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Update

Property/casualty insurers see 37% drop in nine-month profits

NEW YORK—Hit by Hurricane Andrew losses, the U.S. property/casualty insurance industry's net income plunged 37.1% to $6.35 billion from $10.09 billion for the nine months ended Sept. 30, reports the Insurance Services Office Inc. and the National Assn. of Independent Insurers.

Twenty-four major insurers surveyed by *Business Insurance* reported a 23.4% drop in net income to $3.8 billion from $4.95 billion for the same period (*BI*, Nov. 30).

The industry's combined ratio de-

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Insurance Regulation

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Punitive damage awards

Supreme Court's review of new case may clarify Haslip guidance

By JOANNE WOJCIK

WASHINGTON—The U.S. Supreme Court has reopened the debate over the constitutionality of punitive damages by granting review of a $10 million award by a West Virginia jury.

The West Virginia Supreme Court said the award was justified because the defendant's conduct "was really mean," even though the jury found there were no actual damages other than a $19,000 legal bill.

Some lawyers believe the motivation for the high court's decision last week to review *TXO Production Corp. vs. Alliance Resources Corp.* may be to clarify its most recent punitive damages decision in *Pacific Mutual Life Insurance Co. vs. Haslip*.

Critics have charged that the 1991 Haslip decision was too vague to provide adequate guidance for lower state and federal courts.

In Haslip, the $1.1 million Alabama award that included $840,000 in punitive damages was upheld by the high court because the state had guidelines for jurors to follow in assessing punitive damages and adequate appellate procedures to satisfy due process (*BI*, March 11, 1991).

"The court recognized that Haslip left too many unanswered questions," said Ellis Horvitz of Horvitz & Levy in Encino, Calif., a punitive damages expert.

"The large number of cert petitions" that have been filed with the court "shows the issue was not resolved" by the Haslip decision, suggested Martin Connor, president of the American Tort Reform Assn. in Washington.

"Hopefully they realize that their opinion in Haslip really did

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More storm losses seen in reinsurers' year-end results

By JUDY GREENWALD

U.S. reinsurers already reporting huge losses from Hurricane Andrew will face even more storm-related claims in the fourth quarter.

Forty-one U.S. reinsurers polled by the Reinsurance Assn. of America reported $1.8 billion in gross losses and $540.6 million in net losses from Hurricane Andrew in the third quarter.

In addition, 37 reinsurers reported $157.6 million in gross losses and $93.3 million in net losses from Hurricane Iniki.

But even given insurer retentions, those numbers still leave a big discrepency between the losses reported by primary insurers and those reported by reinsurers, indicating that more claims are in the "pipeline."

Insured losses exceed $11 billion for Andrew and $1.6 billion for Iniki (*BI*, Oct. 26). Remaining losses will be reflected in fourth quarter or even first quarter 1993 results, observers say.

"Where were all the losses?" asked Michael Smith, an analyst with Lehman Bros. in New York, adding, "I think the fourth quarter will be worse."

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HIAA endorses tax on health benefits

Revenue would finance universal coverage

By JERRY GEISEL and MARK HOFMANN

WASHINGTON—The endorsement by the board of the Health Insurance Assn. of America to tax workers on employer-provided health benefits adds more support to the growing drive to tax benefits.

That would boost employers' and employees' tax burden by billions of dollars and stick employers with significant administrative problems.

In a stunning reversal, the HIAA board last week approved a draft proposal that calls for taxes on employer-paid health benefit costs for coverage that exceeds an "essential" level, which the federal government would help to define.

Revenue from such a tax would be used to help pay for coverage for the poor.

HIAA members are now being asked to comment on the proposal, which also would try to expand coverage by requiring employers to offer workers—though not initially pay for—health benefits.

The HIAA board also proposed that the government pay for health insurance for individuals below the poverty level and that

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An unenviable task

But new Lloyd's chairman David Rowland is ready: Open-door policy, loyalty to names to mark tenure

LONDON—David Rowland, who last week was officially elected by the Council of Lloyd's as the market's first full-time, paid chairman, faces an unenviable task.

Mr. Rowland concedes as much. Thousands of members are suing Lloyd's members agencies; policyholders for the first time are questioning the security of Lloyd's syndicates; and more losses at Lloyd's are in the pipeline: at least $1 billion pounds ($1.55 billion) for the 1990 accounting year, which closes this Dec. 31, and 500 million pounds ($775 million) for 1991.

But Mr. Rowland believes that after spending 36 years as a Lloyd's broker, he should give something in return—even if it means coping with the greatest challenges ever to face the 304-year-old institution. "It's better to have tried and lost than never to have tried at all," he says.

While Mr. Rowland, 59, will not take over as chairman until Jan. 1, he already has had a major say in Lloyd's future plans. He was chairman of the task force that created a blueprint for reforms at Lloyd's (*BI*, Aug. 31; Jan. 20). And he was involved in the decision to hire Peter Middleton as Lloyd's chief executive.

In only several months, Mr. Middleton has smoothed over some of the angst among the market, the membership and Lloyd's executives. For instance, he has delayed for six months any litigation that Lloyd's might file against members for defaulting on cash calls, including halting proceedings in the 172 lawsuits already filed. And he has lent his ear to disgruntled members, who sing his praises as a man who listens.

Mr. Rowland last week discussed his plans as chairman—a post in which he will earn an annual salary of 450,000 pounds ($698,400), including pension benefits—as well as the future of Lloyd's with International Editor Stacy Shapiro.

* * *

Was Peter Middleton your selection?

A search was conducted by Lloyd's and a number of candidates were looked at. There was

Photo courtesy of Sedgwick Group P.L.C.

a committee of the council to deal with this, and I was invited to join them at the last stage and then had some discussions with Peter Middleton of my own.

I certainly make no bones about it: I am personally very attracted to my job because I look forward very much to the prospect of working with Peter. Everything I've seen in the last few weeks confirms the instinct I had when I met him.

And were the initiatives he has taken initiated by the two of you together?

No, I would only say that I have encouraged the attitude that Peter has taken. . .and I have always felt that we must do everything we can to reduce the confrontation between Lloyd's and a section of the names. After all, we are a society of names. It is true that a section of them are suffering very badly. Many of them feel angry and disadvantaged.

They're still our names. We have an absolute duty to them, and we must do everything possible to help them.

