them totally. If there are any you don't trust, then don't open an account with them.

"Each broker should know that you regard your relationship with him as important to you. The more you stress this, the more responsible the broker feels and the more he will want to bend over to act in your best interests on a day-to-day basis and thus fulfill another role in the security process," he said.

Mr. Crawley also maintained that brokers acting for reinsurance companies should know more about their clients' security.

He said it was not enough for them to know basic statistics, underwriting philosophy and one or two top people at a reinsurance company.

Mr. Crawley recommended complete familiarity with internal reporting systems, financial statements and appropriate senior managements.

"Only brokers," said Mr. Crawley, "can bring about prevention of the malaise." ■

Insurer data lacking worldwide: Accountant

By ROGER SCOTTON

HAMILTON, Bermuda—The frequent shortage of up-to-date financial information about insurers is a worldwide problem that bedevils the assessment of insurer security, a British accountant says.

But, considering there is a lack of standard data reporting in a major and mature insurance market like the London market, "it is not surprising that there is a lack of disclosure and consistency elsewhere," said John Holloway, a London-based partner with accountant Coopers & Lybrand.

Mr. Holloway made his remarks during the second annual International Reinsurance Forum held last month in Bermuda. The two-day conference was co-sponsored by Coopers & Lybrand and British conference and publishing company Hawksmere Ltd.

Although some regulatory authorities around the world will perform what Mr. Holloway described as "early warning tests" on individual insurers, reliance on statutory supervision is no substitute for an independent assessment of insurer security, he said.

One of the difficulties of performing such an assessment, however, is the absence of an "internationally agreed, codified and authoritative generally accepted set of accounting principles for insurance companies," Mr. Holloway said.

"Practice varies and there is a lack of comparability," he said.

"Statutory and GAAP accounting is well-defined in the U.S. In the U.K., a statement of recommended practice has been issued by the Assn. of British Insurers and, as a result, there have been some improvements in the published 1987 accounts of some companies, although differences in practice persist," Mr. Holloway said.

But, he added: "Generally, the standard of reporting differs widely so that for many jurisdictions, the task of evaluating the financial position of an overseas insurance company is a difficult one, resulting in the need to apply healthy skepticism and much subjectivity."

A study of the published accounts of the United Kingdom's largest insurance companies shows a considerable lack of uniformity in the measurement of earnings and net assets, he said.

However, the European Community aims to achieve full harmonization of financial reporting in EC member nations during the next four years, Mr. Holloway said.

"To this end, a draft insurance Fourth Directive is being studied by working parties on behalf of the European Parliament and the Council of Ministers," Mr. Holloway said.

"It is proposed that the annual accounts of insurance undertakings within the European Community shall give a true and fair view of assets, liabilities, financial position, and profit or loss."

"This," said Mr. Holloway, "is no mean task."

The final directive should be approved in 1989 and implemented by each of the EC's 12 member states before 1992, he said. In the process, Mr. Holloway predicted that "disclosure exemptions" currently available to British insurers will be removed.

These exemptions, permitted under the 1985 U.K. Companies Act, apply to:

- Reserves. There is no need to quantify changes in reserves.
- Investments. There is no need to disclose market values of investments.
- Balance sheets. There is no need to give certain information or to classify assets and liabilities under appropriate headings.

Mr. Holloway recommended "a methodical approach" to published financial information and to the identification of year-to-year trends.

He urged insurance buyers and ceding companies not to ignore remarks in chairmens' statements and directors' reports.

Particular attention also should be paid to changes in management, ownership, auditors, scale and direction of operations and accounting policies, especially where this involves a switch to "a less prudent basis of accounting," Mr. Holloway advised.

The nature of the insurers' business, premium growth, reinsurance arrangements and the degree of dependence on reinsurers are key factors in any security assessment, he said. And, Mr. Holloway added, those who want to devise their own in-house security rating may want to consider a cumulative points system based on key ratios.

'It is not surprising that there is a lack of disclosure and consistency,' says John Holloway.

"For example, ratios considered to be favorable would merit high marks and those perceived to be unfavorable low marks," he said.

"Growth in annual premiums written of, say 40%, would merit a low number of points, as would high exposure to long-tail liability classes of business. These adverse factors might be offset by high points because of a very favorable ratio of premiums written to shareholders' funds.

"New and small companies would be penalized under this kind of point system, depending on their pedigree," he said.

Mr. Holloway's range of corporate "risk factors" also includes companies based in countries that are significantly in debt to the International Monetary Fund and to insurers in countries where there are severe foreign exchange control restrictions.

He also advises careful attention to insurance companies that:

- Expand rapidly into new lines of business.
- Are owned by non-insurance companies that may not have a long-term commitment to the industry.
- Have transient managements.
- Provide limited financial information.
- Appear to "trade in" insurance by maintaining large gross accounts while reinsuring a disproportionately high percentage of it.
- Generate negative cash flow.
- Are slow claims payers and have a reputation of being administratively inefficient.

"In short, beware of companies lacking an appropriate measure of managerial and/or financial probity and prudence, having regard to their type of exposure to underwriting, foreign exchange, reinsurance and investment risks," Mr. Holloway said. ■

Attempt to quantify disaster losses stalled

By STACY SHAPIRO

LONDON—An attempt to quantify Lloyd's of London syndicates' true portion of the October 1987 European windstorm losses and the July Piper Alpha drilling rig explosion is being foiled by underwriting agents who refuse to fill out a questionnaire from the Lloyd's Underwriting Agents' Assn.

The LUAA, concerned about the accumulation of disaster losses among Lloyd's syndicates through both direct insurance and London market excess-of-loss reinsurance, wanted managing agents to quantify their gross losses from the two disasters and detail their reinsurance programs placed with other Lloyd's syndicates.

But managing agents balked at the idea. Although all managing agents were supposed to return their answers to LUAA Chairman Robin Gilkes by last Wednesday, only five to 10 agents had done so as of early last week.

Mr. Gilkes on Nov. 8 asked all managing and combined managing/members' agencies for detailed information about their syndicates' reinsurance with Lloyd's syndicates for the disasters.

The October windstorm—known in the market as 87J—and the Piper Alpha disaster, together with Hurricane Alicia in 1983, could cost world insurers and reinsurers billions of dollars (*BI*, Sept. 12).

But Lloyd's managing agents have said that aggregate losses to syndicates will be minimal because of their reinsurance programs.

For example, based on letters written in July by managing agents, Lloyd's syndicates will only retain tens of millions of dollars of the estimated $1.4 billion Piper Alpha loss (*BI*, July 11).

The LUAA is "concerned that two recent catastrophe losses, the October storm and Piper Alpha, seem to have been off-loaded on to the reinsurance market and then (are) disappearing," said Mr. Gilkes in the Nov. 8 letter.

"As we are dealing with the largest non-marine and marine physical damage losses the insurance world has ever seen, we would expect Lloyd's underwriters to be paying rather more than what appear to be a few fairly modest retentions.

"Your committee feels that we need to go beyond the rather comforting letters which managing agents have sent out on Piper Alpha," Mr. Gilkes continued. Therefore, he asked that all managing agents fill out a questionnaire to determine where these losses "are finally going to rest so that your members' agents get the information which they need for themselves and their names."

The one-page detailed questionnaire asks for estimated totals of gross exposures and final gross loss for each syndicate on each of the three disasters—the 87J windstorm, the Piper Alpha and Hurricane Alicia—broken down into direct insurance, facultative and pro rata reinsurance and LMX reinsurance losses.

The questionnaire also asks for the amount of reinsurance available to cover the exposed aggregate losses and the percentage of this reinsurance written by Lloyd's syndicates.

Mr. Gilkes confirmed last week that he has received a lot of flak over his letter and questionnaire "to put it mildly. We were trying to be helpful to the market. But people thought we were putting our nose into other people's business and we're not. Only Lloyd's can do that."

For example, Mr. Gilkes received a letter from Peter Aitchison, executive chairman of Lloyd's underwriting agent Cotesworth & Co. Ltd., that said Mr. Gilkes hadn't asked the right questions.

"We, too, are concerned at the bland and meaningless statements that are circulating," said Mr. Aitchison in a Nov. 14 letter. "There is no doubt in our minds that Piper Alpha will cause nasty blood stains on the white marble."

However, the LUAA questionnaire as drafted does not help members' agents obtain an answer to a simple question, namely whether a syndicate will exhaust its reinsurance and have to pay significant retained losses, said Mr. Aitchison.

Mr. Aitchison told *Business Insurance* that Mr. Gilkes' attempt was "laudable." However, he said that the LUAA questionnaire does not take into account the uniqueness of Piper Alpha as being a big loss from a single event, instead of a natural disaster that spawned many claims. And the way the questionnaire is worded allows the underwriters to be subjective about their syndicates' exposures, he said.

The LUAA wants managing agents to quantify their gross losses from two 1987 disasters.

Instead, Cotesworth wants to know what type of coverage each underwriter was writing at the time Piper Alpha exploded and then "we will make our own opinion" about whether the syndicate can handle the loss, said Mr. Aitchison.

Cotesworth will ask each syndicate that includes members represented by Cotesworth about its gross exposures as of July 1, 1988, for several different types of coverage. Cotesworth also will ask about the syndicate's reinsurance for Piper Alpha claims.

Mr. Aitchison admits "if you are looking at where the ultimate (Piper Alpha) loss is, I think there is more coming to Lloyd's" than was first believed.

Meanwhile, Lloyd's underwriter T.E. Berry, whose syndicate is managed by Cotesworth, has refused to answer Mr. Gilkes' questionnaire.

"We are confident that all of the above losses (including 87J and Piper Alpha) will be contained within the syndicate's protection and would be prepared to show any supporting agent the manner in which we keep our aggregates, together with our reasoning on arriving at what we consider to be the correct level of (reinsurance) protection necessary," said Mr. Berry in a Nov. 16 letter.

"Mr. Berry and my opinions are parallel," said Mr. Aitchison.

Meanwhile, Mr. Gilkes says he has received a few answers to his questionnaire and is sure that the 50 syndicates he oversees as a members' agent will respond.

However, he said the LUAA will not accumulate all the figures together because "the LUAA has no authority to do so." ■

ILU seeking approved status from NAIC

By STACY SHAPIRO

London

LONDON—The Institute of London Underwriters wants the National Assn. of Insurance Commissioners to place the ILU on its list of approved alien reinsurers.

If the NAIC refuses, the ILU would like all state insurance commissioners to grant it the status of an approved reinsurer in their individual states.

"We want to be on an equal footing with Lloyd's" of London in the United States, said ILU General Manager Peter Worsfold. "The difficulty is to persuade people what the institute is, that there is another market beside Lloyd's in London and that we monitor our members' accounts."

Mr. Worsfold will attend the NAIC conference in New Orleans later this month to lobby for the ILU to be listed as an approved alien reinsurer.

To be approved, the institution would have to meet the requirements of the NAIC's Non-Admitted Insurers' Information Office in New York, which investigates the financial records of alien companies. Individual state insurance commissioners check with the NAIIO before admitting alien companies.

The ILU, founded in 1884, is a trade association that monitors the performance and financial strength of its 113 members, which write mainly marine and aviation insurance. ILU member companies write premiums totaling at least 2 billion pounds ($3.68 billion) on the ILU's own policy forms, making the ILU as large as Lloyd's marine market (*BI*, Aug. 29).

"We are unique," said Mr. Worsfold. "No other association vets its members' financial strength, which is well above DTI (British Department of Trade and Industry) standards. Our friends on the other side of the pond should recognize this."

"We've been around 100 years. How many ILU companies have gone bust? None. How many have been in financial difficulty? None," added ILU Assistant General Manager Anthony Funnell.

The ILU does not maintain a trust fund in the United States like Lloyd's, but each of the ILU's member companies have established trust funds and posted letters of credit to write business in the United States, said Mr. Worsfold.

In addition, the ILU is not covered by an act of Parliament like Lloyd's under which it is self-regulated. But, "we do have self-regulation already," he said. For example, in the last few years the institution has asked one company to increase its capital, another to change its reinsurance arrangements and another to reduce its underwriting. All complied with the ILU's requests.

Last year, the ILU was approved to write marine, aviation and transportation reinsurance in the state of Maryland (*BI*, June 15, 1987). The ILU submits each member's DTI returns and annual report and accounts to Maryland annually, said Mr. Worsfold.

The ILU would like to first be approved in states that need large quantities of marine reinsurance capacity, like Texas, California and New York, added Mr. Funnell. "Once we had (those) under our belt, it is likely the smaller maritime states would follow suit."

Sedgwick results

Although Sedgwick Group P.L.C.'s pretax profits plunged 24% during the first nine months of this year, stock analysts are more optimistic about the company's year-end results.

Sedgwick last month announced that pretax profits in the first nine months of 1988 dropped to 70.8 million pounds ($130.3 million) from 93.2 million pounds ($171.2 million) for the first nine months of 1987.

Revenues also dropped nearly 10% to 458.9 million pounds ($844.4 million) from 507.9 million pounds ($934.5 million) for the corresponding period of 1987.

Despite the decline, Sedgwick's pretax profits are slightly greater than stock analysts' estimates, which hovered around the 70 million pounds ($128.8 million) mark.

As a result, analyst Kitcat & Aitken has now increased its year-end profit forecast for Sedgwick to 77 million pounds ($141.7 million) from 75 million pounds ($138 million (*BI*, June 20).

Modern technology

While the Romans were able to lay cobblestones all over Great Britain centuries ago, modern-day construction crews are having a more difficult time laying cobblestones around Lloyd's of London's futuristic building.

The cobblestones that surround the building have leaked, according to Lloyd's sources, causing water to seep into the lower levels of the building each time it rains. Currently, crews are waterproofing and re-laying the cobblestones.

College grant

Lloyd's of London broker Bowring Macalaster & Senior Ltd. in Glasgow is sponsoring a professor in risk management at Glasgow College, the only institution in Europe to offer a risk management degree.

The Bowring Professorship in Risk Management last month was filled by Gordon Dickson, who assisted in the design and launch of Europe's only bachelor of arts degree in risk management at the college in 1982.

Le Rocher changes

Le Rocher U.K. Ltd., the British subsidiary of Prudential Reinsurance Co. that had written only facultative reinsurance, is now writing property treaty reinsurance worldwide and is writing liability treaties except in the United States.

In addition, according to Managing Director Claude Nyssen, the company announced recently that:

- Steve Kiln, formerly an underwriter at Terra Nova Insurance Co. Ltd., has been appointed director and chief underwriter.
- Paid-up capital has been increased to 12 million pounds ($22.1 million) from 6 million pounds ($11 million).
- Authorized capital has been increased to 20 million pounds ($36.8 million) from 6 million pounds. ■

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Poor public image

Prop. 103 is evidence of consumers' disdain for insurers

By John R. Dunne

IF THERE WAS ANY DOUBT about the depth of the public's disdain for the insurance industry, last month's election results from both California and Florida should answer any lingering questions.

The passage of Proposition 103 in California—mandating a 20% reduction in nearly all property/casualty rates from Nov. 20, 1987, levels—and the defeat of a Florida proposal to cap awards for pain and suffering in personal injury actions are without question the most dramatic testimony to the industry's negative public image today and the continuing loss of formidable support for the industry among legislators and regulators.

The California experience, which culminated in what one trade journal described as "a fight for the hearts and minds of the California voter," was a disastrous as well as costly defeat for the insurance industry. While there is still time, leaders of the industry must recognize the importance of rebuilding the industry's severely wounded reputation in order to deflect future crippling initiatives that are certain to come from legislators, regulatory agencies and an unwitting public.

But neither legislators nor insurance regulators can draw any smug comfort from the devastation of Proposition 103, which not only mandates price reductions and repeal of the industry's exemption from state antitrust laws, but also requires that the state's previously appointed insurance commissioner be elected. The very fact that the initiative was generated by broad public dissatisfaction is clear evidence that the California Legislature failed to respond to a fundamental need of its automobile-dependent public.

While the industry's image problem has not yet passed the "point of no return," that point is much closer than most are willing to admit and will be crossed unless there is a significant re-evaluation by the industry of how public perceptions profoundly influence public policy decisions made by regulators.

The public outcry for "justice and fairness" comes at a time when the property/casualty insurance industry is confronted with three major threats to its continued solvency: the uncertainty of reinsurance recoverables; the misdirected policies of the Tax Reform Act of 1986 as they relate to the discounting of loss reserves; and the black hole of environmental impairment liability. Yet these problems will be addressed, in part, in public and governmental forums, scenes from which industry leaders have been noticeably absent and consequently of little influence. If the industry is to be viewed with a sense of justice and fair play, its leaders must become involved in the political process, the means through which the rules of fairness are defined and the principles of justice are reduced to statutes and regulation.

A recent survey of the insurance industry's chief executive officers, conducted by the accounting firm of Ernst & Whinney, illustrates the root cause of the industry's current woes.

The survey revealed a consensus among insurers that legislation and regulation are the greatest impediments to achieving corporate goals, particularly the industry's primary goal of increased profitability. The industry's public image is inextricably linked to regulation and these are serious factors that must be considered in any corporate strategy to improve profitability and productivity. Indeed, as the events of this past Election Day bear out, they must be considered alongside premium volume and loss ratios in measuring corporate performance.

Yet, paradoxically, those same executives failed to attribute any priority to enhancing the industry's public image, which underlies and often determines public regulatory decisions.

This asymmetry between corporate goals and current obstacles to meeting those goals is disturbing. Sixty-two percent of those executives surveyed cited regulation and legislation as their most pressing problem and an obstacle to achieving corporate goals and objectives. This concern outpaced—by almost 2-to-1—the next most cited problems: competitive environment, taxation and lack of a trained staff. Yet, only 4% of the surveyed group identified improvement of the legislative and regulatory climate as a corporate goal.

Equally startling were the responses to queries about the public's perception of the industry as an impediment to meeting defined company targets. Only 5% of those executives considered it a current obstacle, and just 4% saw it as an anticipated obstacle. Furthermore, a mere 2% of the respondents saw enhancement of the industry's image as a specific corporate goal.

Clearly the passage of Proposition 103 can be attributed to the negative image the public has of insurers and to a clear lack of confidence in elected officials and regulators who were perceived as having failed to address the sentiments of a public still smarting from dramatic fluctuations in the industry cycles.

Yet, insurers have not heeded previous public warnings. A recent public opinion poll found that 60% of those surveyed think that insurers make a

Speaking out

coordinated effort to move premiums upward, 50% said insurers were not to be trusted and 40% thought that federal regulation of the insurance industry is necessary. Is it any wonder that the various state attorneys general have received so much public approbation for their tenuous federal case charging that the industry manipulated the market to restrict coverage under the general liability form?

The future viability of the free enterprise business of insurance—underwriting and brokering—hangs in a precarious balance. Insurers face a crisis with the potential to alter the very way in which risks are covered in this country. As a result of the California vote, companies are threatening to engage in a mass non-acceptance of automobile insurance policies or are abandoning a state's market altogether. For example, Allstate Insurance Cos. is preparing to depart from another state with an auto insurance crisis: Massachusetts (*BI*, Nov. 21).

This reaction will invite the rise, once again, of alternative markets—risk retention and purchasing groups, insurance pools and self-insurance—which currently account for about 30% of total premium volume and provide, as one agent representative said, "a window of opportunity" for banks, which were granted certain powers under Proposition 103. If the void that is certain to result from such large-scale withdrawal is not met by a wholly private market mechanism, then it is relatively certain that a "public utility" model—if not a total public agency approach—will be instituted and the traditional private auto insurance market will have passed into the sunset.

On a larger scale, the notorious success of the California initiative is certain to spawn similar proposals in many other states. In the wake of his victory in California, Ralph Nader boldly announced that he anticipated commencing similar actions in a half-dozen other states that recognize the public initiative procedure.

The federal government, particularly Congress, will read this course of events as one more reason to "federalize" insurance regulation or, at least, repeal the limited antitrust exemption under the McCarran-Ferguson Act. And who is going to convince Rep. James Florio, D-N.J., that his ongoing efforts to bring federal oversight to solvency regulation and guaranty funds is not in the public's interest?

If the industry seeks to mend its wounds in the state legislatures, it cannot expect to be supported without evidence of a dramatic change in the way it manages public sentiment and takes other steps to restore consumer confidence in the market. Legislators, after all, are experts—or should be—on the subject of public image and balancing the public's needs and sentiments with sound policy decisions.

Lawmakers, when faced with an increasingly polarized insurer-public relationship, will be in an unenviable position, no matter how well they may understand and appreciate the plight of insurers and the difficulties that insurers encounter in an ever-more-regulated system. The facts of political life being what they are, legislators will invariably side with the public that elects them. The problem is not so much one of a legislator's not understanding the nuances of the insurer-public relationship, as it is a failure of insurers to fully appreciate the bond the representative has with the public.

A relief from the burdens of regulation, a reprieve from the incessant "industry bashing" and a return to those halcyon days—at least between market cycles—of strong performance and high profitability will only come after a concerted effort by the industry to enhance its image through substantive efforts to identify problems in the marketplace. Those include:

- Providing coverage for long-term health care expenditures.
- Reducing the incidence of insurer insolvency.
- Expanding the domestic capacity for risk placement.
- Providing some assurance of long-term availability and affordability of insurance through long-range planning, stabilized rate structures and, above all else, service to the public.

Wild fluctuations in rates, ranging from increases of 250% to 1,000% to rate reductions of up to 75% simply cannot be justified. The public expects more, namely: access to a stable insurance market.

As the entire corporate structure pursues these substantive goals, the industry's top executives must, themselves, be personally involved in educating and influencing the public's representatives so that they will understand and provide a balanced response to those efforts. The CEO who is willing to mix it up with legislators—whether sitting across a legislator's conference table or testifying at a public hearing—is in a unique position to bring the insurance industry's message in a dynamic, attention-getting and convincing fashion. The leaders of the industry must be involved and that means being prepared to get their hands dirty in providing support and enhanced credibility for the traditional industry lobbyists.

The net result will likely be a public official who is less prone to make political hay simply by blaming insurance companies for rising premiums and shrinking coverage.

And, with a sustained campaign of involvement by top management, those same policymakers may well begin to think and act creatively to encourage the free enterprise system to fill the public's needs, rather than resorting to time-proven, ineffective public mechanisms.

Efforts to restore the industry's image not only will serve insurers well in their relations with legislators, whose assistance will become indispensable as Proposition 103-type proposals spring up nationwide, but also will assist in other current and anticipated obstacles to profitability, including attracting qualified

Continued on next page

John R. Dunne, R-Garden City, is deputy majority leader of the New York State Senate. Sen. Dunne currently serves as ranking majority member on the Senate Committees on Insurance, Judiciary and Environmental Conservation.

Insurance reform around the globe

International issues

By Jerome Karter

AS 1989 APPROACHES, many countries are reviewing recent and forthcoming changes in local insurance practices.

Let's go globe trotting for a first-hand view:

• **Mexico.** South of the border, Mexican insurers have changed the formula for calculating motor tariffs. Until recently, automobile insurance rates were based on the type of vehicle being insured. But today, rates are being calculated on the sum insured as well as on the vehicle's model and year of registration.

In addition, escalating material damage and theft losses have forced underwriters to raise deductibles for these hazards, as well as increase premiums proportionate to the vehicle model and year.

Mexican insurers also are considering a proposal to introduce an inflation index clause that will allow repair and replacement recovery for material damage and theft losses.

• **Colombia.** During 1988, the Colombian Banking Superintendency, which oversees regulation of insurance, modified the "malicious damage" endorsements to the basic fire policy.

Previously, a policyholder could cover perils such as explosion, civil commotion and vandalism under the basic fire policy. But coverage for loss due to "subversive acts" fell into a gray area.

Today, the Colombian fire policy clearly defines the extent of coverage afforded. As in the past, the explosion peril will indemnify loss or damage that results from any internal or external event, including any resultant fire. Explosion resulting from vandalism is specifically excluded.

The endorsement covering the perils of strike, riot, civil commotion and vandalism has been changed to exclude material damage and fire following "subversive acts."