I therefore applaud Peter's attitude, which is to embrace them into our thinking. Bringing people into discussion about a common problem

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Update

P/C insurers' net income drops

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teriorated to 113.4% from 108.4% for the comparable period a year ago, says the III and the NAII, whose data accounts for 96% of the country's property/casualty business.

Pretax underwriting losses increased 59.5% to $23.91 billion from $14.99 billion for the same period in 1991. Net written premiums increased 2.6% to $174.48 billion from $170.04 billion.

Pretax investment income before capital gains increased 1.2% to $25.65 billion from $25.35 billion. Surplus increased 4.9% to $161.56 billion from $153.98 billion.

Blues liquidator sues auditor

CHARLESTON, W.Va.—Ernst & Young is facing a $55 million damage suit filed by the liquidator of Blue Cross & Blue Shield of West Virginia Inc.

The firm acted both as outside auditor for the defunct BCBS plan and as statutory auditor for the West Virginia Insurance Department, according to the lawsuit, filed last week in Kanawha County Circuit Court in Charleston.

Ernst & Young repeatedly misled West Virginia regulators about the insurer's financial condition between 1988 and 1990, alleges the complaint, which charges the firm with negligence, breach of fiduciary duty, conflict of interest, conspiracy, breach of contract and fraud. The suit seeks $35 million in compensatory damages and $20 million in punitive damages.

BCBS of West Virginia, ordered into receivership in 1990, is insolvent by $42 million, said Betty Cordial, special deputy insurance commissioner.

In a statement, Ernst & Young said its audit opinions warned regulators about the insurer's financial problems. The firm said the suit "is totally unfounded and will be dismissed."

Pollution cover limited for spill

LA CORUNA, Spain—Pollution liability coverage for the oil tanker that split in two off Spain's northwest coast last week is capped at about $10 million by international conventions, but oil spill funds could provide about $83 million in additional coverage.

Hull and cargo claims together could top $20 million.

The tanker, the Aegean Sea, is insured by The United Kingdom Mutual Steam Ship Assn. (Bermuda) Ltd. protection and indemnity club. The P&I club wrote its standard $500 million pollution liability coverage for the tanker. But, because Spain is a signatory to the Civil Liability Convention, the P&I club's liability will be limited to around 7 million special drawing rights ($9.7 million), based on the ship's tonnage, said International Oil Pollution Convention Fund Director Mans Jacobsson. If the pollution liability exceeds the convention limit, the convention fund will meet claims up to 60 million SDRs ($83.4 million), he said.

No claims estimates were available last week.

The tanker was carrying 79,000 tons of Brent crude oil owned by Repsol S.A. of Madrid. The cargo was valued at around $10.5 million.

Hull coverage for the Aegean Sea was placed in international markets by Seascope Insurance Services Ltd. London sources say the tanker was valued at around $10 million. Aegean Sea Traders Corp., a Panamanian-registered firm operating out of Greece, owns the ship.

The tanker was transporting the oil to La Coruna from the North Sea when it hit rocks outside the La Coruna harbor.

Farley makes a deal with PBGC

WASHINGTON—Farley Inc. will step up contributions to its five underfunded pension plans and give the Pension Benefit Guaranty Corp. an interest in certain common stock as part of an agreement that enables the company to emerge from bankruptcy.

Chicago-based Farley will immediately contribute $3.5 million to the plans to make up for missed contributions. Also, over the next five years, it will contribute $2.5 million to the plans in addition to its regular contributions.

The PBGC also will receive a priority interest in 325,000 shares of Fruit of the Loom Inc. stock, currently valued at $15 million, and a secondary interest in 2 million additional shares. Farley is a major stockholder of Fruit of the Loom.

The Farley plans have about $58 million in unfunded liabilities.

New Jersey health bill enacted

TRENTON, N.J.—Months of rancorous debate over how to reimburse New Jersey hospitals for uncompensated care ended last week with the enactment of a law that allows the state to use $1.6 billion of unemployment funds through 1995 to reimburse hospitals.

Meanwhile, two labor unions have filed a lawsuit challenging a hospital uncompensated care funding mechanism in New York that is similar to the mechanism successfully challenged in New Jersey.

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Errors & omissions

• In this week's story on FAS 112, comments by Hewitt Associates' Chris Christiansen should read: Many employers already use accrual accounting if a so-called post-employment benefit meets the *second* set of criteria but does not meet the *first*.

• Employers can deduct adoption assistance benefits they provide to employees as a business expense, but the employer contribution is included as taxable income to employees. A Nov. 30 article incorrectly reported that employers could not deduct the cost of the benefits.

Mission reinsurer offsets upheld by state high court

By DOUGLAS McLEOD

SAN FRANCISCO—Reinsurers of defunct Mission Insurance Group units may offset amounts they owe the Mission estate with amounts the estate owes them, the California Supreme Court has ruled.

In a 4-3 decision, the state Supreme Court affirmed an appellate ruling that reciprocal reinsurance agreements between Prudential Reinsurance Co. and Mission units created mutual credits and debts that may be offset under state insurance law.

The ruling comes in the last of a series of closely watched offset cases, all of which have affirmed reinsurers' right of offset in states with offset provisions in their insurance codes.

The New York Court of Appeals, the state's highest court, ruled earlier this year that Kemper Reinsurance Co. may offset loss payments owed to the insolvent Midland Insurance Co. against premiums Midland owed Kemper Re (*BI*, April 6).

In 1990, a panel of the 7th U.S. Circuit Court of Appeals similarly affirmed the offset rights of reinsurers of the defunct Reserve Insurance Co. (*BI*, July 30, 1990).

The California ruling now represents the "state of the art" in offset cases, incorporating analyses of both the Midland and Reserve cases, said Dean Hansell, a lawyer with LeBoeuf, Lamb, Leiby & MacRae in Los Angeles, representing reinsurers in the

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Poe, Brown to combine

Merger creates strong regional broker, 15th-largest in U.S.

By LAURA MAZZUCA

TAMPA, Fla.—The merger of two Florida-based brokers—Poe & Associates Inc. of Tampa and Brown & Brown Inc. of Daytona Beach—will create the largest regional brokerage in the Southeast and one of the nation's 15 largest overall.

The agreement, announced last Monday, was reached after a month of negotiations, said J. Hyatt Brown, chairman and president of Brown & Brown. Poe & Associates approached Brown in late September with the merger proposal.