The Banking Superintendency has created a new type of endorsement for "malicious damage caused by third parties." This endorsement covers all destruction or physical damage caused by malicious acts of third parties, including terrorist acts—that is, acts caused by individuals who are members of a subversive group. This endorsement is available only when the policyholder purchases strike, riot, civil commotion and vandalism coverages.

• **Venezuela.** The insurance superintendent in Venezuela has announced several changes to the existing fire insurance tariff. Although the proposed tariff regulations are scheduled to take effect on Jan. 1, 1989, it is expected that additional time may be needed to resolve some points that are still under discussion.

If adopted as proposed, the new tariff will:

- Modify and/or detail existing rating structures in order to discourage liberal interpretation of the tariff and off-tariff rates. Rates are not expected to rise.
- Increase the number of discounts available for loss protection steps. The current tariff allows a single discount to be applied but only when all conditions of protection are met. The new tariff will introduce separate discounts for each form of protection, such as outdoor hydrants, sprinklers, extinguishers, surveillance services, etc. However, the separate discounts will be subject to a maximum allowable percentage reduction.
- Change the basic definition of fire. Under the old tariff, fire was defined as fire and lightning. But the proposed tariff seeks to add the current extended coverage perils of falling aircraft and broad-form explosion to the basic definition of fire.
- Reduce the existing earthquake insurance rate by 30% to 60%. At the same time, a fixed-amount deductible in the amount of 10 million bolivars ($268,000) will be introduced. (The present tariff does not allow a deductible for the earthquake peril.)
- Permit a sublimit for the peril of flood (currently not permitted by the tariff).
- Modify the two types of first loss policies available in Venezuela, which are the absolute first loss policy and the relative first loss policy.

Absolute first loss policies allow one blanket loss limit for *all* assets, including buildings, machinery and equipment and stock. The present tariff allows the policy's coinsurance clause (Article 17) to be deleted when the total amount at risk exceeds 100 million bolivars ($2.7 million).

Under the proposed tariff, however, values at risk will have to exceed 1 billion bolivars ($26.8 million) before the coinsurance clause can be deleted. Also, the proposed tariff will maintain the existing requirement that values be reported at least annually.

Relative first loss policies require that the policyholder declare a separate blanket limit for each class of asset. This type of policy traditionally has been used to insure industrial risks with values less than 100 million bolivars but will be used to insure risks with a loss limit between that amount and 1 billion bolivars if the proposed tariff is put into effect.

• **Peru.** In Peru, underwriters are taking a hard-line approach to paying claims.

The current property treaty, negotiated by the government-owned Reaseguradora Peruana S.A., mandates that any location with property values in excess of $10 million—not inclusive of business interruption values—be inspected by an authorized firm. Recommendations made by inspectors must be carried out within a specified period of time, i.e., between 30 to 90 days.

Underwriters in Peru will deny an otherwise locally covered claim if the policyholder fails to carry out recommendations within the stipulated time frame or fails to have an appropriate site inspected.

• **Argentina.** The insurance commissioner recently empowered a group of insurers to write private pension schemes and complementary life insurance plans in Argentina.

Although Argentina's high inflation rate usually discourages long-term investment vehicles, the government is promoting private pension schemes as an alternative to its underfunded mandatory retirement plan because benefit levels under the government-run scheme have not kept pace with the Argentine economy.

• **Namibia.** During 1988, Namibia (formerly South-West Africa) introduced its own political riot insurance facility.

Operating under the acronym NASRIA (the National Special Risks Insurance Assn.), this consortium of 11 local Namibian insurers and Lloyd's of London underwriters provides recovery for material damage losses that result from any type of riot, whether political or otherwise.

Like its counterpart, the SASRIA (the South African Special Risks Insurance Assn.), NASRIA covers consequential loss in the form of standing charges, like rent payments.

Coverage is limited to 5 million rand ($2.1 million) until insurers build up sufficient reserves to warrant an increase. Moreover, policy rates currently are two to three times higher than those charged for SASRIA coverage.

• **Philippines.** In mid-1988, the insurance commissioner amended the physical damage section of automobile policies to exclude "any accident, loss, damage or liability, directly or indirectly, proximately or remotely occasioned by, contributed to, by, or traceable to, or arising out of, or in connection with" the perils of strike and riot.

However, strike and riot coverage can be bought back for an additional premium equal to 1% of the sum insured.

• **Taiwan.** Recent changes in the Taiwan property insurance tariff will allow rating exemptions for foreign multinationals that meet the following criteria:

- Operate a manufacturing facility.
- Maintain per location insurable values in excess of $200 million Taiwanese ($7.1 million).
- Have foreign ownership equal to or greater than 50%.
- Maintain a "global" property program.

Applications for exemption must be submitted to the tariff committee, which will grant a "reasonable" rate based on fire protection measures, the location and type of risk and the deductible.

• **Japan.** Beginning July 1, 1988, the Japanese Foreign Non-Life Insurance Assn. (FNLIA) increased rates by more than 50% under "non-fire" earthquake contracts, also known as *Dosan Sogo* policies. Essentially *Dosan Sogo* are inland marine coverages that were intended to insure moveable property, but they have gained popularity as a means of circumventing capacity restrictions on earthquake shock coverage.

After considerable internal controversy, FNLIA members agreed on Nov. 11 to relax the rating guidelines applying to *Dosan Sogo* policies, but only for risks with a sum insured in excess of 1.5 billion yen ($12 million). Policies with a lesser sum insured will still be subject to FNLIA's increased guidelines.

• **Austria.** Austria, which is not a member of the European Community, adopted legislation in 1988 that parallels the EC's product liability directive.

In effect, Austria's 99th Federal Law stipulates that "manufacturers and importers of products are required to take out insurance or otherwise make suitable provisions to meet their liability for damages under this federal law in such a way and to such an extent as is usual and good business practice."

* * *

Some of these changes are *faits accomplis* but others, like the property tariffs in Mexico, Venezuela and Japan, should be monitored during the coming year. Additional subjects that should be followed during 1989 include: product liability activity in non-EC countries as well; the implementation status of the EC directive in member states; and the relaxation of trade barriers in the EC in 1992.

Jerome Karter is senior vp and manager of the International Department of Johnson & Higgins in New York. His column appears the first Monday of every month.

Industry's poor image

Continued from previous page

personnel, enhancing insurance's reputation as a profession and academic discipline through which future insurance executives may pass.

The impact of Proposition 103 on the California insurance industry or its reverberations on other segments of the industry will not be known for some time. Unknown is whether insurers will withdraw from the state's auto insurance market and, if so, for how long. Unknown is whether California's success will lead to passage of similar measures elsewhere. Unknown is whether it will bankrupt as many as 75 insurers, as recently estimated by the commissioner of insurance.

What *is* known is that if the industry continues to fail to recognize the importance and strength of public perception, and how such perception is the common denominator in many of the obstacles impeding the fulfillment of laudable corporate goals, all informed regulators and an unwitting public will pursue solutions without industry influence. An industry that has repeatedly found responses to the public's needs *can* meet the call for political involvement if the signal comes clearly from the top as a matter of immediate priority.

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ASK A BENEFITS ACTUARY

5 ways to calculate HMO contributions

Q **How should my company determine its contribution to a health maintenance organization?**

A This question comes from an employee benefit manager at a company that has been mandated by a health maintenance organization to make participation in the HMO available to its employees. The company also offers a self-insured medical and dental plan.

The benefit manager, who is attempting to determine the contribution that the company will make toward HMO coverage, is aware that the Health Maintenance Organization Amendments of 1988 have changed the rules for determining employer contributions to HMOs (*BI*, Oct. 17; Aug. 22).

Prior to the HMO Amendments of 1988, the company would be required to contribute the same amount toward the cost of covering an employee in an HMO as it paid toward the cost of covering an employee in its self-insured medical and dental plan. For example, if the employer paid $100 per month for the coverage of an employee under the medical and dental plan and $250 per month for coverage of the employee and his or her family, then these same dollar amounts would have to be paid to the HMO. However, the full $100 per month for employee-only coverage would not have to be paid to the HMO if the total HMO premium for employee-only coverage was less than $100.

The HMO Act no longer requires that an employer make an equal contribution toward the cost of coverage under an HMO. Instead, it requires that the employer's contribution not "financially discriminate" against the HMO.

A report on the HMO Act prepared by the Senate Committee on Labor and Human Resources indicates that the Department of Health and Human Services is expected to write regulations further defining how a company's contribution to an HMO is to be determined so as not to financially discriminate against the HMO. The Senate Committee Report also provides five examples of methods for determining whether the company contribution would be considered financially discriminatory to the HMO.

The first method follows the pre-amendment rule described above of making an equal contribution to both the HMO and non-HMO option.

The second method would allow the company's contribution to the HMO to reflect the attributes of enrollees in the HMO vis-a-vis the non-HMO option. These attributes might include age, sex, family status, prior claims experience in a non-HMO option and other factors that might reasonably predict utilization and the cost of coverage.

For example, an employer that offers one HMO and one non-HMO option might find that the average age of individuals with employee-only coverage is 32 for the HMO and 42 for the non-HMO option. Since older individuals utilize medical services more than younger individuals, it might be reasonable for the employer to contribute to the HMO for each employee 75% of its contribution to the non-HMO alternative.

However, a report prepared by the congressional conference committee that hammered out the HMO Amendments raises questions about whether either age or sex can be considered under this second method for determining if the company's contribution to the HMO is financially discriminatory.

The conference committee report says, "There should be no doubt about Title XIII of the Public Health Service Act or this conference report with regard to sex or age discrimination. Nothing in either the statute or this report authorizes or permits an HMO or an employer to engage in conduct that constitutes a violation of any federal or state sex or age discrimination law."

Because of the age and sex discrimination concerns raised in the conference committee report, it is not clear whether the age-related adjustment described above is permitted under the HMO Amendments.

The third method would permit an employer to require from each employee a reasonable minimum contribution to an HMO that does not exceed 50% of the employee contribution to the principal non-HMO option. For example, if a company required a contribution of $20 per month for employee-only coverage under the principal non-HMO option and $50 per month for coverage of the employee and dependents, then the employee contribution to the HMO of $10 or less per month for employee-only coverage and $25 or less per month for family coverage would be considered reasonable under this method.

A fourth method would allow an employer to contribute the same percentage to the HMO's total premium that it contributes for its non-HMO option. For example, if a company paid 87% of the total cost of its non-HMO alternative, then the company could pay 87% of the premium charged by the HMO.

The fifth method would permit a company and an HMO to negotiate contribution arrangements that are mutually satisfactory. Such arrangements would be deemed to satisfy the requirement that the company contribution not financially discriminate against the HMO.

These changes made by the HMO Amendments of 1988 were effective Oct. 24, 1988. Each company offering an HMO alternative should review these new methods for determining its HMO contribution. These new methods may present an opportunity for employers to reduce their employee medical care expenditures.

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

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

Mr. Miner

This month's column on actuarial issues in the benefits field is written by William J. Miner, an actuary with The Wyatt Co. in Chicago. Richard E. Sherman, 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'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.

Conversion policy must offer same benefits

Legal briefs

Where a group life and health insurer gave an individual policyholder the privilege of converting to an individual policy, the insurer was obligated to offer the same coverage for pregnancy expenses as was afforded in the group policy, the U.S. Court of Appeals for the 5th Circuit ruled.

Michael Baker, while he was employed by the Biloxi Freezer Co., enrolled in a group life and health plan underwritten by Washington National Life Insurance Co. Normal pregnancy benefits were incorporated into the group policy by an amendment effective on the same date the certificate was issued to Mr. Baker. The certificate of insurance and master policy also contained a conversion privilege amendment.

Mr. Baker was later terminated from his job on July 8, 1983, at which time his wife was three months pregnant. The insurer acknowledged responsibility for Mr. Baker's claim for pregnancy until July 31.

At that time, it terminated coverage under the group policy because he was no longer eligible for employee coverage. Although the Bakers made a timely and sufficient tender in an effort to exercise the conversion privilege, the insurer advised them that the normal maternity benefits would not be covered by its conversion policy.

Mr. Baker sued and won in the trial court.

The appellate court said that in the absence of any stated restriction, an insurer's use of general language agreeing to convert imports a promise to continue the basic coverage. The court said that the bald promise of "conversion" meant "continuation." The trial court judgment was affirmed. *Baker vs. Washington National Insurance Co.*, U.S. Court of Appeals for the 5th Circuit, Aug. 5, 1987 (*BI*, 02/April-$10).

Loss of consortium

The exclusive remedy doctrine barred a loss of consortium suit by the wife of an injured employee against the employer, the Supreme Court of Vermont ruled.

Gertrude DeRosia commenced a loss of consortium action against her injured husband's employer, The Book Press Inc., and the employer's workers compensation insurer, Liberty Mutual Insurance Co.

The suit alleged that Liberty Mutual's negligence in inspection of the workplace was the cause of her husband's injuries, on account of which she suffered damages for loss of consortium. The insurer sought to have the case dismissed but the trial court refused.

The appellate court agreed with the insurer's argument that the workers compensation law was intended as an exclusive remedy for recovering damages for workers' injuries.

The court said that the workers comp statute provides employers with liability that is "limited and determinate." Thus, the appellate court said that Mrs. DeRosia's claim was barred.

DeRosia vs. The Book Press Inc., Supreme Court of Vermont, June 26, 1987 (*BI*/02/July-$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.*

Non-Profit Task Force Forum

Improve risk management in non-profit sector: Experts

By KARI BERMAN

CHICAGO—Non-profit organizations must improve their risk management procedures to reduce their exposures, risk management and legal experts concur.

"Organizations that are part of the non-profit sector have to exercise strict risk accounting measures, identify the risk and decide how to best manage it," said James Strickland, president of Austin, Texas-based Human Services Risk Management Exchange.

For example, non-profit organizations' misunderstanding of the insurance coverage they purchase is one major obstacle to implementing effective risk control measures, Mr. Strickland said.

"Often organizations don't know what their policies say and, as a result, they can't control what they do not even perceive as risks," he explained during the "Non-Profit Sector Risk Management Task Force Forum" held Nov. 11-12 in Chicago.

The task force—which is composed of representatives from insurance, legal, academic, government and non-profit organizations—was organized by Charles Tremper, a professor at the University of Nebraska College of Law in Lincoln and is financed by the New York-based Ford Foundation. The task force was established to study ways non-profit entities can improve their risk management programs.

Nancy Baker-Velasquez, a partner at Baker, Romero & Associates, a broker in Covina, Calif., agreed that non-profit organizations generally do not understand how to manage risks.

"Lack of understanding of both the insurance market and risk management programs often lead non-profit organizations into problems of canceled policies, excess premiums or duplicated coverage," she said.

"We send our clients regular informative newsletters announcing new issues, legislation and coverages so that they are constantly reminded of the importance of controlling their risk exposures," Ms. Baker-Velasquez said.

Insurers and non-profit organizations must work together to overcome such problems, an underwriter suggested.

"Insurance companies are prepared to do more business with non-profits as long as they will employ risk reductions programs and help protect themselves," said Bruce Henrikson, a vp of Crum & Forster Managers Corp. of Illinois in Chicago.

However, it often is difficult to implement effective risk management programs in the non-profit sector as a result of the traditionally high turnover rate at such organizations, according to Mr. Strickland.

"By the time an organization gets one set of employees trained and aware of risk management and loss prevention issues, they are ready to leave, and you have to begin again," Mr. Strickland said.

"Employee turnover tends to be significantly higher among non-profit organizations, especially among day-care providers," he explained.

The Non-Profit Sector Risk Management Task Force is calling for the establishment of a national non-profit center to assist organizations in understanding and meeting risk management needs.

According to the task force, the proposed center could function within the structure of an existing national organization already serving non-profit organizations.

Such a center would supply non-profit organizations with a neutral source of information about providers, risk management training alternatives, legal issues and advice on loss control measures, the task force says.

The experts also suggested specific ways non-profit organizations could improve their risk management programs now.

Organizations should keep a summary of policies, premiums and expiration dates readily available in case of an emergency, Ms. Baker-Velasquez advises.

She also recommends that organizations develop disaster recovery plans that include keeping lists of employees and their phone numbers and vital computer records safely off premises.

In addition, a qualified fire protection engineer should inspect the organization's premises annually, she said.

And, for loss control purposes, "it is wise to photograph or videotape all office equipment, furniture and supplies so that in the event of a claim, the job of settlement will be simplified," Ms. Baker-Velasquez said. ■

Experts seek liability lid for non-profits' directors

CHICAGO—A group of legal and risk management experts hopes many states will pass legislation that would limit the personal liability of directors and officers of non-profit organizations.

The Non-Profit Sector Risk Management Task Force, financed by the New York-based Ford Foundation, is drafting legislation that would prohibit non-profit organizations from bringing personal liability suits for breach of duty against their directors or officers, according to task force member Charles Tremper, a professor at the University of Nebraska's College of Law in Lincoln.

Mr. Tremper, author of "The Non-Profit Sector Legal Liability and Risk Management Sourcebook," asked the Ford Foundation to fund a study of how non-profit groups could improve their risk management activities.

'Prominent figures are wary of serving on non-profit organization boards,' says Lizabeth Moody.

Under the legislation, directors and officers of non-profit organizations still would be subject to personal liability suits brought by third parties, employees or clients of the organization.

However, the task force believes the protection it hopes legislators will provide directors and officers of non-profit organizations would help those organizations attract more qualified individuals, Mr. Tremper said at the "Non-Profit Sector Risk Management Task Force Forum" sponsored by the task force last month in Chicago.

"Directors and officers of non-profit organizations know that they are at great risk and are very uncomfortable because of it," said Lizabeth Moody, a professor at the Cleveland-Marshall College of Law in Cleveland.

"Prominent figures are wary of serving on non-profit organization boards because of their concerns about liability responsibility," Ms. Moody said.

For example, a national survey of volunteer directors and officers for non-profit associations released earlier this year found that 18% of the respondents would refuse to plan or approve of any activity that could lead to a third-party liability claim, and that 8% have resigned because of fears about their potential liability.

The survey, the "Liability Crisis and the Use of Volunteers by Non-Profit Associations," was conducted by the Washington-based American Society of Association Executives.

Another legal expert believes those fears are well-founded: "I think that there will be an explosion of non-profit insurance claims, and most of the actions will be in D&O coverages," said Lyle Sparks, a partner with the Chicago-based law firm of Lord, Bissell & Brook.

—By Kari Berman

Volunteers may open door to liabilities

By KARI BERMAN

CHICAGO—Non-profit organizations—which often fail to use any of the time volunteers donate to properly train them—need to implement strict risk management policies for volunteers, risk managers and legal experts agree.

"The common use of volunteers by many non-profit organizations may be seen as heightening the organizations' riskiness. If volunteers are not well-trained or properly supervised, they may be more likely than employees to commit acts resulting in liability," said Charles Tremper, a professor at the University of Nebraska College of Law in Lincoln, Neb.

Mr. Tremper made his remarks at the "Non-Profit Sector Risk Management Task Force Forum" held in Chicago last month. The conference was sponsored by the task force, which is funded by the New York-based Ford Foundation.

Volunteers, who perform tasks ranging from delivering flowers in hospitals to executing administrative duties in an office, as well as paid employees, must be educated about the liability exposures they face in performing their services, according to legal experts said.

The workers also must understand that they may not be exempt from liability claims filed by either the organization or by third parties simply because they are not compensated for their services, they said.

Executives of non-profit organizations should understand that volunteers are susceptible to liability suits, risk managers point out.

"If you volunteer then you have to do it right, and if you volunteer and your volunteering is negligent then you are liable," said Harvey Dale, a professor at New York University School of Law in New York.

For example, Mr. Dale pointed out that in litigation brought against non-profit organizations because of the action of their volunteers, courts can rule that a volunteer must pay the portion of a damage award that the organization is unable to pay.

However, he also pointed out that courts have ruled that non-profit organizations must assume all liability for the actions of their volunteers.

In addition, executives of non-profit organizations also should make sure they are familiar with liability laws, understand that volunteers are susceptible to liability suits and have read the fine print in the organizations' insurance policies, risk managers at the forum said.

"Over the last two decades there has been an increasing concern about the effect of potential liabilities and the exposure of those offering their services," said Lizabeth Moody, a professor at the Cleveland-Marshall College of Law in Cleveland.

"In each of the numerous non-profit organizations I have served, someone has either sued or threatened suit against the organization, resulting in some large settlements along the way," Ms. Moody continued.

Prior to the 1930s, charitable organizations in the United States were protected from tort liability largely due to a mistaken interpretation of English law, according to Mr. Tremper.

However, most state courts in the 1930s began to abolish charitable immunity for non-profit organizations.

Health care spending tops $500 billion

By DEBORAH SHALOWITZ

WASHINGTON—National spending on health care increased 9.8% in 1987 to $500.3 billion from $455.7 billion in 1986, according to a federal agency.

This compares with health care expenditures totaling $419 billion in 1985 and $388.5 billion in 1984.

Health care expenditures claimed 11.1% of the gross national product in 1987, up from 10.7% in 1986, reported the Health Care Financing Administration, which is part of the Department of Health and Human Services. Health care expenditures claimed 10.4% of the gross national product in 1985 and 10.3% in 1984.

Per capita health expenditures in 1987 rose 8.8% to $1,987 from $1,827 in 1986, HCFA reported.

Private health insurance and self-funded health care plans paid for 32% of national health care expenditures last year, HCFA reported.

Patients directly paid 25% of the costs, while government programs paid for 41%. Specifically, Medicare paid for 17% of the expenditures, Medicaid paid for 10% and other government programs paid for 14%.

Miscellaneous other payers funded the remaining 2% of health care expenditures.

Of the money spent on health care in 1987, hospital care accounted for the largest share—39%—while physicians' services accounted for 20% and nursing homes claimed 8%.

Other personal care accounted for 21%, and miscellaneous spending accounted for the remaining 12%.

Flood insurance

A voluntary flood-hazard reduction program under consideration by the federal government could reduce premiums for flood insurance by between 30% and 40%, according to a government official.

Under a proposed community rating system being developed by the Federal Insurance Administration, which is part of the Federal Emergency Management Agency, flood-prone communities would be encouraged to reduce potential flood damage. In return for preventive action, the community would receive government credits to be converted into reductions in National Flood Insurance Program premiums for policyholders in the community.

Depending on the community activities undertaken, the credits could amount to savings of between 30% and 40% of premiums, estimated Michael Buckley, an engineer with FEMA.

Some of the flood management techniques proposed for credit include:

- Increasing public information activities, such as notifying all flood-prone property owners of the hazards of floods and advising them of potential protection measures.
- Providing detailed flood data of areas not mapped in detail by FEMA.
- Implementing a flood warning and emergency response program for the community and for critical facilities.
- Improving the carrying capacity of channels, pipes and retention basins.

A nine-to-10-month trial of the proposed community rating system will begin this month, after which the program's success will be evaluated.

If FEMA approves the program, it could begin as early as Oct. 1, Mr. Buckley said.

Under the National Flood Insurance Program, which began in 1968, the federal government reimburses insurers that write flood insurance if premiums do not cover losses. Also, the government is a direct underwriter of flood insurance through private agents.

Washington

Builders' fines cut

The Labor Department last month reduced to $430,000 from $5.1 million fines proposed against construction companies involved in the April 1987 L'Ambiance Plaza apartment collapse in Bridgeport, Conn.

Twenty-eight construction workers were killed and another 16 were injured in the incident (*BI*, May 4, 1987).

The $430,000 settlement will cover the government's costs in investigating the incident, according to a Labor Department spokesman.

San Antonio, Texas-based Texstar Construction Corp. will pay $300,000 in fines and joint venture partners TPM International of Darien, Conn., and George F. Macomber Co. of Boston will pay $100,000. Three other companies will pay the remaining fines.

Earlier last month, an agreement was reached among 15 insurers to pay at least 95% of a $41.1 million settlement of all claims stemming from the accident (*BI*, Nov. 21).

Benefits mandate

State human service commissioners are recommending that employers nationwide be required to offer health care coverage, among other measures, to increase health insurance coverage for the nation's 37 million uninsured.

In a report released late last month by the American Public Welfare Assn., which represents the 50 state human services departments, local public welfare agencies and individuals, the group recommended that all employers with seven or more employees provide health care coverage for workers and their dependents after 28 days of consecutive employment.

Employers would be required to provide a basic benefit package including coverage for:

- Inpatient hospital services and those outpatient hospital services deemed medically necessary.
- Physician services.
- Prenatal, well-baby and well-child care.
- Diagnostic and screening tests.

"We view this basic package as a starting point to provide services at the core of primary prevention and catastrophic health care," the report states.

"We recommend phasing in other important services over time, specifically, prescription drugs, dental services for children (and) eye care."

Under the proposal, employers would pay a minimum of 80% of premiums for full-time workers with annual family incomes at or

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Washington

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greater than 200% of the poverty level. For workers earning below 200% of the poverty level, the employee share of the premium would be subsidized in part by the government on an income-based sliding scale. If family income is below 75% of the poverty level, the government would cover the employee's total share of the premium.

For part-time workers with family income at or greater than 200% of the poverty level, the premium cost would be split on a sliding scale between the employer and the employee based on the number of hours worked per week. The group defines a full-time employee as one who works 20 or more hours per week.

Under the proposal, companies with six or fewer employees could purchase health insurance through state or regional pools. The report did not specify how these pools would operate.

Also, self-employed individuals should be allowed to deduct 100% of the cost of health insurance premiums from their income taxes, the report recommended. Currently, the self-employed can deduct only 25% of the cost of health insurance.

The APWA also recommended expanding Medicaid eligibility to cover lower-income families.

Copies of the report, titled "Access," are available for $6 from the APWA, 810 First St. N.E., Suite 500, Washington, D.C. 20002-4205.

Railroad wage base

Railroad employers and employees will be making a greater contribution to the Railroad Retirement System next year.

Starting in January, the first $48,000 of railroad workers' annual wages will be subject to the payroll tax for Tier I benefits, up from $45,000 this year. Tier I benefits are comparable to Social Security benefits, which some railroad workers do not receive.

However, the rate at which these earnings are taxed will remain at 7.51%, paid by both employers and employees.

Under the Tier II portion of the program—which corresponds to the private pension plan benefits that many employers offer their employees—the tax rate for railroad employers in 1989 will rise to 16.10% from 14.75% this year. And, the Tier II tax paid by employees will rise next year to 4.90% from 4.25% of wages.

Also, the taxable wage base for Tier II will climb to an employee's first $35,700 of wages, up from $33,600 this year (*BI*, Nov. 23, 1987).

As a result, employers will pay a maximum of $5,747.70 per employee for Tier II benefits, up from $4,956 in 1988. The maximum Tier II tax paid by an employee in 1989 will increase to $1,749.30 from $1,428.

About 1,000 railroads now contribute to the Railroad Retirement System, which covers about 340,000 active employees.

Agency reauthorized

The federal agency that provides political risk insurance to U.S. companies investing in developing countries will continue operating for another four years.

President Reagan last month signed into law a four-year reauthorization of the Overseas Private Investment Corp., allowing the facility to operate until Sept. 30, 1992. The agency must be reauthorized by Congress every four years. ■

Work comp forum eyes cost controls

INDIANAPOLIS—The International Workers' Compensation Foundation Inc. will focus on health care cost-containment issues during its first national forum Feb. 8-11 at the Fairmont Hotel in New Orleans.

The foundation is a new educational and research affiliate of the International Assn. of Industrial Accident Boards & Commissions, whose members are governmental agencies involved in the administration of workers compensation laws in the United States, Canada, Australia and New Zealand (*BI*, Sept. 12).

"How to balance quality health care and escalating costs is a matter of great economic significance," said John N. Shanks II, the foundation's president.

The health care cost component in workers compensation claims makes up a growing portion of the benefit dollar each year, and educated speculation suggests that it may exceed 50% in the near future, the foundation reports.

Speakers during the 2½-day forum will include more than two dozen physicians, chiropractors, attorneys, union spokesmen, insurer representatives, state workers compensation administrators and federal officials as well as work comp rehabilitation and cost-containment service providers.

In addition, Michael A. Morrisey, a scholar with the University of Alabama's Center for Health Risk Assessment and Disease Prevention, will present a historical perspective of health care cost issues in his keynote address Feb. 9.

Other topics include a variety of approaches to cost containment, including the use of physical and vocational rehabilitation. In addition, speakers will discuss what employers, insurers, health care institutions, and state and federal governments should be doing to help control work comp costs.

The registration fee is $250, or $195 for governmental representatives or IAIABC associate members, who include a wide variety of professionals and service providers.

The registration deadline is Jan. 6.

Checks should be made payable to the International Workers' Compensation Foundation Inc., P.O. Box 2102, Indianapolis, Ind. 46206.

Registrants may pick up their conference packets at the Fairmont Hotel beginning at 3 p.m. Feb. 8. A reception will follow at 6 p.m. Sessions begin at 8:45 a.m. Feb. 9 and continue until noon Feb. 11.

Hotel reservations can be made through the foundation or individually by calling 504-529-7111.

For information about associate memberships, contact Mr. Shanks at 317-636-5511.

Markets

Met Life agrees to buy Allstate unit

New York-based Metropolitan Life Insurance Co. has agreed to buy the group life and health brokerage operations of Allstate Insurance Co. of Northbrook, Ill.

Allstate, a unit of Sears, Roebuck & Co., announced earlier this year it was selling its group life and health brokerage operations, which reported $416 million in revenues in 1987.

"Our customers can be assured that the change in ownership will not cause any interruption in coverage or service," said Herb Lister, chairman of Allstate Life Insurance Co.

The agreement is subject to completion of a definitive agreement between Met Life and Allstate and regulatory approval.

New MGA

The MMI Cos. Inc. of Bannockburn, Ill., has entered into a joint venture with Azimuth Underwriting Managers Inc. in New York to form a new underwriting manager.

The new company, Azimuth American Managers Inc., will bind reinsurance and excess insurance on behalf of American Continental Insurance Co. of Kansas City, Mo.

American Continental is licensed in 48 states and has recently received an initial B rating from A.M. Best Co.

Azimuth American Managers Inc., which is scheduled to begin operations after Jan. 1, will be located at 100 William St., New York, N.Y. 10038; 212-227-0600.

Princeton expands

The Princeton Insurance Co., a leading insurer of medical malpractice coverage, plans to begin offering the coverage to medical centers and physicians in Maryland.

The company will now offer liability coverage to qualified medical centers and physicians in Maryland through its new office in Hunt Valley.

The company is awaiting rates and insurance policy form approval from the Maryland Insurance Division and hopes to begin writing coverage in Maryland early next year.

In New Jersey, Princeton insures nearly 16,000 health care professionals, including almost 8,000 physicians, surgeons and dentists. In addition, the company insures more than 30 hospitals and several nursing homes, clinics, rehabilitation centers and long-term care facilities.

Princeton reported $132 million of gross written premiums, $205.6 million in assets and more than $28 million in surplus 1987.

For more information contact Paul H. Math, Regional Vp, 4 North Park Drive, Hunt Valley, Md. 21030-1812; 301-785-0900.

Tillinghast expands

New York-based Towers, Perrin, Forster & Crosby Inc. is now offering risk management consulting services in Washington, D.C., through its Tillinghast division.

In addition to existing actuarial and claim management capabilities, the Washington office will now offer clients exposure identification, risk assessment and risk financing advice.

Steven R. Danielsen will coordinate the new risk management practice. Prior to joining Tillinghast, Mr. Danielsen was the corporate casualty risk manager for J.C. Penney Co. in New York.

For more information contact Mr. Danielsen at 4601 N. Fairfax Drive, Arlington, Va. 22203; 703-527-7500.

Prudential expands

Prudential Health Care Plan of Connecticut Inc. will market its PruCare Health Maintenance Organization to Connecticut employers.

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Markets

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Prudential Health Care Plan is one of the nation's largest managed care programs with more than 1.5 million enrollees throughout the United States.

In Connecticut, more than 250 physicians have joined the PruCare provider network.

For more information contact Mike Clark, director-group marketing, 50 Founders Plaza, East Hartford, Conn. 06105; 203-528-7151.

New offices

McGriff, Seibels & Williams Inc. has opened a new office at 3500 Parkway Lane N.W., Suite 110, Norcross, Ga. 30092; 404-368-2076.

Science Applications International Corp. has opened a risk management services office at 711 Bay Area Blvd., Suite 210, Webster, Texas 77598; 713-338-1936.

LMG Excess Ltd. has opened a new office at 49 Ridgedale Ave., East Hanover, N.J. 07936; 201-428-8080.

Mergers/acquisitions

The Great Lakes Reinsurance Co. of Toronto has acquired the treaty and facultative reinsurance operations of **The Travelers Indemnity Co.** in Brussels, Belgium.

Meeker Sharkey & Moffatt, a Cranford, N.J.-based insurance agency, has acquired **Michael Bentley Insurance Management Co. Inc.**, an agency in Freehold, N.J.

Third-party administrator **North American Benefits Network Inc.**, an affiliate of Swiss Reinsurance Co. in New York, has acquired **Ameritrust Benefits Management**, a unit of Ameritrust Co. of Cleveland. Ameritrust Benefits Management provides administrative services for self-insured employers.

Norwest Insurance Inc., a Des Moines, Iowa-based agency, has acquired **Hopkins Insurance Agency Inc.** of Des Moines.

Peoria, Ill.-based **RLI Corp.** has signed an agreement to acquire **Aviation Underwriting Specialists Inc.** of Chesterfield, Mo.

London broker **Robert Fraser Group** has acquired a controlling interest in **Coastal Brokers Insurance Services Inc.** of San Ramon, Calif.

General Re Corp. of Stamford, Conn., has completed its previously announced sale of **General Reassurance Corp.** to **Reassurance Acquisition Corp.** General Reassurance will change its name to Life Reassurance Corp. of America.

Jardine Emett & Chandler Pennsylvania Inc., a unit of Jardine Emett & Chandler Inc., the nation's 9th-largest brokerage, has acquired **Schauseil Insurance Associates** of Horsham, Pa.

Giddings, Corby, Hynes Inc., a Modesto, Calif.-based broker, has purchased **Central Insurance Agency** of Turlock, Calif.

Accident Underwriters Inc. of Dallas has merged with **Health Special Risk Inc.** of Mendota Heights, Minn., and now is being called Health Special Risk Accident Underwriters. The underwriting manager and claims administrator has offices in Dallas; Mendota Heights, Minn.; Atlanta; and Los Angeles.

Irvine, Calif.-based **Consolidated Care Corp.**, a managed care corporation, has acquired **Rogers Sinclair & Associates**, a disability management and medical bill audit firm in Lexington, Ky.

Jardine Emett & Chandler Inc. Arizona Inc., the Phoenix, Ariz.-based subsidiary of Jardine Emett & Chandler Inc., the nation's ninth-largest brokerage, has acquired **R.W. Milne Co. Inc.** of Phoenix.

North Star Reinsurance Corp. of Parsippany, N.J., will acquire the domestic treaty reinsurance operations of **Constitution State Management Co.**, a subsidiary of Travelers Corp. ■

Few to imitate LTV's accounting move

By TRUDY RING and CAROL WILEY
Crain News Service

Few companies are likely to quickly follow LTV Corp.'s lead in recognizing post-retirement health care liabilities on their balance sheets in advance of the adoption of an accounting statement requiring such action.

Dallas-based LTV announced last month it had recorded a $2.26 billion charge to recognize post-retirement liabilities accrued up to Jan. 1 of this year (*BI*, Nov. 28). This charge was reflected in its financial results for the nine months ended Sept. 30.

LTV has accrued an additional $240 million in post-retirement benefit liabilities in 1988, a company spokesman said. Three-fourths of this was reflected in the nine-month results, and the rest will be reflected by the end of the year.

These numbers include the full actuarial amount of post-retirement medical and life insurance benefits for the company's 70,000 retirees, as well as the amount of these benefits that its 48,000 active employees have earned to date, the spokesman said.

The Financial Accounting Standards Board has proposed that companies switch to accrual from cash accounting for post-retirement welfare benefits and deduct millions of dollars from earnings each year to reflect their liability for these benefits. If FASB adopts this proposal, it will not go into effect until fiscal years beginning after Dec. 15, 1991 (*BI*, Oct. 17).

LTV, however, saw some advantages in recognizing its liability in advance of the FASB rule.

"We have a unique opportunity (to recognize these costs) while we're in Chapter 11," the spokesman pointed out. While the company is operating under Chapter 11 of the Federal Bankruptcy Act, recognition of this charge does not create problems with debt covenants, he said.

Another company that has recognized its post-retirement health care liability, Wheeling-Pittsburgh Steel Corp. in Wheeling, W.Va., also is in Chapter 11 reorganization. The steelmaker recognized $149.7 million in post-retirement health care liabilities in 1987.

However, employee benefits officials at other corporations and employee benefit consultants expect few companies to follow LTV's lead immediately, noting LTV's unusual situation.

"I would be surprised if companies took (the recognition of costs) early, because it's going to make the balance sheet look bad," said Fred Hamacher, vp-compensation and benefits at Dayton-Hudson Corp. in Minneapolis.

He said he found LTV's action premature, though he added that LTV executives likely had reason to recognize the liabilities now because of the company's Chapter 11 reorganization.

"When you've got a negative net worth, what's a bigger negative net worth?" he said.

LTV's negative net worth increased to $5.3 billion as a result of the post-retirement and other charges.

Meanwhile, most companies are waiting for the final FASB regulations to come out before taking any action.

"FASB has changed its view so many times," said Tom Hartlage, director of benefits financing at Batus Inc. in Louisville, Ky.

"We're still waiting to see the FASB ruling, and no decisions have been made," said a spokeswoman for Southwestern Bell Corp. in St. Louis. "We expect others will do the same."

Patricia J. Ibbs, principal of PJI Benefits, an Atlanta employee benefits consulting firm, said some employers are recognizing the cost of post-retirement health benefits before the final FASB ruling, "but it is not widespread."

William Madden, senior vp in the Deerfield, Ill., office of SEI Corp., said because the FASB ruling will not take effect for several years, "it's premature to absorb it all today." Corporations need the time before the FASB ruling takes effect "to help contain the cost. . .to put money aside so that when the time arrives, there will be some assets to charge off the expenses."

Companies that do emulate LTV's action might be those that would post a loss anyway or that want to report an expense at the same time they are reporting a large gain, said Michael Johnston, actuary and partner with Hewitt Associates in Lincolnshire, Ill.

Also, companies that are undergoing a change in ownership might take this charge before the acquisition is completed to get it out of the way, added Anna Rappaport, managing director in William M. Mercer-Meidinger-Hansen Inc.'s Chicago office.

"I think (LTV) will be the rare exception," she added. ■

Agent/Broker Topics

A monthly editorial section sent exclusively to agents and brokers

Trouble in paradise

Proposition 103 dominates PIA convention in Orlando

By LAURA MAZZUCA

ORLANDO, Fla.—California's controversial Proposition 103, and the groundswell of consumer antagonism toward the insurance industry that propelled it, is foremost on agents' minds, judging from the heated discussions at the 57th annual convention of the National Assn. of Professional Insurance Agents.

The underlying mood of apprehension at the PIA convention, held Nov. 13-16 in Orlando, Fla., the home of Walt Disney World, seemed to echo that of last year's meeting, which was held in Chicago a week after the stock market crash (*A/BT*, Dec. 7, 1987).

But agents attending this year's PIA convention appeared to be even more concerned with Proposition 103 than they were worried about the stock market crash a year ago.

Proposition 103, if implemented, would roll back for one year most commercial property/casualty "insurance charges" in California to 20% lower than November 1987 rates (*BI*, Nov. 28; Nov. 21; Nov. 14). Some insurers have stopped writing new business in California while the California Supreme Court decides an industry challenge of the proposition constitutionality, while other companies have vowed to pull out of California if the proposition is upheld.

The defection of insurers will threaten the business of thousands of California insurance agents, as their ability to place property/casualty coverage shrinks, according to a PIA spokesman.

"Potentially, Proposition 103 could actually work to damage not only agents but the very consumers who think they're actually doing themselves a favor," said the PIA spokesman. "What in fact they're doing is reducing rates to a potentially unreasonable level and almost begging insurance companies to leave California. Consumers are shooting themselves in the foot because they're not going to have markets or coverage."

The broader implication of Proposition 103 is that its spirit will spread to other states, the PIA spokesman said.

"California serves as an inspiration for other states," he said. "We think there's a very strong possibility that this will inspire a slew of auto reform initiatives in many states."

Agents at the PIA convention spent most of their time speculating on whether Proposition 103 was an aberration or a portent of things to come.

"The California marketplace has been turned upside-down by Proposition 103," said James V. Swanson, president of Swanson Insurance Co., an agency in El Cajon, Calif., during a panel discussion on 1989 market conditions. Mr. Swanson is also the president of the California/Nevada chapter of the PIA.

"Proposition 103 is a dagger in the heart of consumers, agents, insurers and, ultimately, the economic viability of the state," said Willis J. Hargrave Jr., outgoing president of the national PIA, after the PIA's board of directors voted unanimously on the first day of the convention to join efforts in the courts and the California Legislature to block Proposition 103.

"PIA National, along with PIA of California/Nevada, are acting swiftly to achieve repeal. We will work to form a broad-based coalition to overturn this measure before it comes to law," said Mr. Hargrave, president of Harco Insurance Services in Houston.

The association also is calling on insurers to remain in the California marketplace during the court-imposed stay in order to help stabilize the market and preserve the business of agents in the state.

More than 70 insurers are said to be threatening to pull out of one or more lines of property/casualty insurance in the state—especially personal auto insurance—as a result of Proposition 103, and Mr. Swanson predicts that if adjustments are not made to the law, "there will not be much of an auto market in California."

"We recognize the frustration companies have, but we strongly urge them to remain in the marketplace until the issue is fully resolved by the courts or other-

Continued on next page

PIA convention

Continued from previous page

wise," said Mr. Swanson.

In panel discussions and breakout workshops at the PIA convention, the implications of Proposition 103 hovered over other industry problems—such as the softening commercial property/casualty insurance market, changes in the tax law and the threatened repeal of the McCarran-Ferguson Act—making it difficult for speakers to predict the future of the market.

In a general session panel discussion, "Blueprint for Operations in 2001," panelists representing agents, insurers and regulators agreed that the impact of Proposition 103 and the consumer movement would make it nearly impossible to predict the industry's future (see story, page 36B).

And, although workshops addressed perennial subjects—like target marketing, agency management, automation, perpetuation and what insurers want from their agents—workshop speakers picked up on the edgy mood and expanded their presentations to include speculation on Proposition 103.

"Is anybody here from California?" was the frequent question moderators and speakers threw out to workshop attendees. Californians usually responded with a sheepish grin or a chagrined shake of the head.

But the concern wasn't just focused on the Golden State's legislative action. Agents from the East Coast—particularly those from New York, Massachusetts and New Jersey—also are nervous about the atmosphere in their states.

Robert A. Leibold, president of Northbrook Property & Casualty Insurance Co. in South Barrington, Ill., a subsidiary of Allstate Property & Casualty Insurance Co. in Northbrook, Ill., verified that Allstate would not be renewing its property/casualty licenses in Massachusetts after June 1989 because it "can no longer support" assessments from the state's assigned risk pool for substandard auto risks (*BI*, Nov. 21).

Agents from New Jersey complained about the historically turbulent automobile insurance market in their state.

However, in spite of many muttered complaints about the maneuvers of consumer activist Ralph Nader and the voters in "the land of fruits and nuts," PIA executives and other industry officials agreed that the insurance industry is at least partially at fault for the consumer revolt in California and other states.

"As we wind up 1988, we face a groundswell of political activism by those who are trying to seize our industry's agenda; those who are trying to tell us how to run our industry," said incoming PIA President David L. Ream in his inaugural address.

"It's costing us millions and it's eroding the profits of agents and companies alike," said Mr. Ream, a principal with North Coast Insurance Systems Agency in Cleveland and former president of the PIA of Ohio.

"We've underestimated the political activism of consumers and the influence of consumer groups that thrive on social turmoil such as an insurance crisis."

To counteract the industry's poor public perception, Mr. Ream proposed that agents, insurers and consumers work together to "build a better business climate."

"Market shares and profits have a way of taking care of themselves if we just do what's right by our customers," said Mr. Ream.

Pricing irregularities, excessive use of confusing insurance jargon and the public's perception that the McCarran-Ferguson Act gives the industry a "preferred status" are all justifiable reasons for consumer disgruntlement with the insurance industry, said Mr. Swanson during a panel discussion.

He suggested that insurers show "more accountability" to the public in order to head off a potential tide of bad feelings toward the industry.

To counter public misconceptions about insurance, Mr. Hargrave, the outgoing PIA president, pointed with pride in his state of the association address to the establishment last year of the PIA's consumer liaison group (*A/BT*, Dec. 7, 1987).

The "PIA has reached out to build closer ties with our valued customers, whose buying decisions will pay our salaries and decide our future," he said. "By improving our dialogue with consumers, we hope to quiet the voices of consumer dismay that have so damaged our business in the last few years.

"We also intend to build greater public understanding of our unique role and strength as caring and concerned insurance providers and thereby rebuild the public's desire to do business through us before they consider other delivery systems," he said.

While Proposition 103 was foremost on the minds of agents attending the PIA convention, the continuing soft commercial property/casualty insurance market was another frequent topic of discussion, with agent and insurer representatives accepting their share of the responsibility for market cycles.

The soft market is the result of "pricing irresponsibility" by insurers and "rookieism" in their rating systems and classifications, said Robert L. Bailey, president of State Auto Insurance Cos. in Columbus, Ohio.

However, agents must do their part as well in order to squelch rapid market cycling, said Fred R. Marcon, president of the Insurance Services Office Inc. in New York, speaking during the general session panel. An agent's ability to "educate, automate and communicate" will become increasingly important in 1989 and beyond, as the industry's premium growth stalls.

In addition, the insurance industry must no longer be interpreted as a "pass-through" mechanism, in which consumers blindly pay premiums, insurers unquestioningly pay claims and prices continue to escalate, added Mr. Marcon. Instead, loss trends should be closely scrutinized by both the industry and legislators, to determine why excessive losses and the subsequent higher premium rates occur.

However, in spite of soft markets, Proposition 103 and other threats to the industry, many attendees felt confident that the independent agent would weather the storm.

The very fact that agents are smaller and adaptable ensures that they will be better able to shift gears than large insurers in the event of societal changes, said Robert A. Nicosia, president of Pilgrim Insurance Agency in Nutley, N.J., and national director of the PIA of New Jersey, in a panel discussion on the future of the agency system.

"Change has been in this business for years," added Mr. Marcon of ISO. "But today, it's the rate of change we have to deal with." ■

Current issues won't fade soon, panelists say

By LAURA MAZZUCA

ORLANDO, Fla.—Although insurance industry experts predict that the soft commercial property/casualty insurance market will show signs of change by next year, problems in the industry today will influence agents and insurers into the next century.

Representatives from insurers, agencies and regulatory bodies addressed both short-term projections and the agency system in the year 2001 during panel discussions at the 57th annual convention of the National Assn. of Professional Insurance Agents in Orlando, Fla.

In the short run, some panelists believed that low interest rates and a stable reinsurance market would help turn the soft market as early as April 1989, while others were more pessimistic about improvements before the end of next year.

And, the long-term picture for the year 2001 and beyond depends on the social, economic and political atmosphere in the country's next century as much as on changes in the insurance marketplace.

"It's much easier to predict what's going to happen in 2000 and 2010 than it is for what's going to happen next week," said Fred R. Marcon, president of the Insurance Services Office Inc. in New York.

However, he ventured to predict that any recovery in the market in 1989 would not occur until late in the year. "It is clear that the recovery is slow," said Mr. Marcon.

ISO statistics indicate that net written premium growth for the four quarters ended in June 1988 was 4.8%, compared with 9.4% growth for all of 1987, said Mr. Marcon. And, ISO projects the growth rate will not pick up this year as the projected premium growth figure for 1988 is 3.5%.