The agreement calls for the publicly held Poe & Associates to issue Brown & Brown shareholders more than 3 million shares of common stock, representing 36.6% of the Poe & Associates shares outstanding after the merger.

Poe & Associates Chairman William F. Poe said he believes the benefits of the merger will far outweigh the sizable costs.

"We're not as strong a marketing and sales organization as Brown & Brown," said Mr. Poe, pointing to Brown & Brown's revenues growth from $2 million in 1980 to $34 million in 1992. "His salesmen are the No. 1 people in the organization."

Mr. Brown, in turn, believes that Poe & Associates' expertise in financial services and its

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FAS 112's cost will be small compared with FAS 106

FASB targets benefits again

By SARA J. HARTY

NORWALK, Conn.—A new accounting rule will force employers to take a closer look at their bookkeeping for workers compensation, disability payments and other so-called post-employment benefits not related to retirement.

Statement 112, approved last month by the Financial Accounting Standards Board and which generally goes into effect in 1994, requires employers to switch to accrual accounting from pay-as-you-go accounting for several types of benefits paid to inactive or former employees.

However, the cost of FAS 112 to employers will be small compared with the huge charges against income employers are taking as a result of FAS 106, which requires employers to adopt accrual accounting for their retiree health care obligations.

The final draft of FAS 112 is virtually identical to an exposure draft issued by FASB in May for comment (*BI*, May 25).

Statement 112 is an amendment to earlier FASB statements 5 and 43. FAS 5 deals with accounting for "contingencies," or unexpected expenses and liabilities. Statement 43 deals with ac-

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Surplus lines standards set

California approves revised regulation

By LOUISE KERTESZ

SACRAMENTO, Calif.—Many non-admitted insurers and surplus lines brokers are pleased with the revised version of a California regulation governing placements with non-admitted insurers.

Revised Regulation 2174 of the California Code of Regulations, which had faced stiff opposition from brokers and insurers, was approved last week by the California Office of Administrative Law (*BI*, Aug. 3). The regulation, which immediately went into effect, requires surplus lines brokers to demonstrate, among other things, that a non-admitted insurer meets minimum financial standards before placing coverage with that insurer.

Brokers and insurers complained that the previous version would, by requiring surplus lines brokers to file with the department a non-admitted insurer's rate and product information before placing coverage, destroy the flexibility critical to the market.

The requirement was deleted "mainly due to a good deal of opposition voiced at hearings and in written comments," said Dennis Ward, chief of the en-

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State Regulation Under Scrutiny

The NAIC: Too little, too late?

Critics increasingly question group's effectiveness

By DOUGLAS McLEOD

Facing its sixth year of congressional scrutiny, the National Assn. of Insurance Commissioners is standing in the harshest public spotlight in its 121-year history.

The NAIC, long accustomed to congressional inquiries on specific insurance regulatory issues, is now scrambling to defend the concept of state insurance regulation itself.

Investigations by Rep. John D. Dingell, D-Mich., and others in Congress have raised a number of questions about the NAIC and its operations. These include how much control the NAIC actually has over state insurance regulation; who sets the association's agenda and influences its actions; and whether the NAIC is structured to reach its regulatory goals effectively.

As with the fractious debate over federal vs. state regulation, these questions provoke differing answers from NAIC officials, former regulators, insurance industry representatives and industry analysts.

Some feel the NAIC has too little real power; others feel it has as much as it needs. Some maintain that its committee system moves too slowly in developing model laws and rules for the industry; others say the system works well despite its deliberate pace.

Most observers agree on one thing, though: Intense pressure from congressional attention has forced the NAIC to move faster on solvency issues than it would have otherwise.

Bruce Bunner, president of Centre Reinsurance Co. of New York and a former California insurance commissioner, said that while the NAIC has a number of flaws, "I have to step back and say they have done a pretty credible job considering the hurdles they have to deal with."

"I absolutely believe that our regulatory system—even though it is far from perfect—is preferable to any of the alternatives that have been proposed or any that I can imagine," maintained William H. McCartney, Nebraska insurance commissioner and the NAIC's president.

Founded in 1871, the Kansas City, Mo.-based NAIC initially focused on developing uniform financial reporting rules for insurance companies. The organization has since expanded to fill a number of other roles. These include:

- Developing model laws and regulations to guide state legislatures in amending their own insurance codes.
- Maintaining the Securities Valuation Office, which provides uniform valuations for stocks, bonds and other insurance company assets.
- Analyzing the financial strength of insurers through its Insurance Regulatory Information System.
- Maintaining other market information data bases that track consumer complaints, disciplinary actions, and individuals and companies that have been involved in fraudulent activities.
- Providing audit and computer support services to insurance departments through its financial services division.
- Tracking non-U.S. insurers writing business in the surplus lines market through its Non-Admitted Insurers Information Office.

For years a relatively small operation, the NAIC began to grow rapidly in 1988 as it faced increasingly complex regulatory problems, including several huge insurer failures.

Perhaps not coincidentally, 1988 was also the year Rep. Dingell launched a series of hearings that would lead to his insurer solvency regulation bill, H.R. 4900, which calls for a transfer of some regulatory duties to a proposed new federal agency (*BI*, April 13).

Through the early 1980s, the NAIC had a staff of only about 60. That jumped to 98 in 1988 and 142 by 1991.

Its annual budget, meanwhile, hovered around $6 million through most of the 1980s but rose to $9.8 million in 1988 and to $16.2 million by 1991. In 1992, the NAIC expects to spend about $18.7 million.

That total is still small compared with some state insurance department budgets: The largest department—California's—had a budget of $89 million in 1991, and the 1991 total for all insurance departments was $503.5 million, according to NAIC figures.

Most NAIC revenue comes from fees paid by insurance companies and others for its services. Of $18.6 million in projected

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Money, staff add up to superior insurance regulation

States earmark more funding

By MEG FLETCHER

Adequate funding is a key to effective state insurance regulation, but it is not the only one.

Insurance departments also need dedicated, qualified staffs and a consistent regulatory philosophy of balancing consumers' needs with those of insurers and producers.

Marked improvement in regulation in recent years is largely due to better funding, according to regulators, consumer representatives and industry spokesmen.

Obviously, there is no consensus on what makes a good department. Insurance companies, for instance, prefer a hands-off approach, while consumer groups favor more extensive oversight.

Among the states often cited for the quality of their regulation are California, Illinois, New York and, at least recently, Texas. These states also are among the best funded.