"We see no measurable improvement or strong erosion in 1989," he added.

And, carryover issues from this year—such as tax reform and threats to the McCarran-Ferguson Act—will have an impact on the insurance market throughout next year and beyond, said Mr. Marcon.

"This time around, in this soft cycle, the industry has new challenges that it didn't have in the last soft cycle," he said.

For example, "some insurers still don't have a handle on what they're going to be paying on federal taxes" in 1989, said Mr. Marcon. Moreover, when the 101st Congress convenes, "they'll be looking for additional tax dollars," he added. "So there's an uncertainty here that insurers weren't faced with before."

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Baby boomers offer insurers new markets for their products

By LAURA MAZZUCA

The 74 million-strong baby boom generation, now in its peak years of personal lines insurance spending, will continue to offer the insurers new opportunities for product sales and development over the next 20 years as the generation edges toward retirement, a study shows.

"If you can match your services to the needs of this baby boom and ride that demographic high ridge, you will enjoy the largest markets," said Philip M. Lankford, research director for Allstate Insurance Co. in Northbrook, Ill., which commissioned the study.

Mr. Lankford presented the results last month at the 57th annual convention of the National Professional Insurance Agents in Orlando, Fla.

"From 1946 to 1964 there were 74 million births, which make up 30% of today's population," he explained. "The baby boom affected our society in many ways. Maternity wards and schools were crowded in the 1950s, colleges expanded in the 1960s and the labor market was expanded in the 1970s."

And, the impact of the boomers continues to affect the insurance industry.

"The family life cycle describes the experiences common to us all as life unfolds: starting as a young single adult, getting married, settling down, buying a car, your first home, having children, moving into the peak productive years in the late 40s and early 50s, preparing for retirement and eventually retirement at 65," said Mr. Lankford.

"As we look at the different sized age groups moving through the life cycles, we see the changing opportunities for our products," he said.

For instance, today's robust personal lines market is a direct result of the coming of age of the boomers, who are buying homes and cars in record numbers. "These may be the good old days for personal lines insurance," suggested Mr. Lankford.

Product needs will shift by the 1990s, when the bulk of the baby boomers in their 40s and 50s approach their peak earnings years, said Mr. Lankford. "During the next decade to the year 2000, investments and the interest-sensitive life insurance products are important," he said.

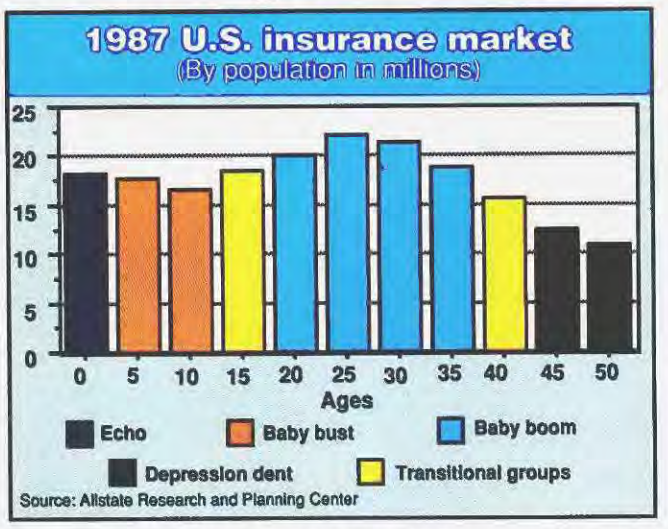
From 2000 to 2010, as the boomers prepare for retirement, needs will again shift, and there will be continued growth in investments and life insurance investment products, predicted Mr. Lankford.

Expanded health insurance and long-term care insurance will become another necessity for the aging boomers, and Mr. Lankford predicted that these will be the "hot growth markets as the boomers retire."

Additionally, the soft housing market at the turn of the century will encourage consumers to consider investments in tax-deferred annuities as an important part of retirement planning, he said.

Finally, from 2010 to 2020, when a large part of the population will start to retire, "the growth markets will be those that service the elderly and sick, such as medical insurance, Medicare supplemental insurance and long-term care," said Mr. Lankford.

In fact, the population of elderly in the United States—people aged 75 and older—is growing twice as rapidly as any other group and will reach 14 million in the year 2020, he added.



Another factor in the development of changing markets is what demographers call the "baby bust" generation, which resulted from the record low birth rates in the late 1960s and early 1970s, said Mr. Lankford.

These "busters" will move into the personal lines life cycle just as the boomers grow out of it, which will help sustain homeowners and auto insurance sales. However, the numbers of the baby busters represent a decline of 8 million from the boomers, which will result in a slowdown in personal lines growth.

"This marks the end of the 30-year growth that the industry has enjoyed so much," said Mr. Lankford. "From then on, your growth must come through increased competition."

As product needs change, so will the system of delivery, predicted Mr. Lankford. "The dilemma is automation or higher wages: As an employer you can invest in computers or higher-cost staff," he said.

Automation, which offers computerized functions like underwriting, rate comparisons, target marketing, etc., "will decrease your need for labor, particularly for entry-level clerical positions."

However, automation can be costly, and entry-level employees will still be needed to run the system, he added. The industry will face a shortage of entry-level employees, "but there are many alternatives open to us in automation, part-timers, retirees and new migration to the United States," he noted.

For instance, the number of immigrants is on the increase, with immigrants now representing almost 30% of U.S. population growth. These represent an untapped talent pool for insurance employees, said Mr. Lankford.

"These demographic changes forecast problems we've not encountered before but one filled with opportunities for those employers that are flexible, look ahead and prepare for them," Mr. Lankford concluded. ■

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PIA panel

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Mr. Marcon said the other uncertainty is the "continuing assault on McCarran-Ferguson," which among other things offers insurers a limited exemption from federal antitrust law. McCarran-Ferguson will continue to be threatened as long as "we as an industry are not able to convey accurately and clearly the benefit of this exemption to the consumer," he added.

Mr. Marcon

Such unresolved problems create an atmosphere of uncertainty, which is not conducive to an underwriting recovery, said Mr. Marcon.

Other panelists were more optimistic about a market recovery next year. Continued low interest rates and the stable state of the reinsurance market could mean an improvement in the market as early as April 1989, said Robert L. Bailey, president of State Auto Insurance Cos. in Columbus, Ohio.

However, Mr. Bailey preferred to qualify any predictions by viewing the market by segment rather than as a whole. For example, personal lines rates have remained stable throughout the soft market, and he predicts personal lines products will remain strong through 1989.

In small commercial lines, which seems to closely follow trends in personal lines, relationships between agents and small business people will lend more stability, said Mr. Bailey. This cycle is "flatter," with fewer fluctuations than large commercial lines, he added.

The soft market is most clearly evident in larger commercial lines, and insurers must curb "pricing irresponsibility" to turn the market around, said Mr. Bailey.

"To the extent that independent insurers deviate from cost-based pricing, the length of recovery certainly is in question as far as we're concerned," agreed Mr. Marcon. "An insurer does so at its peril."

The profitability of commercial lines underwriting will continue to decline through at least some of next year, said Robert A. Leibold, president of Northbrook Property & Casualty Insurance Co. in South Barrington, Ill. However, he predicts pricing stability by the end of 1989.

Some of the same problems facing the industry today were expected to continue influencing operations into the next century in another PIA panel discussion, titled "Blueprint for Operations in 2001."

"Competition will continue to be fierce in our business" as product needs change, but the insurance business "thrives" on such an environment, said Dale R. Comey, president of property/casualty operations for Hartford Insurance Group in Hartford, Conn.

"We have to do everything we can to keep our customer base," Mr. Comey also pointed out. This means automation, product improvement and improved customer service, he added.

Mr. Comey

Agents also must work to anticipate the shifting needs of their clients, and demographic studies such as one presented at the PIA convention by Allstate Insurance Co. can provide agents with clues on how to attract and retain business, he said (see story, page 36B).

"There has been too much emphasis on problems and not enough on opportunities available to independent agents," said Robert Nicosia, president of Pilgrim Insurance Agency in Nutley, N.J. Solid demographic information on future trends "helps agents across the board, but they have to listen to it and utilize it."

Such information also can prove helpful to insurers in the design of new products, said Mr. Bailey.

Demographics are important to independent agents even if they are predominantly geared toward property/casualty insurance, "particularly members of the PIA who are largely property and casualty-oriented agents but nevertheless are beginning to see the need to involve themselves in life insurance-related products," said Mr. Comey. "We even see that at the Hartford—the need to extend our capabilities to meet the needs of our customer base."

Although some panelists were reluctant to get too specific when asked "What will agencies be like in 2001?", the Allstate demographic study helped them extrapolate on future agency operations.

Using the Allstate demographics as an example, Mr. Bailey suggested that agents of the future will focus on the upscale market, as the economy dictates more "polarization of income."

Most projections centered on increased cooperation between agents and insurers.

Mr. Bailey predicted that marketing and service orientation will become increasingly important for both parties, with flexibility and open lines of communication a must. "We'll have to adjust all the time to make sure we're filling the void," he added.

Because of this, agents will become "true partners" with their insurers by assuming more financial risk, which is the ultimate indication of a real partnership, said Mr. Nicosia. He explained that agents could become responsible for a portion of a customer's losses, which would make agents more selective about the risks they accept for an insurer.

In the future, large insurers will spin off their personal lines divisions into separate entities, predicted Mr. Nicosia. In fact, personal lines will become "the white-hot area in the next 12 years."

In addition, Mr. Nicosia envisions a steady decline in the number of agencies over the next five years, after which there will be a boom of personal-lines-only agents to cash in on that trend.

The profile of agency employees will change drastically in the future as well, continued Mr. Nicosia. He pointed out that many agency principals are still reluctant to hire women as producers but that this will change as the number of women in the workforce continues to rise.

Some of the projections made by the panel underscored future challenges for the insurance industry.

For instance, the continuing consumer assault on the McCarran-Ferguson Act could eventually result in its repeal, said ISO's Mr. Marcon.

If McCarran-Ferguson is repealed, small insurers will be unable to survive—and even large insurers will be in trouble—since it will be more difficult to operate without shared loss information, he said.

Banks, too, will continue their encroachment on the insurance industry, with disastrous results for agents, said Mr. Nicosia.

"The banks are tremendously more incompetent than our companies" and are therefore "the biggest threat in the next 12 years" because they offer consumers the convenience of one-stop shopping, he said.

Additionally, the current invasion of foreign insurance companies will escalate in the personal lines insurance market and may tie into banks through lobby sales—a double threat to the independent agency system, said Mr. Nicosia.

"On a level playing field, no one can beat the independent agent," but this unfair balance may be a major threat, he said. ■

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Consultant offers E&O prevention tips

By LAURA MAZZUCA

Good records, careful billing procedures and a good working relationship with clients are three of the best defenses an agent can use to guard against errors and omissions lawsuits, a consultant says.

Agents E&O insurance is becoming more expensive because of an increase in E&O litigation, according to Ronald T. Anderson, consultant and president of insurance educational publisher Buck Mountain Press in Steamboat Springs, Colo.

Mr. Anderson spoke on E&O liability prevention during a workshop last month at the 57th annual convention of the National Assn. of Professional Insurance Agents in Orlando, Fla.

Citing statistics from Utica Mutual Insurance Co. in New Hartford, N.Y., which writes E&O coverage primarily for independent agents, Mr. Anderson noted that for every 100 policies an agency binds, 12 E&O claims will follow.

And, although 60% of these claims seek less than $5,000 in damages, E&O disputes can drag on for anywhere from nine to 28 months if the case goes to trial.

But, there is good news: While 70% of Utica's E&O claims go to trial, 72% of those usually are settled in an agency's favor, Mr. Anderson said.

As a result, E&O litigation is becoming less of a financial threat to an agency and more of a "management problem," said Mr. Anderson. It's "an annoying problem that costs a lot of time to get rid of."

One way to avoid an E&O allegation is to recognize areas in which an error or omission can occur and eliminate any related exposures, he said.

According to Mr. Anderson, most E&O exposures arise from one of three areas: misunderstood authority, insurer insolvencies and poor agency management.

A client's misunderstanding of the three areas of authority—actual or express; implied; or apparent—generates the most E&O actions, he said.

As an example of a misunderstanding of actual authority, a client may file a suit claiming that the agent had the power to bind coverage, while the insurer may not have given the agent that authority.

Actual authority usually is spelled out in the agency/insurer contract. Actual authority also can be established in an oral agreement, but it's much more difficult to prove in court, Mr. Anderson explained.

In a case involving implied authority, a client can assume the agent is responsible for some detail that may have been omitted from a written contract and may file an E&O suit alleging that the agent had implied authority to look out for the client's best interests.

Assumption of implied authority is generally still valid in court, said Mr. Anderson.

Apparent authority is the most dangerous area in E&O liability, since a client will frequently assume that anyone connected with the agency is licensed to place insurance and therefore is responsible for any error or omission. Because of this, Mr. Anderson suggests that anyone employed in an insurance agency—including clerks, receptionists, etc.—be licensed.

An insurer's insolvency also can result in an E&O suit being filed against an agent, according to Mr. Anderson. The increasing number of insurance company insolvencies is "a major problem in this country and will continue to be," he said.

While in the past, an agent was not held responsible for a subsequent insolvency if an insurer was sound when a policy was bound, many courts today may rule that the agent *is* responsible, since he or she should have scrutinized an insurer's financial status before placing business with it, Mr. Anderson said.

However, in the most recent ruling on the subject, the Texas Supreme Court ruled that an agent is not liable for the solvency of an insurer with which he or she has placed coverage. The agent involved in the case, Higginbotham & Associates in Fort Worth, Texas, had been sued by a client who alleged the brokerage was negligent in placing his coverage with Proprietors Insurance Co., a Delaware, Ohio-based insurer declared insolvent in August 1981 (*BI*, Feb. 15; Sept. 28, 1987).

To guard against the possibility of E&O suits arising from insurer insolvencies, Mr. Anderson recommended that agency principals put someone in charge of monitoring insurer solvency in-depth by checking resources such as A.M. Best Co. reports, Standard & Poor's Corp.'s credit ratings, stockholder reports, trade magazine articles and other information. Copies of this material should be kept to be used as evidence in the event of an E&O allegation, he added.

However, a cursory examination of an insurer's Best's rating is no longer enough to hold up in court, Mr. Anderson explained.

Among the "red flags" that agents should look for when monitoring an insurer's solvency are:

- Combined ratio. However, while a combined ratio exceeding 100% shows that the insurer is losing money on its underwriting activities, the losses can be offset by investment income, Mr. Anderson noted.
- Lines of business. Insurers should be monitored by line of coverage, according to Mr. Anderson.
- Surplus. An insurer's surplus should grow 10% per year to compensate for inflation, said Mr. Anderson, who also warned agents of insurers that grow too fast and may be financially unstable.

Other areas to watch are: the number of policies issued; any slowdown in claims payment activity; the actions of related companies; an insurer's withdrawal from a territory or a line; and unexpected management changes.

Solid agency management and administration also can prevent E&O allegations, according to Mr. Anderson.

Under basic agency law, the three parties to an agency transaction are the insurer, the agent and the third party, or client, he explained. The agent is the conduit between the insurer and the client;

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he or she bears the responsibility for administration and channeling funds back to the insurer, he said.

For agents, the relationship of principal, or who he or she serves, changes halfway through the transaction, said Mr. Anderson. When the agent is selecting coverage and an insurer and is binding coverage, he is primarily responsible to the client.

However, after the coverage is bound, the agent is working directly for the insurer by handling administrative duties, he noted.

Because of this, the independent agent is in a unique operating position and is open to E&O allegations made by clients who may not understand the agent's responsibilities to the insurer, Mr. Anderson explained.

Agents should keep "clean files" and maintain standard forms and operating procedures for all office functions, Mr. Anderson said. Forget about the automation industry's exhortation to make yours a "paperless agency"; paper files are essential as evidence if an agency is slapped with an E&O claim, Mr. Anderson said.

Because electronic files can be tampered with, deleted and are harder to present as evidence in court, he suggested agents keep paper backup files, even if their agencies are fully automated.

Clients may not understand the agent's responsibility to the insurer, says Ronald T. Anderson.

Agency principals should keep in mind how the agency's files would look to a jury: "The way you operate will impact a jury one way or the other," he said.

Misuse of office technology and equipment also can get an agent into E&O trouble, he pointed out.

Phone logs are important since they track specific coverage information discussed with the client, he said. Whenever a client is contacted by phone, a notation should be made in his file on what was discussed.

Telephone answering machines are a convenience for busy agents, but they can increase E&O exposure if messages are inadvertently erased, he said. To avoid this, Mr. Anderson suggested assigning an agency employee who understands the system to transcribe answering machine messages.

FAX machines also can be an area for exposure, he said. While FAX material is admissible as evidence in court, some courts won't accept a FAXed signature as original. Also, the thermal paper deteriorates and is not good for long-term filing.

But, in spite of careful record-keeping and cautious business placement, an agency may still end up in court with an E&O contention. If this happens, Mr. Anderson suggests that the agency principal:

- Hold a staff meeting to inform the employees.
- Tell the staff that there will be no attempt to correct the alleged error or omission. This action would not only be an admission of guilt, but also can be construed as an attempt to defraud the insurer, he explained.
- Collect detailed notes and memos from anyone involved in the claim.
- Consider the E&O claim a management problem that will be around for a limited period of time.
- Don't change an agency's operating procedures after E&O investigations are under way, he said. ■

Choose E&O policy carefully

By LAURA MAZZUCA

As many as 46% of independent agents no longer purchase errors and omissions liability insurance because they cannot afford—or they think they do not need—the coverage, a consultant says.

However going bare "is not a solution," asserted Ronald T. Anderson, consultant and president of insurance education publisher Buck Mountain Press in Steamboat Springs, Colo.

Mr. Anderson suggests that agents who do purchase E&O coverage carefully examine policies before signing on the dotted line.

Areas to examine include:

- Coverage. Although he could not cite any exact premiums or coverage limits, Mr. Anderson noted that agencies currently buy average limits of about $825,000 in primary E&O coverage, plus additional umbrella coverage. Average premiums total about $7,000.

Agencies purchasing such coverage should make the aggregate limit as high as possible since E&O claims are "random. You can go 20 years without one, then get three in a year," said Mr. Anderson.

Defense costs should not be included within the limits of the policy, he added.

- Deductibles. Many E&O policies include both loss payment and defense deductibles, said Mr. Anderson. He suggests that the agency maintain a deductible that "you are willing to throw in a pot to get rid of some jerk," since in the event of a claim, it's more cost-effective for the agency's insurer to settle with the complainant rather than for the agency to litigate the matter.
- "Consent to settle" clauses. Such a clause gives the agent the right to reject an offer from the other side. However, in most cases, the agency would be "better off to settle and get rid" of the claim, said Mr. Anderson.
- Tail coverage. Mr. Anderson suggested that agents purchase tail coverage when purchasing claims-made E&O coverage, since E&O claims can be filed after the policy period ends. This is especially important if the agent plans to retire so that he or she is not faced with uninsured claims after retirement.

Additionally, if an agency is going to be involved in a purchase, merger or cluster, the principals should discuss E&O exposures with an expert before taking any legal action, suggested Mr. Anderson.

Clusters may, in fact, actually be partnerships and are therefore increase E&O exposures because of clients' misunderstandings about who has authority to accept business, Mr. Anderson said.

Matrix can help locate target markets

By LAURA MAZZUCA

ORLANDO, Fla.—Informally "brainstorming" potentially profitable target market ideas can be turned into a science by applying a series of analytical questions to each potential market, according to an industry consultant.

Using a "brainstorming matrix" and an "evaluation matrix," agency principals can determine if a target market is right for the agency, said Thomas Chapman, president of the Brownewell Insurance Agency Inc. in Longmont, Colo.

Mr. Chapman addressed agents at the 57th annual convention of the National Assn. of Professional Insurance Agents, held last month in Orlando, Fla.

The first step is for the agency's principal to start a "brainstorming session" with the agency's sales staff, said Mr. Chapman. He suggested that participants retain a sense of spontaneity when coming up with ideas for untapped markets.

For example, in the workshop session at the PIA convention, agents threw out target market suggestions such as salvage yards, poultry farms and concrete construction companies.

Using the brainstorming matrix, Mr. Chapman then helped agents determine the feasibility of targeting each group.

On the brainstorming matrix, each potential target market receives a yes or no rating in seven categories: general liability, product liability, special liability needs, special property needs special auto consideration, workers compensation and whether the target market fits with the agency's existing markets.

For example, using the salvage yard as an example, Mr. Chapman determined that such a market would have both general and product liability needs, as well as special liability needs such as coverage for pollution and heavy equipment. Special property needs could include items such as paper bales; and special auto consideration could include vehicles such as wreckers and tow trucks, he said.

To further evaluate the potential market, Mr. Chapman presented agents with the "evaluation matrix," which then assigns a rating to each market in another six areas: the competitiveness of the program, the agency's expertise in the market, insurance company mass-marketing programs, group size, commission size and association endorsements.

To judge competitiveness, Mr. Chapman suggested selecting the most competitive insurer and comparing its program with another independent agent outside your market area as well as researching programs of admitted insurers with the state insurance commissioner.

To determine the agency's expertise with the target group, the agency principal must consider past agency experience with such coverage and whether the agency can get assistance from an insurance company if necessary.

When rating group size, Mr. Chapman suggested a rating system of one through five policyholders, with groups of fewer than 25 assigned one point; 26 to 75 assigned two points; 76 to 125 assigned three points; 126 to 175 assigned four points; and groups of more than 175 assigned five points.

These numbers refer to the individual businesses within the marketing area rather than individuals in a group plan, explained Mr. Chapman.

When rating commission size, the same five-point evaluation system is used: $300 to $500 in commissions earning one point; $501 to $1,000 earning two points; $1,001 to $2,000 earning three points; $2,001 to $5,000 earning four points; and more than $5,000 earning five points.

Finally, if the target market can be written through an association or franchise program, count two points toward the total.

Using the matrices to reach a final decision on whether to pursue the market, the agent would:

- Eliminate all groups and commission size of one.
- Eliminate all groups that are not mass-market programs.

Then, the agent should review the remaining groups and prioritize the following:

- Which group has the highest total points.
- Use the group's commission size as the tie-breaker.
- Use group size as an additional tie-breaker, if needed.
- Add a subjective category, such as whether the target market would fit into the agency's existing clientele.

In addition to this criteria, Mr. Chapman suggested that agents keep in mind a "profile of the minimum requirements for a good target market prospect."

These are:

- A solid industry.
- Minimum premium volume of $500,000 for the group.
- Minimum commission per account of $501.
- A minimum number of 26 prospects in the group.

After the potential target market has been evaluated and approved, the agency principal must approach the appropriate insurer. To successfully accomplish this, Mr. Chapman presented agents with the following 10-point plan:

- Identify areas of opportunity for the insurer.
- Analyze the agency's production and staff.
- Develop specific information concerning the product line, such as loss ratios.
- Identify any potential problem areas, with suggestions for their elimination in advance.
- Explain how the target group fits into the agency's strategic marketing plan.
- Present the agency's incentive plan for producers.
- Explain the agency's monitoring and control systems.
- Identify the agency's competition in the target group coverage area.
- Explain the internal structure of the plan.
- Tell the insurer what you need to "make it fly."

After receiving a commitment from an insurer, the agency needs to establish a sales center, said Mr. Chapman.

To run an effective sales center, the agency needs to appoint a marketing manager—usually an agency principal—and a sales coordinator.

The sales coordinator's duties will include developing a prospect list; creating an advertising program; coordinating the direct mail program; overseeing the telemarketing program; maintaining expiration

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date records for prospecting; calling on prospects for appointments; sending out thank-you cards to prospects who have been contacted; and monitoring results of department activities.

When developing a prospect list, agents can choose from marketing directories and a variety of list houses that sell prospect lists, many of them categorized.

Prospecting can be done by either direct mail or telemarketing, and both systems have their merits and drawbacks, said Mr. Chapman. For his own agency, he reported June 1988 figures of a 6.6% return on direct mail pieces, compared with 12% on telemarketing.