"Giant strides have been made in increasing insurance department budgets," said William McCartney, Nebraska Insurance director and president of the National Assn. of Insurance Commissioners.

The expansion is "especially remarkable" because many states are generally tightening their budgets, he added.

Between 1985 to 1991, annual funding for all state insurance departments rose 116% to $503 million, the NAIC reports.

By 1993, that total is expected to hit $550 million, up 6.2% from $518 million this year and 9.3% from $503 million in 1991. Those figures include the departments of all 50 states, the District of Columbia and three U.S. territories.

The average state department's budget increased 13.9% to $9.3 million in 1991 from $8 million in 1990.

Averages, though, only tell part of the story. Actual budgets vary quite widely.

California had the largest in 1991—$89 million—and was followed by New York, $59 million; Texas, $56.7 million; and Florida, $40.7 million.

Those four states combined also accounted for nearly half—48.7% or $245 million—budgeted for state insurance regulation last year, the NAIC reports.

At the other end of the spectrum was South Dakota, which spent $757,055 on insurance regulation, a bit more than double the budget of Guam, at $350,000. Smallest was American Samoa, with a $42,500 budget.

The largest change in funding levels occurred in Wyoming last year. Its budget rose 122.5% to $2.3 million in 1991, from $1 million the year earlier.

In most states, legislatures allocate money for insurance regulation

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NAIC

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1992 revenues, about $12.2 million will come from data base, publication and subscription fees; $3 million from other services; and $1.2 million from interest income. Other revenues come from state assessments and meeting registration fees.

Of $18.7 million in projected 1992 expenses, $5.4 million relates to the NAIC's executive and operations divisions; $4.7 million relates to its information systems division; $1.8 million to financial services, which supports insurance department examiners; $1.8 million to the New York-based Securities Valuation Office; and $1.5 million to its office in Washington, which includes the financial analysis division responsible for the IRIS system.

Various other divisions account for the remainder.

The NAIC is projecting a budget in the mid-$20 millions for 1993 and its executive committee has approved increases in most fees to boost revenues, Mr. McCartney said.

When discussing the NAIC, several observers emphasize that the association is not in itself a regulatory agency.

"The NAIC is seen in certain camps as a governmental entity. It is not. It's a trade association," noted William O'Neill, a director with Standard & Poor's Corp. in New York.

"It's not a regulatory organization. It's an organization of regulators," agreed William S. Gibson, vp and director of governmental affairs for Continental Corp. in New York.

The distinction underlines what some observers—including the U.S. General Accounting Office, in reports to Rep. Dingell—have cited as the NAIC's most basic flaw: It has no official power to compel states to follow its model laws.

"I used to call the NAIC the Great American Delay Machine," said Bob Hunter, president of the National Insurance Consumer Organization in Alexandria, Va.

State regulators would propose new laws or regulations to the NAIC, which would then start debating the proposal "and five years later it would come out like chopped liver, totally emasculated," Mr. Hunter said. Many states would then reject the recommendations anyway, he added.

'It's still rare that in such a fraternal atmosphere you would see them taking on their masters, the state insurance commissioners,' Mr. Bernstein says of the NAIC. 'I'm not saying it's wrong, but don't expect that collegiality to result in action.'

When the NAIC develops a model law—usually after long internal debate—it is up to state legislatures to enact the model or not, or to enact it in an amended form. If enacted, it is then up to the state insurance department to enforce it.

Even after a state enacts a model law, insurance departments don't always do a good job applying it, said George K. Bernstein, a Washington lawyer and former New York Insurance Department official who now represents a coalition of insurers, brokers and buyers pushing for federal solvency regulation.

"The tools themselves are only as good as the people who use them, and that's the individual states," he said. "I'm not that optimistic that just giving new tools is going to significantly change the quality of solvency regulation in the states."

Mr. Bernstein also expressed doubts that the NAIC has the will to challenge its members when that seems necessary, for example by "blowing the whistle" on a troubled insurer when the domiciliary regulator fails to do so.

"It's still rare that in such a fraternal atmosphere you would see them taking on their masters, the state insurance commissioners," he said. "I'm not saying it's wrong, but don't expect that collegiality to result in action."

The NAIC has responded to this problem with its accreditation program, seen as a means of pressuring states to enact a core group of NAIC model laws and to maintain minimum standards for solvency regulation.

So far, 14 states have been accredited. That number could rise to 30 or more by next year, Mr. McCartney said. Some new accreditations are likely at the NAIC meeting this week in Atlanta (see story, page 17).

Doubts persist about accreditation, though.

"It probably has had a good effect," said S&P's Mr. O'Neill. "But the reality is that a lot of people look at it with a great deal of skepticism because they haven't failed anybody yet."

Edmond F. Rondepierre, senior vp and general counsel for General Reinsurance Corp. in Stamford, Conn., questioned the wisdom of the NAIC's solvency policing agenda.

"If you endorse the notion that you should have uniformity among 50 states, you endorse the notion that you should junk state regulation and go with a federal system," he said.

"The NAIC is a think tank. It's a forum for exchanging ideas," Mr. Rondepierre said. "To try to convert it into a policeman is a big mistake."

Mr. McCartney said he sees the NAIC's lack of enforcement power as a strength of the system, allowing the association to act as a "facilitator" but leaving the state departments the latitude to regulate on their own.

The accreditation system, he added, has already had positive effects, prodding insurance departments to improve their staffs and increase their budgets despite state budgetary pressures.

"I can tell you with a straight face that the federal government was not the impetus for the program, but the federal government's attention has caused it to be implemented much more quickly than we imagined," Mr. McCartney said.

However, the accreditation program may be an example of what some cite as another of the NAIC's flaws: Its failure to anticipate industry problems and its tendency to react slowly unless under pressure.

"It becomes a fatal weakness when it comes to solvency and

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NAIC

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consumer issues when they can not react timely," Mr. Bunner observed. "It takes a long time to push through change. There's a tremendous regulatory lag."

The NAIC "is almost exclusively reactive" to Congress and crises in the states, Mr. Bernstein added.

"It does not anticipate," he said. "The explosion has occurred before the NAIC addresses a problem."

Officially, the NAIC's agenda is set by its 16-member executive committee, which can approve or reject the issues tackled by its system of committees, subcommittees, task forces and working groups.

Insurance departments of large states like New York and California are often influential in deciding which issues are addressed and how they are dealt with, industry observers say.

In reality, though, the NAIC's agenda is often set for it, some say.