If direct mail is used, agency principals must keep in mind the costs involved, said Mr. Chapman. To qualify for the bulk mail designation, at least 225 pieces of mail with identical content must be mailed. Postage-paid responses can push mailing costs as high as 65 cents per card.

In telemarketing, many agencies make the mistake of delegating telemarketing tasks for producers to do "in their spare time," which ends up tying up expensive sales people on phone calls, he said.

The logical alternative is to hire someone specifically to perform telemarketing, he said. Agency principals should look for a person with high internal drive, a good phone voice and the ability to handle rejection. Pay can vary, depending on how the agency's producers are compensated.

To get expiration dates from new commercial prospects that the telemarketer calls cold, principals should expect to pay a telemarketer about $12 per hour: a $4 per hour base wage, plus an hourly incentive of $8 for every four expiration-dates recorded in an hour. Under this plan, expiration dates cost $3 each, he said.

When setting appointments for producers to make calls later, the telemarketer can make about $14 per hour: $4 for the per-hour base wage, plus an incentive bonus of $10 for every 10 appointments made per hour. Here, the cost per appointment is $1.40.

Using this system, the agency principal is paying a total cost of $4.40 per prospect—a considerable bargain if the agency lands a client, said Mr. Chapman. ■

PIA meeting draws 2,300

More than 2,300 attendees and 106 exhibitors "discovered the magic" in Orlando, Fla., last month at the 57th Annual Convention of the National Assn. of Professional Insurance Agents.

Agents had their choice of 18 different workshops on subjects as diverse as creating a marketing plan, managing agency automation, the latest updates on the umbrella insurance market and how agents can reduce errors and omissions exposures.

Among the exhibitors from across the country were: automation vendors, insurers, consultants and related industry service organizations.

This year's convention also featured a larger-than-usual attendance of insurance company representatives, as evidenced at the trade exhibit, said a PIA spokesman.

The convention's title, "Discover the Magic," tied into the Orlando area's main attractions: Walt Disney World Resort, The Magic Kingdom and EPCOT Center. Other local attractions that drew attendees were Busch Gardens, Sea World and the Kennedy Space Center at Cape Canaveral.

Delegates and their families enjoyed balmy temperatures in the 80s during their stay in Florida, while tornadoes and high winds whipped the Midwest and an early snowstorm immobilized part of the East Coast.

The convention's keynote speaker at the opening luncheon was ABC senior correspondent David Brinkley, who speculated on the success of the incoming Bush administration and fielded questions on politics from the audience.

In keeping with the political spirit, satirist Mark Russell entertained at the concluding inaugural banquet. Mr. Russell, who incorporates stand-up comedy and writes his own satirical lyrics to familiar songs, stars in "The Mark Russell Comedy Special," now in its 11th season on the Public Broadcasting Service. He writes a column that is syndicated by the *Los Angeles Times* in more than 100 newspapers.

—By Laura Mazzuca

IIAA sponsors long-term care policy

The Independent Insurance Agents of America Inc., in conjunction with Travelers Corp., has developed a new long-term health care insurance product that member agents can market to their clients.

The consumer product is the first the IIAA has ever provided and endorsed for member use.

The program, called Independent Care, is underwritten by Travelers and is specifically designed to appeal to senior citizens. Agents can market the product to either groups or individuals.

The program offers long-term care for senior citizens in either their home or a nursing home. Premiums, which depend on the age of the policyholder, average about $1,100 per year.

Independent Care is designed to eliminate many restrictions found in other plans, including Medicare. For example, some plans pay for long-term care only when it follows a hospital stay, while this program does not require any hospitalization. Independent Care also offers a variety of coverage options for home health care, adult day care and nursing home care.

Under the Independent Care program, the policyholder selects an initial waiting period before the policy becomes effective of 20, 100 or 365 days, based on ability to pay. The longer the waiting period, the lower the premium.

Lifetime benefits for care in a nursing home, at home or at an adult day-care center are limited.

For more information on Independent Care, IIAA members can call the national administrator, ACSIA Insurance Services, at 800-321-9352.

A/BT products & services

Application standard

The QWIK APP co. inc. of Tustin, Calif., has developed a computer software system that eliminates the inconveniences associated with the manual completion of insurance application forms.

The system, which utilizes plain paper and either a dot matrix or laser printer, will solve both the problems of illegibly written applications and the difficulty of storing a variety of standard commercial forms, the company says.

Software enhancements also are available to prepare all binders, certificates, claims notices and endorsements using the same data base.

The basic system is available for $565.

An Elite system, which provides additional enhancements, such as capability to print certificates and binders, is $925.

For additional information, contact Nils Martinson, President, QWIK APP co. inc., P.O. Box 3986, Tustin, Calif. 92680-3986; 714-544-1943.

Liability program

An alternative market professional liability insurance program for independent agents has been introduced by the Independent Insurance Agents of America Inc.

The program offers errors and omissions coverage to those agencies that do not fit into the traditional E&O program offered by the IIAA. The new coverage is designed to appeal to excess and surplus lines brokers; agents who sell specialty lines such as aviation insurance, wet marine and professional liability; and agencies with adverse claims experience.

The program is underwritten by Lloyd's of London underwriters through Doran Excess & Surplus Lines Underwriters and brokered by Norex Insurance Brokers Ltd.

Agents should contact their state IIAA associations for more information.

INSIGHT enhanced

McCracken Computer Inc. of Burlington, Mass., has enhanced its INSIGHT insurance management system, making it available for operation on the IBM Application System/400.

The INSIGHT software integrates every agency function, including rating and multiple-company interface. Agencies using the product can streamline prospecting, rating, applications, interface, policy processing and agency management functions on a single system, all without re-entering data from previous steps.

INSIGHT recently underwent a two-year rewrite to meet the new ACORD electronic standards for interface. This, combined with interface arrangements with numerous insurers, allows McCracken users to participate in the industry's goal for single entry/multiple company interface.

A basic INSIGHT system starts at $30,000.

For more information, contact Jack Esselen, McCracken Computer Inc., 10 Mall Road, Burlington, Mass. 01803-4109; 617-273-0010.

Training cassettes

Insurance Learning Systems has developed PRISMS Booster, a set of audiocassettes that aid the insurance professional in reviewing the Productive Results from Insurance Sales & Marketing Systems training seminars offered by the Parsippany, N.J.-based consultant.

The PRISMS Booster system is available in each of the four major PRISMS programs: "PRISMS for Agents," "PRISMS for Company Reps," "PRISMS for Underwriters" and "PRISMS for Claims Adjusters."

PRISMS Boosters feature a separate cassette for each unit of a seminar, such as "Closing Skills" or "Time Management." Included in the tapes are excerpts from and references to the original PRISMS seminars as well as new narration.

The agents' set contains 20 audio cassettes and a reference guide; "PRISMS for Company Reps" contains 16 audio cassettes and a reference guide; "PRISMS for Underwriters" contains 12 audio cassettes and a reference guide; and "PRISMS for Claims Adjusters" contains 18 audio cassettes.

PRISMS Booster costs $125 for the agent, company representative and claims versions and $95 for the underwriter version. Volume discounts are available.

For more information, contact Insurance Learning Systems, 300 Lanidex Plaza, Parsippany, N.J. 07054; 201-884-1001. ■

401(k) administration package unveiled

Minnesota Mutual Life Insurance Co. has introduced a 401(k) plan enrollment package intended to ease the complex administration process while helping small to medium-sized businesses comply with the anti-discrimination requirements of the Tax Reform Act of 1986.

The package, which is available only to 401(k) plans administered by Minnesota Mutual, was developed in response to the tax act's goal to encourage greater participation in 401(k) plans by lower-paid employees, explained Randy F. Wallake, vp of corporate pension sales for the St. Paul, Minn.-based insurer.

The "centerpiece of the enrollment package is the step-by-step time table" that schedules promotional activities beginning 30 days prior to the actual enrollment meeting, he said.

After receiving introductory letters, payroll stuffers and brochures, employees learn about the plan—on company premises—through a custom-designed slide show. Employees also can receive individual consultation on retirement needs and asset allocation.

The 401(k) enrollment package also gives employees:

- Access to a Minnesota Mutual home office and field account executive.
- A toll-free line to contact pension service professionals.

Products & services

- Monthly, quarterly and annual investment reports.
- A newsletter.
- Quarterly participant-level reporting and benefit statements.

The package is available for a nominal fee, however Mr. Wallake declined to say how much employers would pay.

For more information contact Randy F. Wallake, Minnesota Mutual, 400 N. Robert St., St. Paul, Minn. 55101-2098; 612-298-3694.

Home doubles limits

The Home Insurance Co. is doubling its in-house limits for excess liability and umbrella coverage.

The move illustrates the company's "increased commitment to this segment of the market," and should help it secure a larger market share, a company spokesman said.

The new $10 million in-house limit is immediately available to commercial accounts that already have in place a minimum of $5 million in excess coverage, as well as new accounts, the company says.

Home's excess casualty department provides excess liability coverage for a wide variety of commercial risks, such as real estate, including hotels; wholesale and retail operations; contractors; truckers; light manufacturing operations; and service organizations, the company said.

The Home Insurance Co., which writes business nationwide, is a subsidiary of The Home Group Inc.

For more information contact Steve Goldstein, Assistant Vp-Communications, The Home Insurance Co., 59 Maiden Lane, New York, N.Y. 10038; 212-530-6373.

Books/videos

The **"Law of Life and Health Insurance"** helps employee benefit managers analyze claims taking into consideration the legal issues involved. The five-volume set also includes state-by-state coverage of statutory and case law and regulatory issues. The set is available for $420 with a 30-day no-risk examination period. To order, contact Matthew Bender, DM Department, 1275 Broadway, Albany, N.Y. 12201; 800-833-3630. ■

Manville, guaranty fund settle dispute

DENVER—The Colorado Insurance Guaranty Assn. has agreed to pay Manville Corp. $15 million to settle an insurance dispute between the asbestos producer and the insolvent Midland Insurance Co. and Transit Casualty Co.

The payment by the guaranty association will cover all of Manville's claims against Midland and Transit prior to July 1983.

New York-based Midland went into liquidation in April 1986. Transit was ordered liquidated by Missouri insurance regulators in December 1985.

This is the first time the Colorado Insurance Guaranty Assn. has made asbestos-related settlements on behalf of Midland and Transit, according to Tom Rosner, chairman of the association and resident vp at Farmers Insurance Group in Colorado Springs, Colo.

Mr. Rosner pointed out that the settlement is contingent upon approval by the bankruptcy court overseeing Manville's reorganization. The bankruptcy court is expected to approve this settlement and other recent settlements Manville has made with insurers in about one week.

Denver-based Manville, which filed for bankruptcy in 1982, will use the proceeds of the settlement from the Colorado Insurance Guaranty Assn. to pay asbestos property damage claims.

Under its plan for reorganization, which was executed Nov. 28, the asbestos producer will establish two trusts: one to pay asbestos property damage claims and one to pay asbestos bodily injury claims.

The asbestos property damage trust, which began operations last week, is not expected to make its first payment until 1990 and then will pay only pennies per dollar.

The asbestos property damage trust has been initially funded with $300 million. The settlement from the Colorado Insurance Guaranty Assn. and all future insurance settlements will be added to the property damage trust.

The bodily injury trust has been fully funded with $615 million.

—By Stacy Adler

Overseas Union

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is the first major wave of litigation involving the defunct pool, according to Mr. Oliver, former director of former Lloyd's broker Manson Byng & Co. Ltd.

However, other lawsuits have been filed against Overseas Union as a member of the pool. For example, American Home Assurance Co. of New York, an American International Group Inc. unit, filed suit against Overseas Union, three other American Home reinsurers and two New York insurance brokers to recover claims on losses on a book of utility industry liability insurance business (*BI*, May 6, 1985). Mr. Oliver said those lawsuits are still pending.

Accolade is listed as a company in Guernsey but has not filed an annual financial statements return with Guernsey authorities since 1986 and does not have a listed telephone number.

Court papers show that between 1977 and 1982, Accolade—managed by Director Maurice E. Rutty—wrote a wide range of reinsurance coverages, including motor; professional liability; marine excess-of-loss and quota-share reinsurance; London market excess-of-loss reinsurance; and property and bloodstock reinsurance.

For example, according to court papers, among the coverages that Accolade pool members wrote—but which are not part of the massive litigation—were:

- Several reinsurance contracts in 1979 and 1980 for Lloyd's of London syndicates 126/127 and 700/701 underwritten by former Lloyd's underwriter Ian Posgate, who currently faces criminal charges for misappropriating money from syndicates 126/127, managed by Alexander Howden Underwriting Ltd. (*BI*, July 20, 1987).
- Excess-of-loss reinsurance in 1980 for Transit Casualty Co., which was ordered liquidated in Missouri in December 1985 (*BI*, Dec. 9, 1985).
- Several excess-of-loss reinsurance contracts in 1979 and 1980 for Lloyd's aviation underwriter Richard Maylam.
- Excess-of-loss reinsurance for Lloyd's underwriter J.H. Barder.
- Fire contingency cover for Lloyd's underwriter D.E. Harman.
- Bloodstock reinsurance in 1980 for Halvanon Insurance Co. Ltd. in Israel.
- Aviation quota-share reinsurance contracts in 1979 for Sphere Drake (Underwriting) Ltd. and Korean Insurance Co. (U.K.) Ltd.

Altogether, Accolade pool members reinsured business from more than 1,000 cedants.

Altogether, Accolade pool members reinsured business from more than 1,000 cedants and retroceded the business to more than 1,100 retrocessionaires, according to Mr. Oliver, who would not disclose the total premiums written by the pool.

Mr. Rutty handled the Accolade pool runoff between 1982 and 1984, Mr. Oliver said. Then in 1984, Market Run-Off Services—which is 40% owned by Sedgwick Group P.L.C.—assumed responsibility for the runoff of the "problem pool," Mr. Oliver said.

Pool members continue to pay legitimate claims through Market Run-Off Services, but "quite a lot of the claims are illegitimate," Mr. Oliver contends.

One pool member suggested the pool faces claims of between $60 million and $70 million.

While Mr. Oliver said this is an inaccurate estimate, he would not disclose how much had been paid and how much is in dispute.

Besides Overseas Union, the other pool members were: Finnish Marine Insurance Co. Ltd. and Omsesidiga Sjoforsakringsbolaget, located at the same address in Helsinki, Finland; Keskinainen Hameen Vakuutusyhtio in Hameenlinna, Finland; Public Insurance Co. of Singapore; Samvinnutryggingar Reinsurance Co. Ltd., which is in liquidation in Reykjavik, Iceland; Koryo Fire & Marine Insurance Co. Ltd. of Seoul, South Korea; and Universal Casualty & Surety Co. Ltd., domiciled in the Cayman Islands and now in liquidation.

Universal Casualty, which wrote about 20% of the business ceded to the pool, has been hit with losses exceeding $16 million "just from Accolade" and Meridian Underwriting Agency in Bermuda, for which Mr. Rutty was managing general agent, according to Allan Gee, senior manager of Ernst & Whinney in the Cayman Islands and Universal Casualty's liquidator.

Universal Casualty, however, has sold the $2.5 million million in uncollected retrocessional claims it says it is owed to the other seven reinsurance pool members for $440,000, Mr. Gee said.

He explained that the insurer's liquidators calculated that at most Universal Casualty would have recovered about $900,000 of the $2.5 million.

In 12 separate lawsuits each naming a single defendant and filed between March 14 and June 9 in British High Court, seven of the eight reinsurance pool members seek specific amounts from each defendant for retrocessions placed by Accolade directly or through various intermediaries on behalf of each of the plaintiffs. Koryo is the only pool member not named as a plaintiff in the suits.

The lawsuits say: "In breach of the contracts. . .the defendants have failed to indemnify the plaintiffs against liabilities arising on risks reinsured under the said contracts."

The pool members also seek "a declaration that the defendants are liable to indemnify the plaintiffs under and in accordance with the said contracts of reinsurance, all necessary accounts and inquiries of the amount due under the aforesaid declaration and an order for payment of the sums found due upon the taking of such accounts and inquiries."

The suits seek, among other things:

- Nearly $1 million from Incorporated General Insurance Ltd. of Johannesburg, South Africa.

IGI General Manager Basle Fusselin South Africa said the lawsuit was "news" to him. "We have no knowledge of a writ, and we are surprised it hasn't come to us," he said.

- More than $214,983 from Simcoe & Erie General Insurance Co. of Hamilton, Ontario, Canada. Simcoe's attorney did not return phone calls.
- More than $70,291 from Mongard Ltd. of Hamilton, Bermuda. Mongard, a captive owned by St. Louis, Mo.-based Monsanto Co. and managed by Marsh & McLennan (Bermuda) Ltd., has received a letter from the plaintiffs' attorneys about the lawsuit and has passed it along to Monsanto, according to Rieny Marck, assistant vp of M&M Bermuda.

Mr. Marck said the dispute probably arises from Mongard's involvement with underwriting manager Stetzel Thompson & Co. Ltd. which ceased underwriting in January 1984 and was put into liquidation in 1985 (*BI*, Dec. 2, 1985).

- More than $204,020 from Walton Insurance Ltd. in Hamilton, Bermuda, a subsidiary of Phillips Petroleum Co. that is running off its business.

A Walton spokesman did not return repeated phone calls.

In seven other lawsuits filed in the High Court in June, each naming a single retrocessionaire as a defendant, all eight pool members claim they were entitled to retrocede business to each of the defendants under a 1979 obligatory facultative reinsurance agreement.

Under the agreement, the pool could retrocede to the defendants no more than 60,000 pounds ($110,400 at current exchange rates) for any single loss/accident/occurrence or aggregate for any one risk on all clases of insurance and reinsurance placed into the pool. However, financial credit or performance guarantee, life insurance, nuclear perils and war risks could not be retroceded unless they were covered under the orginal marine, aviation or personal accident insurance policies.

The pool members retroceded the business through London broker J.S. Pincham & Co. Ltd. to the defendants through intermediary Groupe Kleber, which is not named as a defendant in the litigation.

In these seven lawsuits, the Accolade pool members are trying to recover, among other things:

- More than $69,052 from John Hancock (U.K.) Insurance Co. Ltd. John Hancock, which has received the writ, is denying liability because "to our knowledge the obligation was met years ago," a spokesman said.
- More than $69,038 from St. Paul Fire & Marine Insurance Co. of St. Paul, Minn., a subsidiary of The St. Paul Cos. Inc.

A spokesman for St. Paul Fire & Marine Insurance Co. (U.K.) Ltd. is not aware of the lawsuit.

In another lawsuit, the eight Accolade pool members are suing Compangnia de Assicurazione di Milano SpA of Milan, Italy, to recover more than $510,892 against a 1978 retrocessional contract that was placed with the defendant by Atlantic Underwriting Agencies Ltd. and/or David Gale (Underwriting) Ltd., neither of which are parties in the recent litigation with the pool members.

"We are honoring our liabilities in an orderly way," a spokesman for the Italian company has said.

The eight reinsurance pool members in six more lawsuits against individual retrocessionaires seek smaller recoverables, damages or both, and ask the court to declare the contracts valid.

In addition, seven of the eight Accolade reinsurance pool members on Oct. 26 filed a lawsuit against seven intermediaries, including Accolade Underwriting Agency and London-based Accolade Underwriting Managers Ltd., for negligence in placing two reinsurance programs with Lloyd Italico, which is not named as a defendant in the litigation and is now

Continued on next page

Pool member denies liability for some claims

By STACY SHAPIRO

LONDON—Overseas Union Insurance Ltd. contends in several lawsuits that it is not liable to pay claims against some reinsurance contracts ceded to it as a member of a reinsurance pool because the pool manager had no authority to bind the coverage.

For example, Singapore-based Overseas Union and Tel Aviv-based Hassneh Insurance Co. of Israel Ltd., which was not a member of the reinsurance pool, claim in a lawsuit filed in Britain's High Court in March against Ennia Schadeverziekering N.V. and Ennia Reassurantie N.V. of The Hague, Netherlands, that "they are not liable to pay claims" on a marine quota-share reinsurance contract in 1981.

The cargo and/or hull and machinery risks were ceded by Commercial Marine Underwriters Inc. of Miami, Fla., which is not party to the lawsuit.

Overseas Union says in the March 4 writ it is not liable to pay claims under the "purported" contract "purportedly" signed by reinsurance pool manager Accolade Underwriting Agency Ltd. on Overseas Union's behalf. The company claims, among other things, the reinsurance is void because Accolade did not have authority to bind Overseas Union to the coverage.

Also, Overseas Union, Deutsche Ruck U.K. Reinsurance Co. Ltd. and Pine Top Insurance Co. Ltd. of London seek a declaration in another suit filed in the High Court on June 13 that they do not have to pay claims against insurance ceded by New Hampshire Insurance Co. of Manchester, N.H., an American International Group Inc. unit.

Overseas Union says it is not liable to pay claims under the 'purported' contract 'purportedly' signed by pool manager Accolade Underwriting Agency Ltd. on Overseas Union's behalf.

The coverage, which the writ says was ceded to Overseas Union through Accolade, covered the cost of repair and/or replacement of defective component parts of goods sold by the Paris-based department store chain Sociente Francaise Des Nouvelles Galeris Reunies.

Overseas Union contends Accolade "did not have the actual or apparent authority" to bind Overseas Union.

New Hampshire has filed a lawsuit against Overseas Union, Deutsche Ruck and Pine Top in the Paris Tribunal de Commerce in France seeking an specified amount of coverage.

New Hampshire's representative in London, American International Underwriters (U.K.) Ltd., a London-based unit of AIG, would not comment.

Meanwhile, Overseas Union is involved with another underwriting agency that recently went into liquidation.

On Oct. 6, shareholders of Winchester Fox & Co. Ltd. agreed the company should be wound up and appointed a liquidator.

Winchester Fox was a leading managing agent in the London market in the 1960s and 1970s, specializing in reinsurance such as London market excess-of-loss reinsurance.

The company, which wrote business on behalf of Overseas Union and others, ceased underwriting in 1985, according to Winchester Fox company documents.

Winchester Fox continued to run off the business until it went into liquidation. Since then, however, the runoff has been handled by Market Run-Off Services Ltd., which is 40% owned by Sedgwick Group P.L.C.

Market Run-Off Services also is handling the runoff of the business written by Accolade pool members, including Overseas Union.0 ■

Overseas Union

Continued from previous page

doing business as Lloyd Italico Y L'Ancora.

Koryo was the only pool member not named as a plaintiff in this litigation.

Meanwhile, ceding insurers have filed three lawsuits seeking to recover unpaid claims on reinsurance placed with the Accolade reinsurance pool:

- Rio de Janeiro-based Instituto Reassaguros Do Brasil in suit filed in High Court in November 1987 is trying to recover about $350,000 from Overseas Union, Accolade and broker Anthony Lumsden & Co. Ltd. of London, which is owned by Sedgwick.

"We believe that Overseas Union is bound by those (reinsurance) contracts," said IRB attorney Tim Taylor, a partner with the London firm of S.J. Berwin & Co.

"As a precaution, we have also filed against Accolade and Lumsden," although neither has been served with the writ, he said. Lumsden is being very cooperative in trying to recover the money, he added.

However, Mr. Oliver of Market Run-Off Services said previously: "They actually owe us more than we owe them."

In a counterclaim, the pool members are trying to recover $255,306.62 from IRB, according to Mr. Taylor.

- Vesta Forsikringsaktieselskapet A/S in Bergen, Norway, and 14 other plaintiffs are suing Overseas Union for unspecified claims and damages for breach of "insurance" contracts allegedly placed with the Accolade reinsurance pool between 1979 and 1982.

Attorneys for the plaintiffs, Bentleys, Stokes & Lowless of London, have refused to comment on the suit.

Mr. Oliver has said $62,000 is recoverable under these reinsurance contracts.