"Currently, John Dingell sets" the agenda on solvency matters, Mr. Hunter noted.

This situation worries some observers.

"I think they have kind of overreacted to Dingell," said Edward Meehan, executive vp of Vermont Insurance Managers and a former Vermont deputy insurance commissioner.

"To the extent that they start passing model acts or adding a lot of unnecessary requirements to the accounting process just to appease Dingell, I think they're all wet," Mr. Meehan said.

Mr. Bunner agreed, commenting that the NAIC's tendency to be "behind the curve" on industry problems and its slow reaction time increase the risk that it will overreact.

One factor slowing NAIC action on industry problems is its extensive committee system: Under its executive committee, the NAIC has five life/health and property/casualty committees; four subcommittees; a few standing task forces dealing with accounting and other issues; and several other task forces and working groups that are reconstituted each year.

Although it is slow, opinions are mixed on whether this structure is ultimately effective in producing sound regulation.

'The (NAIC committee system) process is always grinding along slowly and mired in an incredible amount of detail,' Mr. Hunter says. 'If you miss one meeting, you almost can't catch up. But at the same time, nothing gets done.'

"The process is always grinding along slowly and mired in an incredible amount of detail," Mr. Hunter said. "If you miss one meeting, you almost can't catch up. But, at the same time, nothing gets done."

The NAIC's model fronting bill, for example, has made little progress toward adoption in more than a year, in part because of New York regulators' insistence on pushing their own draft of the proposal, some point out.

Still, Continental's Mr. Gibson observed that "these are normal failures of any organization that relies on committees. The PTA and the Little League are no better."

He cited the extensive wrangling over whether NAIC would accredit states with insurance holding company laws that are more liberal than the NAIC's 1986 model act in their limitations on dividends insurers can pay to parent companies. An NAIC committee eventually approved several more liberal laws (*BI*, Oct.5).

"The process may have looked messy and contentious, but it worked," Mr. Gibson said.

"Like anything, it is fraught with frailties. It's frustrating to deal with sometimes. But it works," Mr. McCartney agreed.

Opinions are also mixed on the degree to which insurer and broker advisory groups influence the work of NAIC subcommittees and task forces.

S&P's Mr. O'Neill said the NAIC "relies altogether too much on industry expertise" in developing regulations.

Several others, however, disagreed.

"I think (industry representatives) were remarkably dominant before. . .(but) I think a lot of that has changed," Mr. Hunter said.

The NAIC has set out to diminish "if not emasculate" the role of industry advisory committees, according to Mr. Rondepierre.

"They are very sensitive to the notion that they are dictated to and pushed around by the people they are supposed to be regulating," he said.

"They don't kowtow to the industry. No way," Mr. Meehan agreed. "Anybody who says that doesn't know what the hell they're talking about."

The advisory committees have had a tough time developing positions on complex issues and reporting to the NAIC within the short time between NAIC meetings, Mr. Rondepierre said.

As a result, individual insurer representatives have approached NAIC officials directly, and industry input "comes in in fragments rather than in composite from a cross-section of the industry," he explained.

Another reason for the diminished role of industry groups is the stronger role played by key insurance department officials who control subcommittees, task forces and working groups, industry sources say.

Some of these officials have become "czars" on certain issues, these observers say, including New Hampshire Deputy Commissioner Robert M. Solitro on accounting issues and Illinois Chief Deputy Director James W. Schacht on liquidation and rehabilitation issues.

While many aspects of the NAIC's operations provoke disagreement, most observers agree on the association's key strength: Coordinating regulation of insurance company financial reporting.

Unlike the case of model laws, the NAIC has full control over

Continued on page 10

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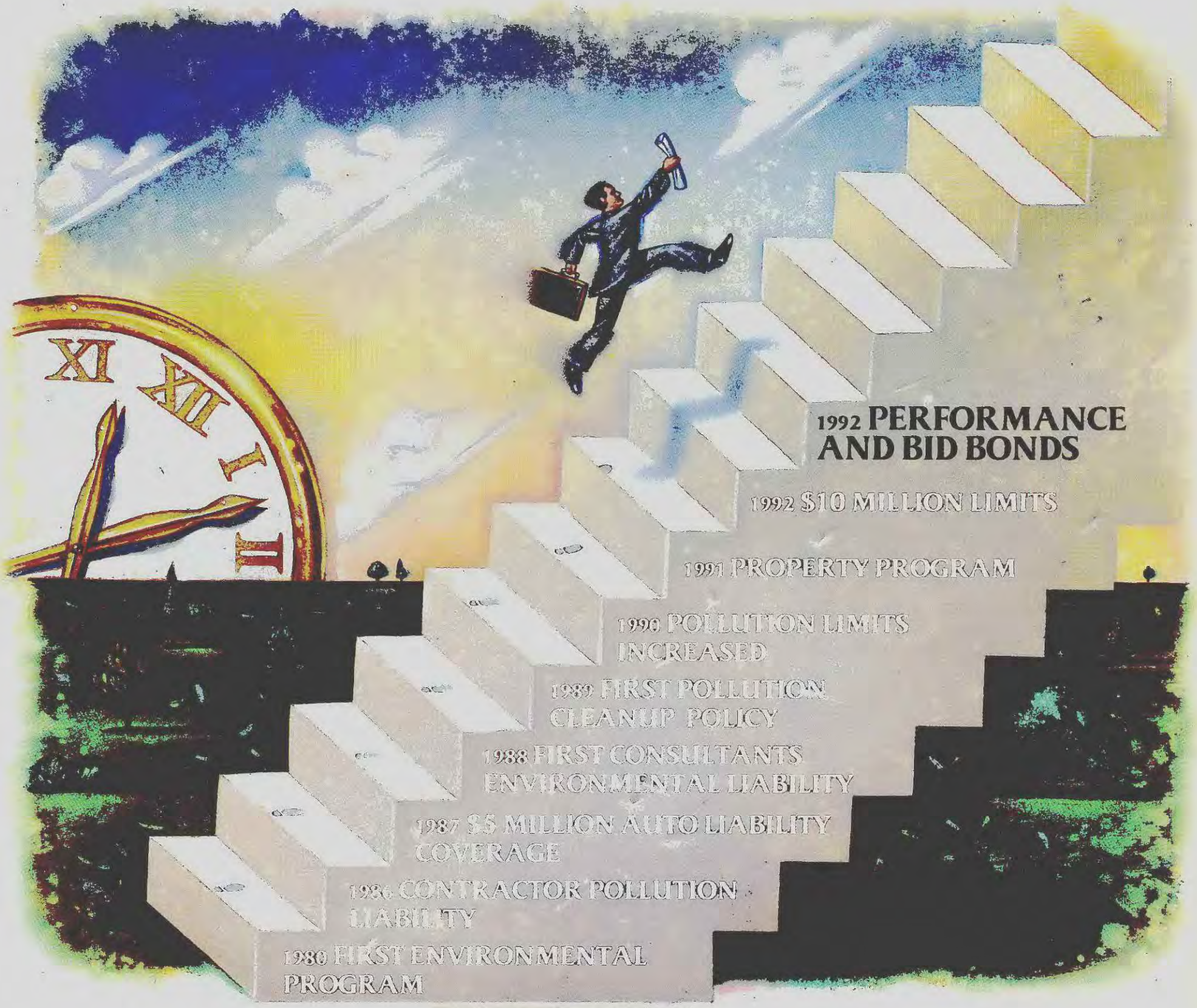

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Opinions

Don't ignore state regulation

THE DEBATE OVER whether the federal government or the states should be responsible for regulating insurer solvency has had one drawback: It has diverted attention from attempts to improve state regulation.

State regulators and the National Assn. of Insurance Commissioners have attempted to improve how they do their jobs following attacks by Rep. John Dingell and others. Without such criticism, for example, the NAIC accreditation program may never have gotten off the ground. But much time and effort that could be used to improve state regulation is instead being diverted to developing federal regulatory proposals.

Don't get us wrong. We still believe that federal regulation could be a workable—if not better—method of ensuring insurer solvency. However, federal regulation is not a done deal, especially with a governor ready to move into the White House. Those with a vested interest in solid, effective insurance regulation—insurers, agents and brokers, and especially risk managers—must work now to improve the current state system while still investigating other options.

State regulation faces problems on many fronts; it would be impossible to analyze, much less solve, all of them in this short space. However, we have a few suggestions to improve current state regulatory systems:

• Appoint insurance commissioners rather than elect them. We'll have to admit that we shudder at the notion of taking power away from the people, but, to us, appointed insurance commissioners simply make more sense.

The first and foremost reason for appointing commissioners is that insurance company regulation should not be subject to political pressures. While many have compared insurance rate regulation to the already politicized regulation of public utilities, there's a big difference: Utilities provide an immediate service to their customers; insurers promise to pay claims—sometimes 20 or 30 years down the road—in exchange for a premium payable now. Cutting insurers' rates to the bone may be politically popular, but does it really benefit consumers if that action impairs insurer solvency?

We also believe that insurance regulation should be less confrontational than it often is under an elected commissioner. California Insurance Commissioner John Garamendi's recent comment that "nothing makes me happier than a fight with an insurance company" does not strike us as an example of a fair and responsible regulatory approach.

While some accuse appointed commissioners of cronyism, that's really not the case. An effective

governor will make sure that his or her insurance commissioner is a honest, knowledgeable regulator—not a political hack. And, we must add that Louisiana—a state in which one former commissioner is now serving time and another has been indicted—elects its insurance regulator.

• Adequate funding. To hope for better funding for insurance departments is probably wishful thinking. However, state legislators must be told that effective regulation requires adequate personnel and systems, both of which cost money.

Insurers and business groups should lobby state legislators to follow the recommendation by the Consumer Interest Insurance Group and direct at least 10% of premium tax revenues toward state insurance department operations. Currently, only 12 of the 45 state departments surveyed by the CIIG meet that threshold.

• Don't be tempted to overregulate. Again, consumer protection is the name of the game in insurance regulation. While regulators must protect consumers—primarily by ensuring the insurers' solvency—too much regulation can be bad. The long, contentious debate fueled by the California Insurance Department over the implementation of Proposition 103 has benefited no one.

Observers uniformly agree that Illinois has one of the better state insurance departments, partly because of adequate funding and partly because of the department's philosophy during the past decade that competition is the best form of market regulation. That's a philosophy that could well be adopted by many other states.

Letters

Health care proposals must empower consumers

To the editor: I have just finished reading "Doctor, the Patient Is Critical" (*BI*, Oct. 30). All the points made are well-taken.

However, no one really addresses the problem from the standpoint of properly and thoroughly educating the consumer/patient.

We have a population that still takes the health care provider's word as gospel, doesn't even consider asking about costs and often has no reliable, unbiased sources from which to receive accurate health care information. The health care business doesn't belong to the Better Business Bureau and doesn't make mortality and morbidity results available for consumer use. Consumers cannot make educated, responsible decisions about services when an unbiased source of information does not exist.

Think of the possibilities if health care consumers had a source for information in each state to answer their health care questions about doctors, hospitals, treatments, etc. More importantly, they also need the knowledge and confidence to empower them to ask the questions in the first place. I do not see these needs addressed in any of the proposals in a consistent manner that empowers all consumers to change the health care system. Why?

If we expect people to be responsible, we need to provide the tools and information they require and can trust.

Virginia Chaffin
Benefits Manager
Human Resources Department
RIBI ImmunoChem Research Inc.
Hamilton, Mont.

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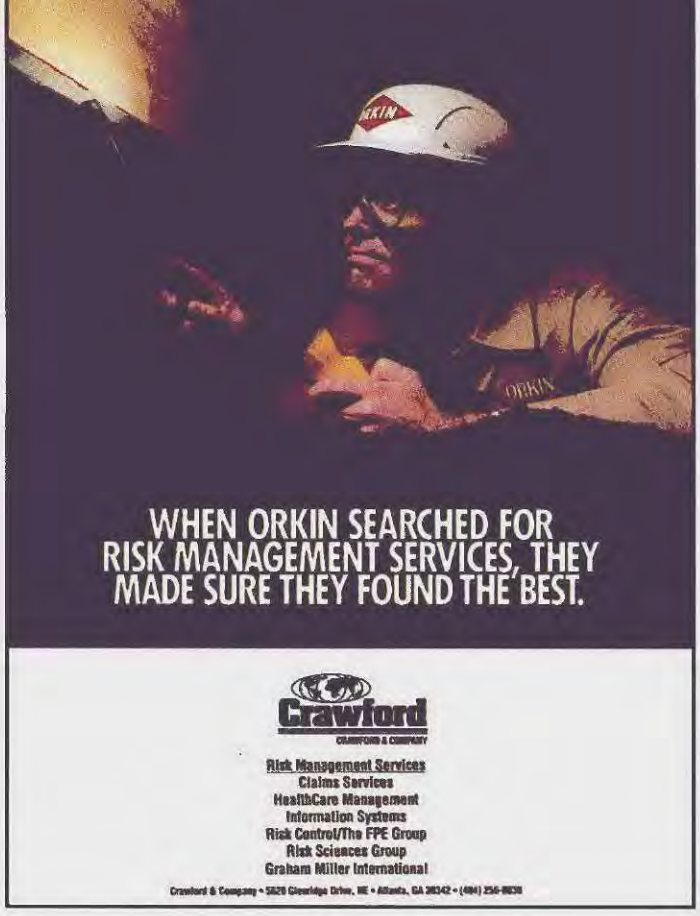