- Assitalia-Le Assicurazioni d'Italia SpA. and 40 other ceding insurers are suing Overseas Union for reinsurance recoverable and damages for breach of reinsurance contracts placed through Accolade. The lawsuit, filed June 29, includes a two-page list of policies issued by the pool between 1979 and 1981 but gives no details of the coverage.

Attorneys for the plaintiffs, Bentleys, Stokes & Lowless would not comment on the suit in past interviews and did not return recent phone calls.

Also, broker J.S. Pincham & Co. is suing Overseas Union for unpaid brokerage fees in connection with a marine reinsurance contract placed in September 1980 to reinsure Mentor Insurance Ltd. The contract was terminated Dec. 31, 1980.

Holman Fenwick & Willan, the London law firm representing the Accolade pool members, did not return phone calls.

Mr. Rutty could not be reached for comment. ■

Minet dispute

Continued from page 2

fore resorting to full-blown litigation, said Mr. Parry. "I firmly believe that (the dispute) will be resolved."

Underwriters of Minet's 75 million pounds ($138 million at current exchange rate) of professional liability coverage in 1982—the year that irregularities at PCW were first discovered—have been refusing to pay the PCW-related losses since Minet filed its first PCW-related claim for about 10 million pounds ($18.4 million at current exchange rate) in 1984. That claim was connected with the return of 38.2 million pounds ($70.2 million) to PCW syndicate members in 1984, underwriters previously said.

Minet and New York-based Alexander & Alexander Services Inc. paid the PCW members 38.2 million pounds to cover losses for the years 1979-1981 for which the members were liable. In return, the PCW members agreed not to sue Minet, A&A or other parties (*BI*, June 25, 1984).

Minet's professional liability underwriters in 1986 publicly announced they would not pay any claims relating to the PCW losses—including the 10 million-pound claim—because former Minet Chairman John Wallrock did not disclose alleged wrongdoings at PCW.

Mr. Wallrock, who resigned as chairman of Minet after he admitted in November 1982 to benefitting financially from PCW reinsurance arrangements, was expelled from Lloyd's in July 1986 for allegedly participating in the misappropriation of PCW syndicate funds (*BI*, July 21, 1986).

The underwriters alleged that since Mr. Wallrock had been aware of fraudulent activities at PCW, Minet also knew about the activities, voiding the coverage.

The underwriters also said they would not pay any claim filed by Minet arising from negotiations between Lloyd's and PCW members, who had threatened to sue Lloyd's, Minet and 36 other defendants over the 235 million pounds ($432.4 million) in underwriting losses for which the PCW members were eventually liable (*BI*, Nov. 17, 1986).

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HMO membership study

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Care Plans Inc. Prudential Plus membership grew 18.4% in the second quarter, adding 101,341 members to bring its total enrollment to 652,935 people.

InterStudy says that the lowdown in HMO membership growth is a result of underwriting changes made by HMOs and changes in purchasing health care by employers.

"Generally, HMOs are concentrating on improving their financial situations, rather than increasing their market share," said Lynn Gruber, vp of managed care research for InterStudy.

"At the same time, some employers are selecting managed care programs which offer more flexibility in benefit design and financial arrangement than HMOs. A number of large employers. . .are reducing the number of health insurance carriers they offer, or are choosing to self-insure," Ms. Gruber said.

In addition, the survey authors say, "Employees willing to change physicians and join an HMO may have already done so, while those not currently enrolled in HMOs have relationships with physicians that they are unwilling to break."

However, InterStudy reports that the changes slowing HMO membership growth are, for the most part, temporary, and that HMOs will continue to become a more dominant part of the health care benefit system.

"Two factors may. . .enhance HMOs' appeal in the long run: the skyrocketing costs of medical care and the popular acceptance of managed care," the survey authors report.

"The continued excessive increases in the cost of health care relative to other goods and services will continue to increase the appeal of managed care. HMOs that deliver high-quality, cost-efficient care will be well-positioned as the costs of indemnity insurance and even more loosely structured managed care plans become unacceptable to employers and/or employees," they continue.

The InterStudy authors also report that the relatively strong performance among open-ended HMOs and Prudential Plus is a good sign for pure HMOs as well.

"Open-ended HMOs may serve as a bridge, allowing employers to offer a managed care product without totally curtailing freedom of choice. As employees become more accustomed to managed care and develop relationships with HMO physicians, they may be willing to accept a closed panel plan," they say.

"As a result, some of the employees enrolled in open-ended HMOs, PPOs and other managed care products may eventually enroll in pure HMOs."

In other InterStudy survey findings:

- Those HMOs associated with national companies that operate HMOs in two or more states were more likely to lose members than were unaffiliated HMOs.

"National firms are re-evaluating their corporate strategies. The firms are attempting to increase the financial strength of the plans by using more aggressive underwriting. The plans are willing to lose enrollees if they can increase revenue per enrollee," the authors note.

According to the InterStudy survey, 36% of the plans affiliated with national companies lost money, compared with only 21% of unaffiliated plans.

"National firms' more cautious approach may result in slowed enrollment growth, but it should improve the long-term financial health of HMOs," they conclude.

- Independent-practice HMOs—in which care is provided through physicians in the community who operate out of their own offices—accounted for much of the HMO membership growth in the second quarter, adding more than 300,000 members.

However, while IPA model HMOs enroll the most members overall, individual IPA HMOs have the smallest average enrollment: 32,725, compared with 60,448 for network HMOs, 61,975 for staff HMOs and 115,727 for network HMOs.

In staff HMOs, services are provided at one or more locations by physicians who are employees of the HMO. In group HMOs, a group of physicians provides care to patients at one or more locations; and in network HMOs, the HMO contracts with two or more group practices to provide care.

- HMOs are getting older. The percentage of plans in existence three to five years grew 27% from the first quarter to the second quarter of 1988, while the percentage of plans aged 1 to 2 years fell 28% during the same period.

The survey authors say, "HMOs created during the rapid expansion of 1984-1986 continue to age, and there are fewer new HMOs to replace them. . . .This trend will continue, resulting in fewer young plans."

- The number of pure HMO plans dropped during the quarter, to 643 plans from 648 in the previous quarter, due to mergers and a decrease in the number of new plans formed. Six new open-ended plans were reported, bringing to total number to 53.

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The study on HMO growth during the second quarter of 1988 appeared in the Fall 1988 issue of The InterStudy Edge, which is published quarterly by InterStudy. Annual subscriptions cost $160, and single issues are $45. For information contact Interstudy, P.O. Box 458, Excelsior, Minn. 55331; 612-474-1176.

New York court pollution exclusion ruling

Continued from page 2

Powers Chemco was a "totally non-culpable policyholder," said Ms. Roth, who is with Phillips, Nizer, Benjamin, Krim & Ballon in New York.

But, Federal Insurance attorney John J. Sheehy said the appellate court ruling was "the right result."

He said the appellate court gave a "common sense practical meaning" to the pollution exclusion.

Furthermore, the Powers Chemco ruling will give insurers more comfort that their policies will not be rewritten by the courts, said Mr. Sheehy, who is with Rogers & Wells in New York.

Powers Chemco also argued to the appellate court that the pollution exclusion should not apply because it did not expect or intend the pollution, and therefore the pollution was "sudden and accidental."

However, the appellate court disagreed. In its decision, the court went one step further and said it does not matter whether the policyholder expected or intended to damage the environment when deciding whether the pollution exclusion applies. What matters, the court said, is whether the toxic chemicals were released into the environment unexpectedly and unintentionally.

If the chemicals are discharged knowingly and intentionally, there would be no coverage, the court said.

It is possible that the appeal of the Powers Chemco ruling could be consolidated with the appeal of the same court's recent ruling in *Technicon Electronics Corp. vs. American Home Assurance Co.*

In that ruling, the court said: "The relevant factor is not whether the policyholders anticipated or intended the resultant injury or damage, but whether the toxic material was discharged into the environment unexpectedly and unintentionally or knowingly and intentionally."

A ruling by the New York Court of Appeals, the state's highest appellate court, would help resolve the current split among New York intermediate appellate courts in how they interpret the pollution exclusion.

There are four intermediate appellate courts in New York. To date, the 3rd Judicial Department and the 4th Judicial Department have issued pro-policyholder interpretations of the pollution exclusion clause, while the 2nd Judicial Department has issued pro-insurer rulings. The 1st Judicial Department has not addressed the issue.

"There is a real conflict in how (intermediate New York appellate courts) are reading the pollution exclusion," said Powers Chemco attorney Ms. Roth.

"There also are conflicting decisions by federal courts interpreting New York law," said Ms. Roth. "There is really a need for the Court of Appeals to decide what the law of New York will be."

Federal Insurance attorney Mr. Sheehy said, "It seems some of the earlier opinions emasculated the pollution exclusion, but now the (New York) courts are reading the clause precisely as it is stated."

The recent decisions by the New York appellate courts in the Powers Chemco case and the Technicon case reflect an emerging trend to uphold the pollution exclusion, according to Mr. Sheehy.

Insurer attorney Stephen Cohen of Robins, Kaplan, Miller & Ciresi in Minneapolis, agreed: "I think we are seeing a trend in New York courts to uphold the pollution exclusion."

Nationally, both federal and state courts also are divided in how they interpret the pollution exclusion clause, according to attorneys (*BI*, Nov. 21).

However, Mr. Cohen said: "Nationally, most—but not all—of the cases are recognizing that the pollution exclusion is not ambiguous" and bars coverage for gradual pollution.

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Powers Chemco Inc. vs. Federal Insurance Co.; 2nd Judicial Department of New York, Index number 8462/85. Technicon Electronics Corp. vs. American Home Assurance Co. et al., defendants, Atlantic Mutual Insurance Co., et al., appellants; 2nd Judicial Department of New York, Index number 953E.

Minet suit names major Lloyd's figures

LONDON—A number of leading Lloyd's of London underwriters, including current Lloyd's Chairman Murray Lawrence, are among the 102 defendants named in a suit by Minet Holdings P.L.C. against its professional liability insurers.

Other prominent current and former Lloyd's underwriters named in the suit, which seeks recovery of Minet's share of the losses from syndicates formerly managed by PCW Underwriting Agencies Ltd., include:

- Robin A.G. Jackson, director of Merrett Holdings P.L.C.
- H.R. Rokeby-Johnson, former underwriter for syndicates managed by Sturge Holdings P.L.C.
- Richard Outhwaite, chairman of R.H.M. Outhwaite (Underwriting Agencies) Ltd.
- Former Lloyd's underwriter Ian R. Posgate, who is facing criminal charges for conspiracy to defraud names on his syndicates.
- Former PCW Chairman Peter Cameron-Webb, who Lloyd's has accused of playing a major role in the plot to defraud the PCW syndicates.

The suit also names two companies managed by H.S. Weavers (Underwriting) Agencies Ltd.: El Paso Insurance Co. Ltd. and Walbrook Insurance Co. Ltd. However, Weavers is not a party to the lawsuit.

The other Lloyd's members named in the suit, who represent various Lloyd's syndicates, are:

A.B. Gray; A.G. Oldworth; B.A. Stewart; B.F. Caudle; B.R. Smith; A.C. Sturge; D.A. Salter; D.J. Walker; D.W. Graves; D.W.H.M. Hughes-Hallet; D.J. Robertson; F. Barber; F.J. Austin; I.N. Thomson; J.R.S. Wace; K.E. Simmons; L. Burdett; M.H. Cockell; P. Foden-Pattinson; P. Fitzsimmons; J.W. Oakes; E.G. Ashton; R. Hampton; R.C.W. Sells; T.J. Hayday; and M.W. Payne.

Other companies named as defendants are:

Abelle-Paix Reassurances; Abeille-Paix Igard; Assicurazioni Generali SpA.; Assitalia-Le Assicurazioni d'Italia SpA.; Baltica-Skandinavia Insurance Co. (U.K.) Ltd.; Baloise Basler Versicherungs Gesellschaft; Bermuda Fire & Marine Insurance Co. Ltd.; British National Insurance Co. Ltd.; British National Life Assurance Co. Ltd.; Bryanston Insurance Co. Ltd.; CNA Reinsurance of London Ltd.; Colonia Versicherung A.G.; Colonia Versicherung Konzern; Commercial Union Assurance Co. P.L.C.; Compagnie Europeene d'Assurances Industrielles S.A.

Also, The Copenhagen Reinsurance Co. (U.K.) Ltd.; Dai-Tokyo Insurance Co. (U.K.) Ltd.; Dart Insurance Co. Ltd.; The Drake Insurance Co. Ltd.; Employers of Wausau Insurance Co. (U.K.) Ltd.; Employers Insurance of Wausau; Excess Insurance Co. Ltd.; Federated Insurance Co. Ltd.; Federation General Insurance Co. Ltd.; Folksam International Insurance Co. (U.K.) Ltd.; Folksam International Insurance Co. Ltd.; General Accident Fire & Life Assurance Corp. P.L.C.; Guardian Royal Exchange P.L.C.; Guardian Royal Exchange Assurance P.L.C.; Haflichtverband der Deutschen Industrie V.A.G.

Also, Highlands Insurance Co. (U.K.) Ltd.; Irish National Insurance Co. Ltd.; Legal & General Assurance Society Ltd.; Lombard Continental Insurance P.L.C.; Louisville Insurance Co. Ltd.; Ludgate Insurance Co. Ltd.; Mentor Insurance Co. (U.K.) Ltd., which is in liquidation; Mutual Reinsurance Co. Ltd.; The National Employers' Mutual General Insurance Assn. Ltd.; The New Hampshire Insurance Co. Ltd.; Norwich Union Fire Insurance Society Ltd.; Norwich Union Holdings P.L.C.; Preservatrice Fonciere; Prevoyance Sociale; and Societa Reale Mutua de Assicurazioni.

Also, Group Royal Belge; Royal Insurance P.L.C.; Royal Insurance (U.K.) Ltd.; Sampo Insurance Co. (U.K.) Ltd.; Skandia U.K. Insurance P.L.C.; Skandia Insurance Co. Ltd.; Sphere Drake Insurance P.L.C.; Sphere Drake Insurance Group P.L.C.; Sumitomo Marine & Fire Insurance Co. (Europe) Ltd.; Sun Alliance & London Assurance Co. Ltd.; Sun Alliance & London Insurance P.L.C.; Taisho Marine & Fire Insurance Co. Ltd.; Tokio Marine & Fire Insurance Co. Ltd.; Turegum Insurance Co.; L'Union des Assurances de Paris; Unione Atlantique S.A. d'Assurances; Unione Italiana di Riassicurazione SpA.; Unione Italiana (U.K.) Reinsurance Co. Ltd.

Also, Wausau Insurance Co. (U.K.) Ltd.; Wausau International Underwriters; Winterthur Swiss Insurance Co.; The World Marine & General Insurance P.L.C.; and The Yasuda Fire & Marine Insurance Co. of Europe Ltd. ■

Minet dispute

Continued from previous page

Last year, Lloyd's and PCW members finalized a settlement, under which Lloyd's contributed 45 million pounds ($82.8 million) to help pay the members' liabilities. The 37 other organizations contributed 55 million pounds ($101.2 million) to the settlement, of which Minet contributed between 10.5 million pounds ($19.3 million) and 12.5 million pounds ($23 million).

Lloyd's also agreed to cover any future underwriting losses related to the former PCW syndicates, while the 1,547 PCW syndicate members paid 34 million pounds ($62.6 million) to help fund the syndicates' losses.

Members also relinquished their rights to sue Lloyd's and transferred to Lloyd's their rights to sue other parties (*BI*, June 20; June 22, 1987; April 13, 1987).

About 99% of the PCW members eventually accepted the settlement offer.

Although the settlement stops PCW members from suing the parties to the settlement, including Minet, it does not stop Minet from suing other parties, like its professional liability insurers, to try to recover its PCW losses, Mr. Pettitt pointed out.

"If you were an accountant or a lawyer and you settled with a party over a loss, you would sign off on that loss and at the same time you would attempt to recover your loss on your insurance policy," Mr. Pettitt said. "That's what insurance is for.

"In this case, the PCW members chose to settle for a certain amount of money," he said. "We spend a substantial amount of money each year on our professional liability coverage and now we have a potential claim which needs to be addressed."

The lawsuit says that the disputed 1982 professional liability coverage consists of one primary policy and five excess policies. It does not give further details of the coverage.

Royal Insurance P.L.C., which is named in the litigation, led the primary coverage, according to underwriters.

The coverage was placed by Lloyd's broker Nelson Hurst & Marsh Ltd.

Officials at Royal declined to comment.

A spokesman at Nelson Hurst & Marsh, which is not named in the suit, said the company ceased its involvement in the dispute once the underwriters "turned down" Minet's claim.

Michael Payne & Others, which managed Lloyd's syndicates that were among the coverage's lead underwriters and is named in the lawsuit, did not return telephone calls. ■

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Monday, January 2
closes
Thursday, December 22

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The Request for Proposal is presently available and can be obtained by contacting **Stevens Day, Executive Director, Massachusetts Workers' Compensation Advisory Council, Department of Industrial Accidents, 600 Washington Street, 7th Floor, Boston, MA 02111 at 617-727-6096** Proposals must be submitted not later than 4:30 P.M. on December 22, 1988, to receive consideration. THE COMMONWEALTH OF MASSACHUSETTS IS AN EQUAL OPPORTUNITY EMPLOYER

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Sub-total 24,719
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Government, Unions and Educational Institutions 979
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Sub-total 26,175
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Largest U.S. reinsurers' nine-month 1988 results

(All amounts in thousands of dollars) (Ranked by net reinsurance premium written)

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General Re	$2,177,406	$1,384,201	$1,736,244	$1,493,726	$1,068,031	71.5%	$382,800	27.7%	99.2%	100.1%
Employers Re	994,216	1,004,132	964,899	992,421	750,703	75.6	260,221	25.9	101.5	98.8
American Re	596,344	714,289	750,977	720,851	547,464	75.9	183,043	25.6	101.5	99.8
USF&G	N/A	530,096	308,355	531,782	366,655	68.9	154,190	29.1	98.0	99.0
Munich Re	486,640	468,035	520,516	482,009	333,742	69.2	156,787	33.5	102.7	99.8
North American/Swiss Re	602,948	424,628	461,883	450,353	296,305	65.8	156,370	36.8	102.6	104.2
Prudential Re	444,164	413,984	494,042	426,147	289,046	67.8	153,003	37.0	104.8	101.6
Transatlantic Re	169,056	233,505	234,365	227,104	185,683	81.8	54,866	23.5	105.3	104.6
Continental Cas	N/A	229,101	171,012	220,764	181,985	82.4	55,172	24.1	106.5	109.9
CIGNA Re	193,853	206,030	204,126	209,437	147,426	70.4	61,053	29.6	100.0	103.5
National Re	189,852	203,107	230,021	206,112	170,342	82.6	38,561	19.0	101.6	102.8
Constitution Re	157,648	194,986	172,110	191,763	140,102	73.1	55,826	28.6	101.7	98.9
Continental Re	112,451	192,253	206,949	186,771	156,806	84.0	50,059	26.0	110.0	104.9
Transamerica Re	147,580	178,244	N/A	147,981	105,953	71.6	51,152	28.7	100.3	N/A
Skandia America Group	313,376	176,565	173,095	201,456	140,464	69.7	61,028	34.6	104.3	105.0
St. Paul Re	N/A	166,843	148,953	156,484	111,109	71.0	49,405	29.6	100.6	100.1
Kemper Re	309,806	160,924	231,617	168,956	139,431	82.5	31,442	19.5	102.0	101.4
US Int'l Re	107,953	156,775	131,864	138,608	99,298	71.6	48,485	30.9	102.5	98.8
NAC Re	172,718	120,220	115,725	123,388	96,853	78.5	34,127	28.4	106.9	107.7
Underwriters Re	146,065	103,088	140,435	117,040	88,822	75.9	23,846	23.1	99.0	122.0
Totals for top 20	**7,322,076**	**7,082,762**	**7,397,188**	**7,245,172**	**5,310,267**	**73.3**	**2,010,284**	**27.2**	**100.5**	**101.5**
Total for all companies	**9,689,036**	**9,049,923**	**9,348,264**	**9,185,898**	**6,738,593**	**73.4**	**2,600,993**	**28.7**	**102.1**	**102.0**

Source: Reinsurance Assn. of America

Reinsurers' results

Continued from page 3

dent and chief executive officer of North American/Swiss Reinsurance Co. in New York.

The proof, he said, is that the majority of reinsurers included in the Reinsurance Assn. of America's industry survey for the nine months ended Sept. 30 reported declining premium volumes.

"It's telling you something" when that happens, he added.

Net written premiums for the U.S. reinsurance industry declined 3.2% to $9 billion in the first nine months of this year from $9.3 billion in the corresponding period of 1987, according to the RAA's survey of 75 reinsurers.

The 20 largest U.S. reinsurers in terms of net premium volume reported a 4.3% decline to $7.1 billion in the first three quarters of 1988 from $7.4 billion last year. The Top 20 results do not include Transamerica Re, which was formed late last year and thus did not report comparable results a year ago.

While premium volume declined, the reinsurance industry's combined ratio remained virtually stable at 102.1% this year, compared with 102% for the comparable period a year ago.

The Top 20 reinsurers posted a 100.5% combined ratio, an improvement from 101.5% ratio for the corresponding period in 1987.

The U.S. reinsurance industry's policyholder surplus rose 10.1% to $9.7 billion as of Sept. 30, 1988, from $8.8 billion on Sept. 30, 1987.

"The nine-month results were pretty much in line with what we had seen develop the rest of the year," said Norman Wayne, president of CIGNA Corp.'s reinsurance division, labeling them as a "non-event."

The nine-month underwriting results essentially reflect business written in 1987, "which wasn't so bad," noted Paul Ingrey, president of F&G Re in Morristown, N.J., a USF&G Corp. subsidiary.

As for business being written now, Michael Fitt, chairman and chief executive officer of Employers Reinsurance Corp. in Kansas City, Mo., said: "Certainly the property business is becoming more and more competitive because that's the business that most of the foreign reinsurers want to write. They are still very nervous about U.S. casualty business."

Besides rate competition, Skandia's Mr. Bensinger pointed out that "there are continuing changes in terms and conditions being requested to eliminate the more beneficial types of provisions" for reinsurers, like sunset clauses, which phase out coverage over a defined period of time.

But for the immediate future, reinsurers generally expect only a slight deterioration in results at year-end.

"We are not going to feel the impact of the current soft market until probably the first or second quarter of next year," said Mr. Fitt.

There will be "somewhat of an uptick" in the fourth quarter, with the reinsurance industry's combined ratio reaching about 103%, predicted Mr. Bensinger.

"In an increasingly deteriorating situation, the combined ratio has got to go up," said Pru Re's Mr. Dwane, who also estimates the industry's combined ratio will reach 103% at year-end.

Some reinsurance executives predict that results will not worsen dramatically next year.

"It will be a slow deterioration. If we have catastrophes, it's going to be a little bit faster," said Bard E. Bunaes, chairman and chief executive officer of New York-based Constitution Reinsurance Co.

North American/Swiss Re's Mr. Thompson commented, "I don't see any change to speak of in the fourth quarter. At the moment, there's no reason to believe 1989 won't be about the same.

Others, though, predict that reinsurers' results could deteriorate markedly next year.

"It's possible things can get pretty bad," said Mark Mosca, vp and manager of the treaty department at NAC Re Corp. in Greenwich, Conn.

Mr. Mosca has observed the "beginning of a move toward protecting premium volume on the part of reinsurers" by being aggressive in their pricing.

"It remains to be seen whether that's a trend or not," he said. "I've just seen a few things over the last couple of weeks that concern me—that make me worry it may be a trend."

"We will continue to see deterioration next year," said CIGNA Re's Mr. Wayne. He anticipates premium growth will "continue to be very, very sluggish," with a net decline industrywide of about 10%, a figure that was cited by several other reinsurers as well.

A 1989 combined ratio of about 105% to 106% "is probably what people are expecting to see," said Skandia's Mr. Bensinger.

Transamerica's Mr. Clark noted that one cause for concern is whether reinsurers delayed bolstering reserves in anticipation of a longer hard market than actually materialized. Reinsurers may "still have some holes to fill," he said, adding that 1989 results might reflect reserve strengthening.