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Department funds

Continued from page 3
from general state funds. Some state departments also receive money from "dedicated" funds, like revenues from insurer examinations, licensing fees, and fines and penalties.

State insurance departments took in $6.6 billion in premium and other taxes in 1990, most of which went into general state revenues.

One way to measure the adequacy of funding is to compare total state premium taxes to the insurance department budget. State budgets should be at least 10% of the premium tax total, recommends the Consumer Interest Insurance Group, an umbrella organization of several consumer groups organized by the National Assn. of Professional Insurance Agents.

Only 12 of the 45 state departments the group surveyed currently meet that threshold. Among those dozen, though, are the Florida, New York, and Texas departments—all among the best-funded and generally respected.

Only two state departments had met the 10% test in 1988.

Several factors are combining to encourage states to open their purse strings to insurance regulators, not the least of which is consumer awareness.

"I think insurance regulators get a better hearing than they did five years ago because of issues that have been raised due to the way insurance affects consumers," said Charles O. Davis, executive director of the National Conference of Insurance Legislators in Brookfield, Wis.

"Legislators are more conscious of insurance issues because their constituents are, which has a snowball effect on increasing their focus on insurance issues and (insurance) department funding," agreed Paul Brown, director of government and public affairs for the Risk & Insurance Management Society Inc. in New York.

Insurance issues "absolutely" have a higher profile now, the NAIC's Mr. McCartney said.

Bob Hunter, president of the National Insurance Consumer Organization in Alexandria, Va., traces wider consumer awareness to the liability crisis of the mid-1980s.

Then came Proposition 103 in California, which sent "shock waves" through the nation because it demonstrated that the insurance industry was vulnerable to consumer complaints, contends Mr. Hunter.

Insurance issues 'absolutely' have a higher profile now, the NAIC's Mr. McCartney says.

"Prop. 103 was a shot across the bow of (insurers') private bureaucracy," Mr. Hunter said. Insurers had to "get cheaper," which they did by cutting agents' commissions and "excess layers of mismanagement." They also began to root out fraud and work with consumer groups, he said.

Legislators now hear constituents say they want insurance departments to provide more services, like more educational information about insurance rates and different types of products, said Stephen Brobeck, executive director of the Consumer Federation of America in Washington.

Another factor behind greater state funding for regulation has been a state desire to head off federal initiatives in insurance regulation. State legislatures have been scurrying to adopt laws giving regulators greater authority in an effort to improve solvency regulation and, in part, to forestall federal initiatives (*BI,* Dec. 9, 1991).

Many state insurance departments are using their larger budgets and greater authority to try to attract, train and retain more talented staffs.

Senior positions are the hardest to fill. Applicants for positions like actuaries, chief financial examiners and senior data handlers must have extensive technical knowledge and often want salaries commensurate with their knowledge regulators say.

Those high salaries can easily exceed those of the state commissioners.

"Several states now pay actuaries more than commissioners," said NICO's Mr. Hunter, who himself is an actuary.

In Minnesota, for instance, the commissioner makes $67,500, while actuaries' pay ranges from $44,099 to $103,586, according to figures from the CIIG.

States that cannot afford their own actuaries often contract out for the services. In those cases, the professional fees must be covered by insurers or rate filing

Continued on next page

NAIC

Continued from page 6
the statutory accounting rules insurers must follow in preparing annual statements. Its Securities Valuation Office also sets asset values that insurers must use in their financial reporting.

"The real teeth of the NAIC have to do with those procedural matters that they as a group can implement," S&P's Mr. O'Neill said, observing that in this case at least the NAIC has de facto regulatory authority.

The NAIC also coordinates insurer examinations by creating teams with representatives from each of its four geographical zones to join examiners from an insurer's state of domicile.

The exam results are then shared with regulators in all states, eliminating the need for repeated exams in different states.