Most observers said the market will not turn until at least 1990.

Mr. Fitt said there will "hopefully" be an improvement by the third or fourth quarter of 1990. "I hope I'm not being too optimistic," he said, tongue-in-cheek.

"We're still very hopeful that the market will turn for the 1990 season," said Mr. Bensinger, noting that the increased tax liabilities created by the Tax Reform Act of 1986 will be one factor triggering a turn.

Until a couple of months ago, Mr. Bensinger said he would have thought that low interest rates would help trigger a turn. However, with interest rates now climbing, "it does pose a bit of a concern" that both primary insurers and reinsurers "may forget too quickly about the last debacle."

Some reinsurers also noted that the impact of California's Proposition 103 on their business is a big concern (see story, page 1). Among other provisions, Proposition 103, which was approved by California voters last month, requires insurers to roll back for one year almost all property/casualty insurance "charges" to a level 20% lower than in November 1987.

Proposition 103 "is something that's playing on all our minds," said Mr. Fitt, adding he is concerned the concept will spread across the country, which would "cause absolute havoc."

If that occurs, "the very fabric of the business will start disintegrating," Mr. Fitt said. "What we need is stability in this business. We don't need these kinds of things happening." ■

Soft market to continue through '89: Broker

By COLLIN NASH

NEW YORK—The property/casualty insurance market will stay soft at least through 1989 while insurers grapple with regulatory attempts to control the market cycle, experts agree.

"Don't hold your breath waiting for the market to tighten," John F. O'Sullivan, managing director of Marsh & McLennan Cos. Inc. in New York, warned those attending a recent seminar sponsored by the New York Chapter of the Risk & Insurance Management Society Inc. in New York.

During the seminar, titled "The Property/Casualty Insurance Marketplace Conditions—Forecast for 1989," Mr. O'Sullivan pointed to several statistical measures that indicate a continuing soft market.

For example, the fact that insurers' combined ratios, particularly in general liability lines, are falling despite rate reductions indicates that "there's not going to be any tightening up at all, and this soft market. . .is going to keep going for a while," Mr. O'Sullivan said.

The industrywide combined ratio for general liability lines tumbled to about 104% as of June 30 from 111% as of year-end 1987 and 115.5% as of year-end 1986, he said.

A sure sign that a soft market has peaked is when insurers begin to write in the less predictable, high excess catastrophic lines that include troublesome exposures such as chemicals and pharmaceuticals, he said. But, "that hasn't happened yet."

In fact, the overall combined ratio (for all lines) moved up slightly from 103% at the end of 1987 to a current 104.8%, indicating that the market is sticking with "more predictable kinds of risks," Mr. O'Sullivan said.

Industrywide, capacity is still not being strained—another indication of a continuing soft market—he observed.

Based on a 2-to-1 net premium-to-surplus ratio, the U.S. property/casualty industry could write $222 billion in premiums this year, $22 billion more than is forecast by A.M. Best Co. for 1988, he noted.

Mr. O'Sullivan also noted that the 2-to-1 premium-to-surplus ratio that has become a standard for regulators and underwriters "creates a Catch-22 kind of situation."

For example, the ratio allows insurers to underwrite a relatively large volume of business in a soft market when rates are inadequate and insurers aren't getting as much premium for the exposures they insure. But, during a hard market, rising premiums cause insurers to hit premium-to-surplus guidelines more quickly, limiting the volume of more profitable business they can underwrite, he explained.

Confronted with this dilemma, insurers usually begin to divest potentially troublesome lines of business regardless of previous experience, which inevitably leads to market tightening, he said.

Several factors could affect when and how quickly the property/casualty market turns, Mr. O'Sullivan added.

While reinsurance availability was one of the driving forces of the soft market of the early 1980s, it has not played as much of a role in the current soft market, he said.

However, unrecoverable reinsurance could be a factor in creating a hard market, he said. Some industry observers estimate that as much as 30% of reinsurance may be unrecoverable, which could translate into a $17 billion loss to insurers, he explained.

While statistics indicate that the soft market will remain so for some time, Mr. O'Sullivan said he believes the industry should intervene to make the market cycle more predictable.

"We in the industry should do something about the cycle," otherwise outsiders will intervene, he said.

The antitrust lawsuits brought by 19 state attorneys general and California's Proposition 103—which rolls back virtually all property/casualty insurance charges in the state to a level 20% lower than a year ago—symbolize "the backlash that happens if we don't take corrective action with respect to the cycle," he said.

Buyers also could be hurt by the regulatory backlash produced by the industry cycle, said Thomas G. Kaiser, senior vp and eastern area manager for Arkwright Mutual Insurance Co. of Waltham, Mass., another panelist.

"If this trend continues" toward regulatory moves to control the cycle, it will impede future capacity growth, Mr. Kaiser said.

Calling it "rent control of insurance," Mr. Kaiser said current regulatory moves reminded him of "the '70s oil crisis when everyone had to wait in line to buy gas because the government decided to set prices."

Mr. Kaiser also said the increasingly global economy and the growth of international risk management is having an impact on the insurance marketplace.

"Increased mergers and acquisition activities," which poured about $100 billion worth of foreign investments into the United States, according to Mr. Kaiser's estimates, "means that the scale of operations for organizations will be more" international in scope and physically larger.

"People are looking for ways to expand their markets, and we're seeing a reinvestment of U.S. dollars that have left the country coming back through foreign investment," he said.

While the so-called liberalization of the European Community targeted for 1992 will bring with it "more worldwide-type insurance brokering," a more important date to the insurance industry will be July 1, 1990, when the EC directive permits cross-border placement of property/casualty insurance, Mr. Kaiser said (*BI*, May 16).

The removal of European trade barriers will create the opportunity to "issue a single all-risk policy to cover anybody's assets within the 12 EC member countries," Mr. Kaiser said.

In addition, several factors are likely to combine to flatten future market cycles, Mr. Kaiser predicted. These include the effects of the 1986 Tax Reform Act, increased regulatory involvement in insurance industry practices and individual company problems, such as the lack of profitability on the life/health side of combined property/casualty and life/health companies' books of business.

Depending on the type of risks that a company has and its premium level, most commercial insurance buyers should see some rate reductions in 1989, Mr. Kaiser said.

Yet other factors point to a "firming of the market by 1990," he said, predicting that the industry combined ratio will increase to to 115%.

Meanwhile, the London market is still taking a cautious approach to underwriting many types of U.S. business, according to William J. Richardson, executive vp and director of Frank B. Hall & Co. in Briarcliff Manor, N.Y.

Lloyd's of London "is not having a terrific time in the property/casualty field, given the slow (domestic) market conditions that prevail at this time," Mr. Richardson said.

As a result, capacity in London markets for traditional property business is up over last year and will increase again in 1989, he predicted.

However, London is less competitive on the West Coast, because "there is a much greater fear (in London) that California will break off and float into the Pacific," he said.

While London still is a market for directors and officers liability insurance, the domestic market continues to write the major portion of this business, Mr. Richardson said.

However, British markets—Lloyd's in particular—will be more aggressive in Europe than in the United States, where the legal system has hampered their competitiveness, Mr. Richardson said.

In other words, for insurance buyers that "find it difficult to secure liability in the U.S. market, London will probably suffice," he said. However, "this is no time to go bargain-hunting in London." ■

IRS rules

Continued from page 1

Indeed, the preamble to the proposed integration rules says that compliance with those rules would not be considered an "automatic safe harbor" to meet the pension non-discrimination provisions.

"Trying to redesign a pension plan without a complete set of IRS rules is like being asked to tell time with a clock that only has one hand," said Howard Weitzmann, executive director of the APPWP.

"Employers are being asked to blaze a trail but could fall off a cliff because there is not a path to follow," said Dick Schreitmueller, research actuary in Foster Higgins' Princeton, N.J., office.

"The cumulative and individual effect of all of these factors—late publication, absence of final rules and lack of all necessary regulations—is to prevent employers from considering options for amending their plans and making rational choices among them," the APPWP said in its letter to Mr. Chapoton.

But, despite these problems, it appears that employers with integrated pension plans must make some decision on their plans' futures by year-end.

For example, a company could rush to make changes by Jan. 1 in its pension plan that it believes will meet the full set of IRS rules.

But, once all the needed regulations are published, the company may discover that the integration procedures it adopted are more generous than required.

While the company then could again redesign the plan to increase integration, and thus lower pension benefits, it could not take back benefits that workers accrued under the old formula. Federal law bars the elimination of accrued pension benefits under anti-cutback provisions.

Observers point out, however, that trying to meet the Jan. 1 deadline is such a herculean task that few companies will try. To meet the deadline, companies would have to master the Nov. 15 rules, which comprise 25 pages of small type in the Federal Register; design new formulas; obtain approval from their boards of directors; and, finally, announce and explain the changes to employees.

"You need to look at the impact on costs and employees. That will be very difficult to do in the next few weeks, especially if companies have not begun to think about it," said Sue Velleman, a managing director in the Boston office of William M. Mercer-Meidinger-Hansen Inc.

"Companies are left in the lurch. No one expected to have only six weeks to make changes and without a complete set of rules," said Frederick Rumack, director of tax and legal services for Buck Consultants Inc. in New York.

Another option for employers is to "freeze" their pension plans, so that benefit accruals after Dec. 31, 1988, would temporarily cease. After the needed IRS rules are published, the company then could adopt new integration procedures and resume benefit accruals.

Such a freeze, though, would have to be announced by Dec. 16 for calendar year plans. Federal law requires a 15-day advance notice to pension plan participants anytime there is a reduction in future benefit accruals.

Such a deadline could be impossible to meet for a huge company with locations scattered throughout the country. In addition, many small firms may only now be aware of the integration rules.

In addition, attempting to tell employees that their pension benefit accruals are being frozen—even if the freeze is only temporary—could frighten employees, no matter how skilled the communications effort deployed.

"It would be an employee relations nightmare. Not many rank-and-file employees would take the company at its word that a freeze is only temporary and is the result of a regulation problem," said Henry Saveth, a managing consultant in A. Foster Higgins' New York office.

"No matter how you communicate it, a freeze will scare people," said Larry Sher, a partner with benefit consultant Kwasha Lipton in Fort Lee, N.J.

There also is some fear among benefit consultants that the IRS might view a freeze as a partial pension plan termination, resulting in full vesting of accrued benefits by participants and higher costs for the employer.

"There is an outside chance the IRS could take that position," said Hewitt Consultant Susan Koralik.

Another option for companies is to do nothing about the Jan. 1 deadline and stick with their current formulas until more rules are published.

However, employers that retain prohibited integration formulas could run the risk of lawsuits by participants and plan disqualification, which would result in adverse tax consequences for both employers and employees, according to Hewitt Associates.

The APPWP says the most sensible solution for the IRS is to authorize employers to allow employees to accrue benefits on a temporary or conditional basis for service after the 1988 plan year.

Those post-1988 accruals would remain conditional until the employer adopts plan amendments to comply with all the needed IRS pension regulations after the regulations are published.

By making accruals conditional, companies that later adopted retroactive design changes that reduced benefits would not be considered to have violated anti-cutback provisions in federal law.

While employers face some unpalatable choices, the new IRS rules will force companies to pay more attention to pension plan design, an area that many experts say has long been neglected.

"Hopefully, some companies will view this as an opportunity to reexamine what their pension plan objectives are," said Kwasha Lipton's Mr. Sher. ■

IRS pension integration rules boost for low-income retirees

WASHINGTON—New Internal Revenue Service rules will alter the decades-old corporate practice of integrating pension benefits with Social Security.

Integration allows companies to reduce retirees' pension benefits by a portion of Social Security benefits earned by the retirees.

While this may seem unfair, companies point out that they pay for 50% of their employees' Social Security benefits through the FICA payroll tax.

In addition, without integration, retirees—especially low-wage earners—could receive more income during retirement through combined pension and Social Security benefits than they received when working. If that were allowed, it would be difficult to retain employees.

While integration formulas vary enormously, one common method currently used is to reduce a pension benefit by half of a retiree's Social Security benefit. For example, if a retiree was entitled to a $500 monthly Social Security benefit, the retiree's corporate pension benefit would be reduced by $250.

Congress, when drafting the Tax Reform Act of 1986, accepted pension activists' long-held complaint that integration allowed too steep a reduction in low-income retirees' pension benefits. The new integration provisions included in the tax law generally are effective for benefits accrued after Dec. 31.

The extremely complex integration provisions generally result in reducing the impact of integration for lower-paid employees with small pension benefits.

For example, regardless of the integration formula used, an employer-provided pension benefit as of Jan. 1 cannot be cut by more than half through integration.

The provisions and newly released Internal Revenue Service rules appear to eliminate the most common type of integration: arrangements in which the Social Security benefit is used to directly "offset" or reduce the employer-provided pension benefit.

Instead, under so-called offset arrangements, the offset could be based on each employee's final average pay as well as "covered compensation," which is defined as the 35-year average of the Social Security wage base.

According to this average, "covered compensation" for employees who retire in 1989 will equal $15,708.

Under one arrangement allowed under the new rules, the employer divides the maximum final average compensation that it will use for offsetting purposes by the "covered compensation" figure.

For example, an employer decides that the maximum amount of final average compensation to be taken into account for offsetting purposes will be $22,000. That number is then divided by the covered compensation figure for the year being calculated, which in 1989 is $15,708. The result—140%—is used to find the "reduction factor" on the IRS tables.

The 140% figure used in this example corresponds with a reduction factor of 0.6% on the IRS tables.

Assume a worker retired next year with a final average salary of $15,000. The employer would multiply $15,000 by 0.6%, which equals $90. To determine the total offset, the $90 would be multiplied by the worker's years of service. So if the retiree worked 35 years, his total offset would be $3,150.

In this example, if the retiree's gross pension benefit totaled $7,500 before integration, he would be entitled to a post-integration benefit of $4,350, plus his Social Security benefits.

Other arrangements permitted by the IRS are more simple, but still favor lower-paid employees.

For example, the new rules would limit the benefits payable to higher-paid workers under a pension plan in which an employer promises to pay a benefit based on a certain percentage of salary up to a designated salary "breakpoint," then pay a benefit based on a higher percentage of salary on wages exceeding the breakpoint.

Under the rules, the disparity between the percentage applied to salary under the breakpoint and over the breakpoint could not exceed 0.75 percentage points or double the lower percentage, whichever is less.

For example, consider a plan under which the benefit was based on 1% of salary up to a breakpoint equal to "covered compensation." Under the IRS rules, the employer could offer a maximum benefit of 1.75% of salary exceeding "covered compensation."

—By Jerry Geisel

Update

Hazard rule exemption killed

PHILADELPHIA—Employers in the construction industry must comply with the federal hazard communication standard, a panel of the 3rd U.S. Circuit Court of Appeals in Philadelphia has ruled.

The court ruled Nov. 25 that the standard is valid for all industries, including construction. One panel of the appeals court in July imposed a temporary stay of the standard for the construction industry because of legal challenges to the rule (*BI*, July 18). Another panel of the court, though, ruled on Aug. 19 the construction industry was not exempt (*BI*, Sept. 5).

However, the Occupational Safety and Health Administration has not determined whether the standard for the construction industry will be enforced immediately or delayed for a few weeks as is common practice when a stay is withdrawn.

In a related action, the 3rd Circuit on Nov. 28 denied a government petition seeking a rehearing of the court's August decision to enforce three provisions of the standard, which the Office of Management and Budget had rejected.

Insurer net aftertax income falls

NEW YORK—The property/casualty insurance industry posted an 8.8% decrease in net aftertax income to $10.3 billion in the first nine months of 1988, due mostly to a reduction in realized capital gains and partly due to a higher tax liability.

The $10.3 billion includes $1.8 billion in realized capital gains in the first nine months of 1988, while 1987 nine-month net aftertax income of $11.3 billion included $3.9 billion in realized capital gains.

The industry's tax liability increased to $2.9 billion in the first nine months of 1988 compared with $2.5 billion in the comparable 1987 period.

The data, released last week, was compiled by the Insurance Services Office Inc. and the National Assn. of Independent Insurers.

However, pretax operating income for the nine months ended Sept. 30 was up 14.1% to $11.3 billion from $9.9 billion for the comparable period a year ago.

The results reflected an $8.4 billion underwriting loss, which deepened 13.5% from the $7.4 billion loss posted in 1987, according to an Insurance Information Institute report. Pretax investment income totaled $19.8 billion, up 13.9% from $17.4 billion in 1987.

The industry reported a 104.9% combined ratio, compared with a 104.1% combined ratio for the first nine months of 1987.

Written premiums for the period totaled $151.9 billion, up 3.8% from $146.4 billion for the comparable period in 1987.

According to a *Business Insurance* survey of 24 major property/casualty insurers, aftertax operating income declined 12.8% for the first nine months of 1988, to $4.9 billion, while net premiums written increased 1.8%, to $67 billion (*BI*, Nov. 28).

Dupont Plaza delays opening

SAN JUAN, Puerto Rico—The Puerto Rican government earlier this month said it would not allow The Dupont Plaza hotel, which was heavily damaged in a 1986 New Year's Eve fire, to reopen until sprinklers are installed on all 20 floors of the building.

The hotel, which was scheduled to reopen in January as the Palm Hotel & Casino, is in its final stages of reconstruction and sprinklers have been installed on the first three floors.

The owners of the hotel, The San Juan Dupont Plaza Corp., say their property and business interruption insurer, a unit of New York-based American International Group Inc., should pay for the sprinklers on all floors.

AIG unit American International Insurance Co. of Puerto Rico wrote $25 million in limits on the building, $2.3 million on the contents and $4.5 million in business interruption.

To date, the insurer has paid $9 million for the hotel's reconstruction and $4.5 million for business interruption losses. The hotel is seeking to recover additional payments for business interruption losses under a master policy written by the Insurance Co. of the State of Pennsylvania, another AIG unit.

AIG attorney Eugene Wollan of Mound, Cotton & Wollan in New York says the insurer is not liable for the cost of sprinkler installation because the hotel had no sprinklers in 1986. The insurer is only liable to restore the hotel to its pre-fire condition, he said.

AIG also paid $1 million in liability limits it had written for the hotel after the fire set by arsonists killed 97 people. No excess liability insurance is known to exist to cover the estimated liability damages of as much as $400 million. The liability cases are still in litigation (*BI*, Feb. 8; Jan. 12, 1987).

Briefly noted

Supporters of **Illinois' medical insurance plan for high-risk individuals** will renew their efforts to fund the program when the Legislature resumes Jan. 9. Gov. James Thompson's July veto of $10 million for the new Comprehensive Health Insurance Plan, which the House overrode last month (*BI*, Nov. 21), was sustained by the Senate last week. . . .**Michael H. Davis**, chief financial officer and treasurer of The Wyatt Co., will succeed V. Clark Baird as president and chief executive officer next July when Mr. Baird retires. . . .Most families of the 167 people who died in the **Piper Alpha** oil platform disaster in the North Sea in July are accepting compensation offers totaling about 100 million pounds ($184 million) from platform operator Occidental Petroleum International Oil Inc. . . .**Quill O. Healey**, 49, has been named president and chief operating officer of Fred S. James & Co. Inc. Richard M. Page, who is relinquishing the position, remains chairman and chief executive officer. Mr. Healey was most recently an Atlanta-based executive vp in charge of James' Eastern offices. . . .**Crown Life Insurance Co.** is withdrawing from the U.S. group life and health insurance business, selling more than three-quarters of the business to Great-West Assurance Co. of Winnipeg, Manitoba, effective Feb. 1, 1989. The company is selling the remaining portion of the business to Employers Health Insurance Co. of Green Bay, Wis., a subsidiary of Lincoln National Corp.

Tornado losses

Continued from page 3

fully covered."

Daniel D. Barry, an analyst with Kidder, Peabody & Co. in New York, said K mart stores generally are stocked with inventory with a retail value of about $4 million. According to Mr. Barry, the Raleigh store probably had sales of around $10 million per year and would likely lose about $2 million in sales during the remainder of the Christmas season.

Meanwhile, David Lee, director of insurance at Fort Worth, Texas-based Tandy Corp., parent of the Radio Shack Computer Center, estimated that the damage at the Raleigh store would cost Tandy about $1 million.

"We will absorb about 10% of that," he remarked.

The all-risk coverage that will pay the remainder of the loss was underwritten by American International Group Inc. in New York, said Mr. Lee.

He said that he expects the Raleigh store to reopen in a different location sometime this week.

Other businesses that were destroyed or sustained major damage included a motel, gas stations, office buildings and Carolina Mack Sales & Service Inc., a Mack truck distributor.

William Hough of Mack Trucks Inc. in Allentown, Pa., commented that the truck distributor was responsible for its own insurance coverage.

Operators of the Raleigh business could not be reached last week. ■

Teale corporations

Continued from page 1

Georgia law requires insurers to have a minimum of $1.2 million in assets in the state.

Meanwhile, Mr. Teale, former president of the now-defunct Insurance Exchange of the Americas, says he will fight the temporary receivership and restraining orders against his firms.

The Georgia department's complaint against Mr. Teale, TRT and Fenmar also names eight other Georgia firms Mr. Teale controls:

- International Underwriting Assn. Inc., a TRT subsidiary that operates a consortium of underwriting agencies placing business with various insurers.
- IUA Management Inc., another TRT unit.
- Aviation Insurance Network Ltd.; Marine Insurance Network Ltd.; World Insurance Network Inc.; Travel, Medical & Political Risk Underwriting Agency Inc.; and Omne Underwriting Agency Inc.—all International Underwriting Assn. members.
- Fenmar Europe Ltd., considered a TRT marketing affiliate.

Neither Mr. Teale nor any of the other defendant companies is licensed as a broker or agent or holds a certificate of authority as an insurer in Georgia, noted Kirkland A. McGhee, assistant state attorney general.

The complaint alleges that Promed Ltd., a Teale-led predecessor firm to Fenmar International, entered into an underwriting management agreement with Victoria in February 1987.

In January 1988, shortly after Mr. Teale's resignation as executive vp and director of Victoria, TRT entered into another agreement to act as a manager for Victoria.

Under this agreement, Mr. Teale and TRT "sought to conduct substantially all the business affairs of Victoria," including binding insurance and reinsurance agreements, receiving and remitting premiums, settling claims, opening and maintaining bank accounts, maintaining books and records and complying with regulatory laws, the complaint says. However, the Promed agreement was never submitted to the Insurance Department for its approval, as required by Georgia law, the complaint charges. In addition, the TRT agreement was submitted and disapproved by the department on Sept. 21.

Despite this, Mr. Teale, TRT and Fenmar International have "continued to perform the functions set forth in those two agreements," and thus have acted as insurers, brokers and agents in violation of state licensing and regulatory requirements, the complaint charges.

Meanwhile, Fenmar International has represented itself as a "contact office and administrative manager" for numerous other insurers, several of them offshore, the complaint notes.

These include American Trust Insurance Co. Ltd., Old American Insurance Co. Ltd., American Marine & General Insurance Co. Ltd., American Transportation Insurance Co. Ltd., American Trade Insurance Co. Ltd., American Atlantic Insurance Co. Ltd., American Indemnity Insurance Co. Ltd., Sent Re Insurance Co. Ltd. and Continental Indemnity Insurance Co. Ltd.

Several of these insurers were described along with Victoria in a January 1988 Fenmar promotional brochure as members of the International Underwriting Assn.

By transacting business on behalf of these insurers, Fenmar and the other defendants have acted illegally as insurers, brokers and agents in Georgia, the Insurance Department complaint charges.

American Trust, a Turks & Caicos-based insurer formerly headed by Mr. Teale, was barred from writing insurance in three states earlier this year (*BI*, July 25), though the Illinois Insurance Department recently reached a settlement that would allow the insurer to resume operations in the state (see related story).

The Georgia department also charges in its complaint that one of its examiners was denied access to books and records of Fenmar, TRT and two other companies run by Mr. Teale while in the course of an October audit of William R. Jacques, a licensed Georgia agent for Victoria and an International Underwriting Assn. vp.

Mr. Teale and his companies continue to deny the Insurance Department access to their records "on the basis that defendants are not insurers, agents or brokers but are instead 'underwriting managers,' " the complaint says.

After noting that the Nov. 23 Victoria receivership order enjoins the insurer from transacting business, the Insurance Department's complaint asks the court to enjoin Mr. Teale and his companies from doing business or disposing of their assets and to enjoin other parties from making any claims against the defendants.

Examiners so far have found slightly more than $300,000 in cash held by Fenmar, according to Mr. McGhee, who said he did not know how much—if any—of the money related to Victoria.

In an interview, Mr. Teale said he would request a court hearing on the temporary receivership and restraining order, at which he will argue that he and his companies have not acted illegally as insurers, brokers or agents.

He added that his companies have turned over to the Insurance Department all documents requested of them.

Mr. Teale would not comment on the Promed and TRT underwriting agreements with Victoria, saying legal questions about the agreements are "sub judice."

The Insurance Department, meanwhile, has taken over the assets of Victoria, which reported earned premiums of $12 million in the first nine months of 1988. The department named Andrew Ekonomou, an Atlanta lawyer, as temporary receiver following the Nov. 23 order by Fulton County Superior Court Judge Don A. Langham.

The Georgia department had suspended Victoria's license Sept. 28 after finding that only $307,540 of its reported $25.3 million in assets were located in the state. About $21 million of the assets—including Treasury bonds and certificates of deposit—were reported to be held by Goldman Dollar Securities Inc., a Paris-based unit of Arab American Trust Fund of Amsterdam.

Aram Investment Co., another Arab American Trust unit, had proposed acquiring Victoria from its sole shareholder, Paul Yorke-Wade, a U.K. citizen, though a hearing on the sale was canceled because of the license suspension.

In the petition, the Georgia department notes that while most of the insurer's assets are allegedly held by Goldman Dollar, an Oct. 31 bank statement showed that assets located in Georgia had dwindled to $41,815.17.

In addition, Victoria's records "are inadequate and in such a condition as to prevent the ascertainment of premium balances owed by third parties and the total amount of claims owned by Victoria Insurance Co. Ltd. to insureds," the petition says.

Anthony Dyson, senior executive with Arab American Trust, said last week that the Insurance Department action was premature, since it told Victoria it had until this week to bring additional assets to the state. At the time the receivership order was issued, Arab American was renegotiating a series of agreements with Mr. Yorke-Wade before transferring funds to Georgia, he said.

He also complained that the $41,815.17 represented the balance in only one Victoria bank account, and that the funds in its three Georgia bank accounts now total $186,225.47.

Mr. Ekonomou, however, noted that $186,225.47 still falls far short of statutory solvency requirements.

"Even if they had four times that, even if they had five times that, that's still not enough to run an insurance company on," he observed.

Mr. Ekonomou conceded that Insurance Commissioner Warren D. Evans had given Victoria until this week to come up with additional assets but said this time period was discretionary, and that the Insurance Department is not bound by it.

When Victoria's bank balance started shrinking, "I think that's what kind of capped it right there," he said. ■

American Trust to write again in Illinois

SPRINGFIELD, Ill.—Illinois Insurance Director John E. Washburn signed a consent order with American Trust Insurance Co. that will allow the insurer to resume writing surplus lines business in the state.

American Trust, a unit of Houston-based KLK Consulting & Management Corp., had been declared ineligible as a surplus lines insurer in March after the Insurance Department was unable to confirm the value of over-the-counter stocks that accounted for most of the insurer's year-end 1987 assets.

A unit of the National Assn. of Insurance Commissioners later valued the OTC portfolio at only a fraction of the amount American Trust claimed as assets in a 1987 statutory financial statement (*BI*, July 25).

Alan Teale was president of American Trust and two other Turks & Caicos-based units of KLK: Old American Insurance Co. Ltd. and American Marine & General Insurance Co. Ltd. However, he resigned as president of all three insurers in July, said J. William Van Derveer Jr., general counsel for KLK and the new president of American Trust.

KLK has contributed about $5 million in Treasury securities to American Trust since July, according to Deputy Illinois Insurance Director Ken Smith. Under the consent order, American Trust also will request its $1.1 million share of a KLK fund invested in Treasury securities and corporate debt instruments.

The consent order also requires American Trust to prepare a revised financial statement showing a discounted value for its OTC stock portfolio. The statement must show the stocks' market value as reported in a 1987 statement prepared under generally accepted accounting principles —$29.8 million—rather than the $40.5 million American Trust had claimed in its statutory statement.

The consent order also provides that American Trust will:

- Receive no credit for reinsurance ceded to its two Turks & Caicos affiliates or any other reinsurer represented by members of the International Underwriting Assn. Inc., a consortium headed by Mr. Teale. American Trust also will not assume reinsurance through members of the International Underwriting Assn.
- Change its domicile to Bermuda through merger with an existing Bermuda-domiciled insurer.
- Limit its annual gross premium volume to $15 million unless it receives prior Insurance Department approval to exceed that amount.

The order also notes that American Trust entered into an "insurance services agreement" with Fenmar International Insurance Services Ltd., another company headed by Mr. Teale, on Aug. 16. American Trust agrees in the order to "approve the underwriting guidelines that will be used by Fenmar in accepting risks on behalf of American Trust."

American Trust has reported a delay in preparing its revised financial statement because the Georgia Insurance Department's temporary receivership order against Fenmar has blocked the insurer's access to documents, Mr. Smith said. ■

'Sick industry' tottering on precipice once more

By MYRON M. PICOULT

Special to Business Insurance

Archaic and inefficient accounting has obfuscated the growth in unhealthy items that now permeate insurers' balance sheets.

USING ALMOST ANY standard, it can be said that the property/casualty insurance industry is a sick industry. In many respects, its malaise mirrors the problems faced by the banking industry in the early 1970s and the more recent difficulties of the savings and loan industry. Archaic and inefficient accounting has obfuscated the growth in unhealthy items that now permeate many company balance sheets.

Mr. Picoult

With few exceptions, property/casualty insurance company executives have had a very poor track record of forecasting their industry's fortunes.

It is somewhat ironic to review third-quarter commentaries about the deterioration of industry pricing in contrast to the plethora of comments made at the bottom of the last underwriting debacle, when industry executives vowed not to get caught again.

Notwithstanding the forthright comments made several years ago, the industry once again totters on a precipice.

As if this were not enough, one also has to deal with the "California Lunacy Game," also known as Proposition 103. In essence, the approval of Proposition 103 was a populist indictment of the property/casualty insurance industry. At best, it is a nuisance and at its worst it is a problem. The end result will either be a man-made catastrophe or a catharsis.

Unfortunately, the insurance industry remains a "whipping boy" for power-hungry politicians. Complicating the morass is the industry's woeful ability to respond effectively to its critics.

The trend in property/casualty underwriting results is clearly down for the next four to six quarters. Balance sheet problems also will proliferate. Attempts by regulatory bodies to dress up interim balance sheets will only exacerbate the ultimate result.

The upcoming fourth quarter is likely to be one of the most interesting in a long time. It may well be an "inoperative" quarter as companies begin to address their miscues and subtly go about the restructuring that will be engulfing the industry.

When speaking about man-made catastrophes, the third-quarter numbers provide a good springboard.

Premium data and underwriting ratios appear to be better than they really are as insurers have raised their retentions. This will all come home to roost.

Our survey covers 21 insurers and represents about 58% of the property/casualty insurance industry's volume. For the third quarter, the results were as follows:

- Written premiums edged up 1.8%. This compares with gains of 3.1% for the first quarter and 2.1% for the second quarter. It should be noted that retentions have continued to rise.

Seven insurers reported actual declines in premium volume, with both GEICO Corp. Group and Fireman's Fund Insurance Cos. showing declines exceeding 20%. On the flip side, the increase in premiums ranged from 0.1% to the 15.9% reported by CNA Financial Corp. In fact, six insurers produced solid double digit premium increases.

The overall range of a 26.6% drop in premium volume for GEICO to a 15.9% increase for CNA is bizarre. While there is clearly rationale for some growth in some lines, the results imply that someone is very right and someone is very wrong!

Earned premiums crept along at a 4.2% growth rate. This is unchanged from the second-quarter growth rate. Notwithstanding management protestations to the contrary, stories about weird rate cuts from time to time persist.

- The average combined ratio rose to 105.8% from 103.8% a year ago. The third quarter combined ratio was 0.8 points higher than in the second quarter. This seems to be low, and we surmise that insurers have used increased retentions to develop lower expense ratios. Our numbers show that the expense ratio moved up to 29.2% from 28.7%, while the loss ratio expanded to 76.7% from 75%.

Two companies, American International Group Inc. and GEICO, recorded combined ratios below 100%. The remaining players were bunched around the 102%, 105% and 108% marks. American General Corp. posted the highest combined ratio at 123%, reflecting additional reserving.

- Pretax net investment income rose 12.4%, which is a little below the first and second quarter gains. Two insurers recorded declines in investment income. The shifting of invested funds into taxable instruments has raised the effective tax rates for most companies.

There was a very wide disparity in the investment income figures, ranging from Kemper Group's 2.8% gain to Chubb Group's 35.6% increase.

Cash-flow trends for the third quarter compared with the second quarter were either slightly lower, slightly higher or materially lower. On balance, we are seeing more shrinkage than we have before. Paid losses expanded 13.4%, which is the sharpest increase of the year. Some companies have pointed to a rise in catastrophe losses as the reason for the increase. We think the cause is a little deeper. Part of the rise probably relates to increased retentions.

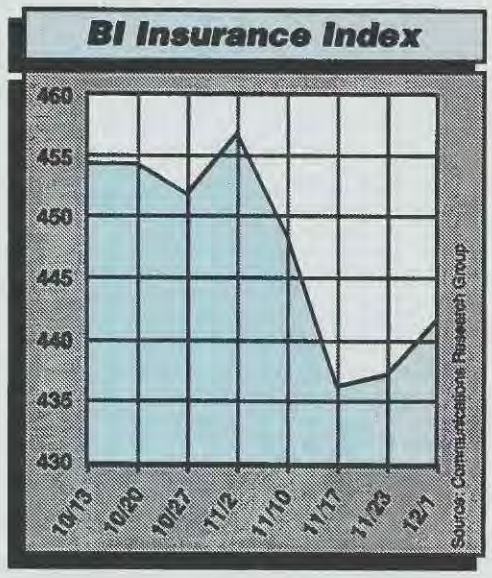
On the reserve side of the table, loss reserves increased an average of 2.9%. This was the smallest gain of the year. In general, reserve increases for 1988 have lagged the 1987 pace.

- With respect to leverage ratios, our data base is not yet complete. The numbers appear to indicate that the average premiums-to-statutory surplus ratio will hover near the second quarter's 2.4-to-1 figure. In reality, the "real" ratio is probably a tad more than 3-to-1 if reserve deficiencies, reinsurance recoverable write-offs, adjustments to miscellaneous assets and bonds were marked to market.

- Property/casualty operating earnings on average declined 15.7%. This follows a 4.5% gain for the first quarter and a 2.7% drop for the second quarter.

The third-quarter decline is just a precursor to what lies ahead. This is indeed a sick industry. However, adversity always creates opportunities. ■

Myron M. Picoult is senior vp and senior insurance analyst with Oppenheimer & Co. in New York. He is the past president of the Assn. of Insurance & Financial Analysts and a member of the New York Society of Security Analysts.



Insurance industry stocks continued to climb last week, with the *Business Insurance Index* rising 4.37 points to 442.0 on Dec. 1 from 437.6 on Nov. 23. Advancing issues were led by Chandler Insurance Co., up 11.8%; Kansas City Life Insurance Co., up 11.3%; Fremont General Corp., up 6.2%; Belvedere Corp., up 5.6%; and Hilb, Rogal & Hamilton Co., up 5.3%. Declining issues were led by Statesman Group Inc., down 5.9%; Tokio Fire & Marine Insurance Co., down 5.0%; Alexander & Alexander Services Inc., down 4.5%; Seibels Bruce Group Inc., down 4.3%; and Navigators Group, down 3.8%. Issues showing the most activity during the period were: USF&G Corp., 3.8 million shares traded; Sears, Roebuck & Co. (Allstate Insurance Co.), 3.2 million shares traded; and Farmers Group Inc., 3.0 million shares traded. The *BI Index* gained 1.0% for the period, keeping pace with the leading market indicators: The Standard & Poor's 500 surged 1.5%; the Dow Jones 30 Industrials gained 0.5%; and the New York Stock Exchange Composite climbed 1.3%.

British Issues

Dec. 1 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence pence
Comml Union	319	10.3	25.3	7.9	321—319
Genl Accident	820	8.1	58.0	7.1	822—814
Gdn Royal Exch	178	9.6	13.1	7.3	179—178
Royal	359	11.7	30.0	8.4	368—359
Sun Alliance	944	7.2	54.7	5.8	962—944
Brokers					
Bradstock	188	10.2	8.0	4.3	190—188
CE Heath	423	13.4	34.5	8.2	424—419
Hogg Robinson	157	13.3	8.0	5.1	157-157
Lloyd Thompson	202	15.9	8.0	4.0	202—200
PWS Holdings	149	21.3	6.0	3.5	152—149
Sedgwick Grp	221	18.4	16.0	7.2	223—219
Steel Brrl Jones	209	18.7	13.3	6.4	210—204
Willis Faber	222	13.1	16.0	7.2	224—220

Source: Philip Olsen/Alan Clifton, Insurance Industry Specialists Kitcat & Aitken Stockbrokers, London

BI Industry Stock Report

DECEMBER 1, 1988 — 11/25/88 THRU 12/1/88

BROKERS		Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
Alexander & Alexander Svcs	NYSE	23.75	-4.5	33.8	28.13	17.75	340	1.00	4.2	16.3	3.71	6.40
Corroon & Black Corp	NYSE	29.50	-0.4	4.4	34.75	28.00	81	1.08	3.7	4.4	5.43	5.43
Gallagher Arthur J. & Co	NYSE	17.88	0.0	11.8	19.13	13.88	52	0.48	2.7	12.3	5.16	3.47
Hall Frank B. & Co	NYSE	2.88	4.7	0.0	5.50	2.50	190	0.00	0.0	-1.6	0.00	N/A
Hilb, Rogal & Hamilton	OTC	15.00	5.3	53.8	14.50	9.75	34	0.00	0.0	12.6	4.60	3.26
Marsh & McLennan Cos. Inc.	NYSE	56.25	-1.3	13.6	59.63	45.25	415	2.50	4.4	13.8	6.74	8.35
Poe & Assoc Inc	OTC	8.25	0.0	17.9	9.25	6.75	0	0.40	4.8	12.7	0.27	30.56
BROKERS	AVERAGE		0.5	19.3					2.8	10.0		
CONGLOMERATES & HOLDING COMPANIES												
Berkley W R Corp	OTC	29.75	0.8	24.0	30.00	23.50	70	0.36	1.2	6.4	17.63	1.69
Berkshire Hathaway Inc. DEL	NYSE	4775.00	0.5	61.9	5000.00	2755.00	72	0.00	0.0	19.2	92.68	1.92
ITT (Hartford Group)	NYSE	50.50	2.5	12.2	54.88	43.25	999	1.48	2.9	6.3	52.23	0.97
Sears Roebuck & Co (Allstate)	NYSE	39.50	-1.3	17.5	46.13	32.25	3221	2.00	5.1	10.3	34.74	1.14
CONGLOMERATES	AVERAGE		0.6	28.9					2.3	10.5		
INSURERS/REINSURERS												
Aetna Life & Cas Co	NYSE	47.38	-1.8	4.7	52.50	39.50	723	2.76	5.8	7.8	53.56	0.88
American General Corp	NYSE	31.00	0.4	-2.4	36.38	27.50	1192	1.40	4.5	7.8	28.04	1.11
Amer Heritage Life Invt	NYSE	26.00	2.0	7.2	27.00	24.00	2	1.08	4.2	11.0	20.98	1.24
Amer Indty Fin'l Corp	OTC	10.38	1.3	15.3	12.00	8.25	5	0.56	5.4	18.2	15.26	0.68
American Int'l Group	NYSE	65.38	3.2	9.0	68.75	49.00	319	0.40	0.6	9.6	33.56	1.95
Aon Corp	NYSE	27.75	2.8	21.3	28.75	21.88	287	1.28	4.6	9.1	15.13	1.83
Argonaut Group	OTC	44.25	1.7	48.7	49.00	29.50	54	0.00	0.0	6.1	29.19	1.52
AVEMCO Corp	NYSE	23.75	1.1	21.0	28.75	17.88	19	0.34	1.4	11.0	7.74	3.07
Belvedere Corp	AMEX	4.75	5.6	8.4	6.00	4.00	117	0.04	0.8	7.0	7.87	0.60
Chandler Insurance	OTC	9.50	11.8	94.7	10.25	4.25	37	0.00	0.0	4.6	7.18	1.32
Chubb Corp	NYSE	56.38	1.8	0.9	63.38	51.25	304	2.16	3.8	6.5	46.13	1.22
CIGNA Corp	NYSE	47.88	1.3	9.1	55.38	42.75	335	2.96	6.2	8.9	49.19	0.97
CNA Fin'l Corp	NYSE	60.75	5.2	9.2	66.13	51.00	141	0.00	0.0	9.6	46.40	1.31
Continental Corp	NYSE	34.50	-1.4	-11.0	41.63	33.75	353	2.60	7.5	11.1	42.10	0.82
Durham Corp	OTC	32.50	0.8	51.2	36.75	21.50	8	0.92	2.8	37.6	26.00	1.25
Farmers Group Inc	OTC	74.13	1.2	84.2	74.25	40.50	3042	1.44	1.9	17.4	22.02	3.37
Fireman's Fund Corp	NYSE	29.00	0.9	11.5	33.50	25.75	247	0.50	1.7	126.1	26.17	1.11
Forum Re (Bermuda)	OTC	1.25	0.0	-63.0	4.00	1.13	22	0.00	0.0	3.5	2.58	0.48
Fremont Gen Corp	OTC	12.88	6.2	33.7	13.50	8.75	461	0.60	4.7	8.7	16.24	0.79
General Re Corp	NYSE	55.38	1.2	-0.9	59.38	45.50	593	1.20	2.2	11.3	26.21	2.11
Home Group Inc.	NYSE	11.38	3.5	-4.2	14.38	10.75	180	0.20	1.8	2.8	17.76	0.64
Hanover Ins Co	OTC	26.50	2.9	14.0	27.75	20.50	313	0.36	1.4	5.0	25.10	1.06
Harleysville Group Inc.	OTC	17.63	-0.7	34.4	18.25	13.38	31	0.48	2.7	6.9	16.65	1.06
Hartford Steam Boiler	OTC	32.25	4.0	40.2	32.75	22.50	69	1.40	4.3	11.0	10.65	3.03
Kans City Life Ins	OTC	39.50	11.3	50.5	39.50	25.25	42	0.00	0.0	11.4	39.22	1.01
Kemper Corp	OTC	24.00	-1.0	17.1	27.50	20.75	227	0.72	3.0	7.6	26.50	0.91
Lawrence Ins. Group	AMEX	9.50	-1.3	111.1	11.63	4.50	1	0.24	2.5	21.1	2.90	3.28
Liberty Corp. S.C.	NYSE	37.88	0.3	6.7	47.25	34.50	8	0.80	2.1	13.1	17.40	2.18
Lincoln Nat'l Corp	NYSE	46.13	0.3	15.0	53.50	40.25	274	2.48	5.4	11.9	36.62	1.26
NAC Re Corp	OTC	30.25	1.7	70.4	31.50	18.50	88	0.00	0.0	13.5	19.92	1.52
Navigators Group	OTC	19.25	-3.8	32.8	20.38	14.50	15	0.00	0.0	9.3	12.88	1.49
Nobel Ins Ltd.	OTC	5.25	-2.4	-40.0	9.50	4.50	15	0.42	8.0	-37.5	7.76	0.68
Northwestern Nat'l Life	OTC	30.00	-1.3	31.1	34.50	22.63	363	1.12	3.7	7.2	35.05	0.86
Ohio Cas Corp	OTC	35.25	0.0	-2.8	38.25	32.25	133	1.88	5.3	6.6	27.86	1.27
Old Rep Int'l Corp	OTC	25.00	2.5	25.0	25.88	19.13	616	0.74	3.0	5.9	27.82	0.90
Orion Cap Corp	NYSE	15.00	1.7	11.1	17.63	13.13	32	0.76	5.1	5.1	9.34	1.61
Phoenix Re Corp	OTC	10.00	5.3	53.8	11.00	6.75	9	0.00	0.0	5.4	11.08	0.90
Protective Life Corp	OTC	13.50	1.9	10.2	15.13	12.25	132	0.70	5.2	16.5	17.25	0.78
Re Capital Corp	AMEX	8.88	0.0	-15.4	11.75	7.88	14	0.00	0.0	19.7	11.49	0.77
Provident Life & Acc Ins Co	OTC	19.38	1.3	55.0	25.00	15.63	223	0.68	3.5	16.3	21.96	0.88
St. Paul Cos. Inc	OTC	42.00	1.2	-8.7	51.00	38.25	1093	2.00	4.8	5.9	35.83	1.17
SAFECO Corp	OTC	24.00	-2.0	-13.5	30.00	22.75	683	1.08	4.5	7.6	21.39	1.12
SCOR U.S. Corp.	NYSE	7.00	-3.4	-24.3	9.50	6.63	94	0.10	1.4	5.0	9.39	0.75
Seibels Bruce Group Inc	OTC	11.25	-4.3	0.0	14.25	11.00	31	0.80	7.1	7.6	12.51	0.90
Selective Ins Group Inc	OTC	24.00	-2.0	26.3	26.50	19.25	60	1.24	5.2	5.3	19.52	1.23
Statesman Group Inc.	OTC	2.88	-5.9	-38.6	5.56	2.94	50	0.05	1.7	-288.0	3.48	0.83
Tokio Marine & Fire Ins	OTC	93.13	-5.0	41.4	98.00	63.25	47	0.22	0.2	56.4	0.00	N/A
Torchmark Corp	NYSE	30.63	2.1	25.0	33.50	24.50	117	1.20	3.9	9.9	12.24	2.50
Transamerica Corp	NYSE	32.50	2.8	9.2	36.75	29.75	362	1.88	5.8	7.5	24.94	1.30
Travelers Corp	NYSE	34.88	0.0	-0.7	40.00	33.00	493	2.40	6.9	12.8	45.28	0.77
Trenwick Group Inc	OTC	13.63	1.0	33.0	13.75	9.75	28	0.24	1.8	13.4	15.41	0.88
United Fire & Cas Co	OTC	29.50	2.6	13.5	29.50	24.00	11	1.08	3.7	4.9	22.56	1.31
United States Fid & Gty	NYSE	30.25	0.8	6.1	34.38	28.88	3769	2.64	8.7	8.1	19.53	1.55
UNUM Corp.	NYSE	27.38	3.3	48.0	27.75	17.88	262	0.48	1.8	11.5	28.53	0.96
USLIFE Corp.	NYSE	34.00	-1.1	19.3	40.13	28.00	243	1.36	4.0	9.0	46.77	0.73
Washington Nat'l Corp	NYSE	26.75	-0.9	12.0	28.75	24.00	651	1.08	4.0	-7.7	32.33	0.83
Zenith Nat'l Ins Corp	NYSE	15.88	0.0	5.9	23.88	15.00	40	0.80	5.0	7.4	12.53	1.27
INSURERS/REINSURERS	AVERAGE		1.1	17.9					3.3	6.4		
ALL COMPANIES	AVERAGE		1.0	18.7					3.2	7.1		

System design: Communications Research Group

Why your client's nest egg is safer at Home.

Home knows all there is to know about insuring fine arts, fine jewelry, fine collectibles—like the precious Fabergé egg pictured above. That's why, when they need coverage for upscale clients, more and more agents are calling Home.

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Along with our underwriting expertise, Home also offers more flexibility of handling. So you can provide your clients with scheduled or blanket coverage on a "valued at" basis, customized to fit their specific needs.

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