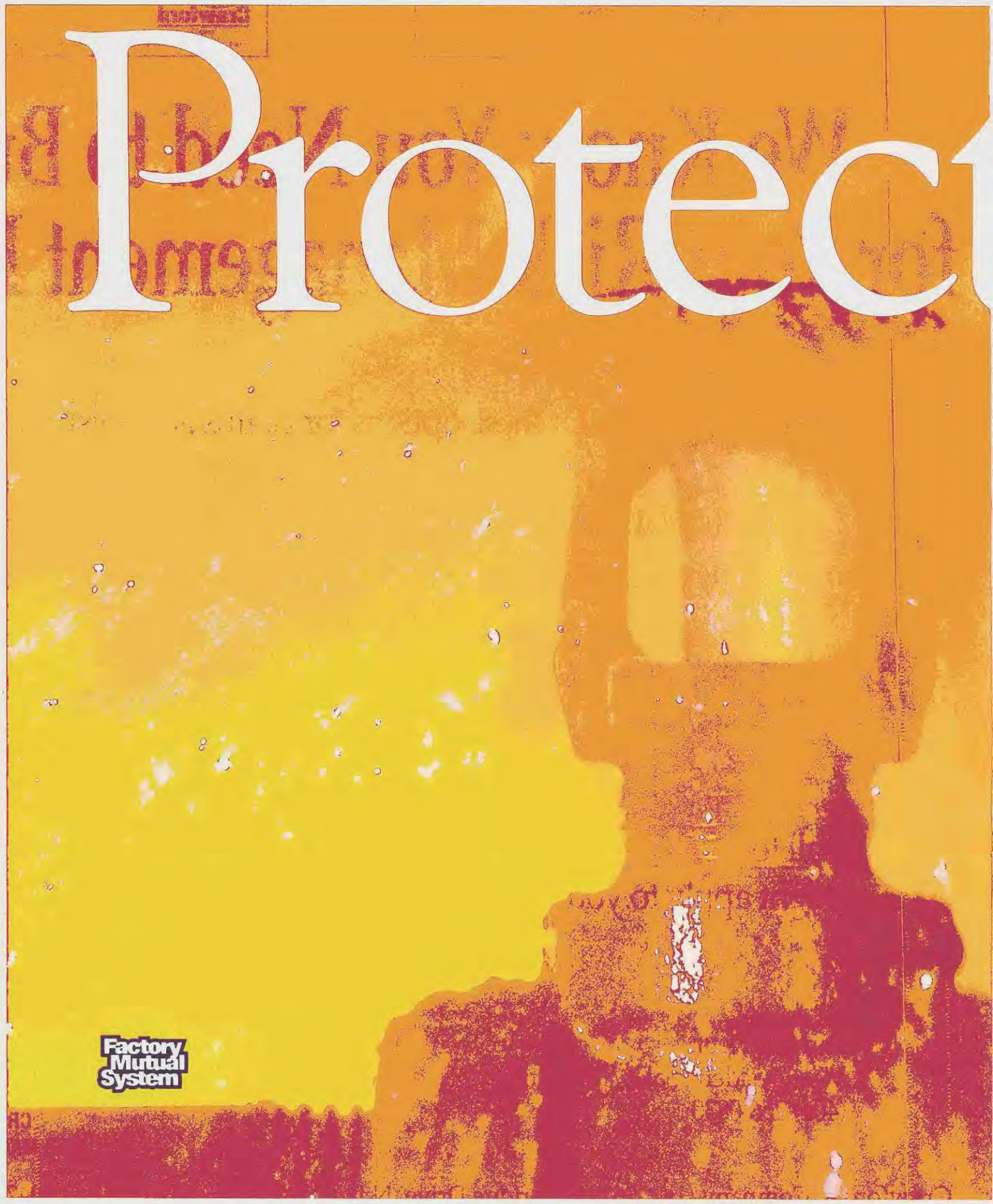
"All of those functions are quite essential. The 50-state system would be quite cumbersome and even impossible without them," Mr. Rondepierre observed.

Despite its shortcomings, the NAIC draws praise even from some of its critics for the accreditation program and other steps it has taken—with congressional prodding—to improve solvency regulation.

"It's doing a lot better," Mr. Hunter conceded.

"Will it be enough to thwart the John Dingells of the world? No," predicted John H. Snyder, senior vp with A.M. Best Co. in Oldwick, N.J.

"I think the whole (state system) is going to be seriously challenged. It's going to be a real white-knuckler." BI



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organizations.

Insurance departments can lower such expenses if they can hire inexperienced people at low levels and train them extensively in regulatory practices on a well-defined career path.

The challenge then becomes keeping an experienced staff member from being lured away by higher salaries offered by insurers or the law or accounting firms that serve them.

In some states, that situation may be changing.

For example, Nebraska's Mr. McCartney said his department now recruits some staff members from several places, including insurance companies.

In this era of corporate downsizing, these government positions do offer one critical advantage: stability.

Commitment to the job is another factor that keeps many top career regulators in their departments, even though they could probably earn more in the insurance industry.

"Our regulators are overworked and underpaid—badly," said David Spector, an attorney with Mayer, Brown & Platt in Chicago and former chairman of the American Bar Assn.'s committee on insurance regulation. "A few key Illinois regulators could triple their salaries in a minute working for insurance companies."

Personal commitment to good regulation keeps them in their posts, though recognition programs can also help, such as the NAIC's Dineen-Gilfillan Award, which recognizes outstanding service from insurance department staffers. Winners to date

'Our regulators are overworked and underpaid—badly,' says David Spector, a Chicago attorney.

are John Montgomery of California, Dick Brock of Kansas, Jim Schacht of Illinois and Terry Lennon of New York.

Most insurance department employees are hired through state personnel offices. Political patronage is not a significant factor in hiring, most observers agree.

Still, politics can intrude. Ex-Missouri regulator Don Ainsworth recalls that after he cut six of the small number of patronage workers he found on his staff, key legislators retaliated by cutting $50,000 from his budget. That represented the salaries of five low-level staffers.

Mr. Ainsworth—now executive vp of Safety National Casualty Corp. in St. Louis—said he ultimately was able to make the legislators understand that he would not stand for such games again, due in part to the governor's support.

Patronage, ironically, is most visible at the top of insurance departments. Many commissioners themselves are appointed by —and serve at the pleasure of— governors. The situation is different when commissioners are elected (see story, page 14).

Turnover at the highest regulatory levels is rapid; the average commissioner's tenure is just under 3.5 years. That fact, along with the revolving door between insurance departments and the industry they regulate, is of concern to consumer groups.

After leaving office, 49% of commissioners worked in the insurance industry directly or indirectly by providing legal, consulting or accounting services to the industry, according a 1990 study by the CIIG. That study covered 106 commissioners who served since 1984.

Such patterns "raise questions about the adequacy and impartiality of decisions made in office," said the Consumer Federation's Mr. Brobeck, who serves on the CIIG and the NAIC Consumer Participation Board of Trustees.

"State insurance commissioners should not be allowed to work for insurance companies for at least a year after they leave office," the CIIG recommends.

"Newly elected governors can greatly strengthen the institution of state regulation by keeping in office an incumbent insurance commissioner—whether he be of the same or different political party—if he is doing a good job," said Mr. Ainsworth, the former Missouri regulator.

Qualified staff and adequate funding will only get a department so far. Successful oversight also requires a consistent philosophy of regulation.

But the beauty of various philosophies is often in the eye of the beholder.

An insurance department's core responsibility is consumer protection, but that requires making sure insurers are solvent and consumers are getting value for their money, said Mr. Spector, the insurance lawyer.

Commissioners need to balance the interests of consumers and insurers and not be afraid to act, said Lenore S. Marema, vp-legal affairs for the Alliance of American Insurers in Schaumburg, Ill.

State regulators generally know the needs of an individual consumer better than the needs of a large, multistate business consumer, said RIMS' Mr. Brown.

"The most important thing is attitude and will," said NICO's Mr. Hunter, who said he considers California Insurance Commissioner John Garamendi the best among current regulators.

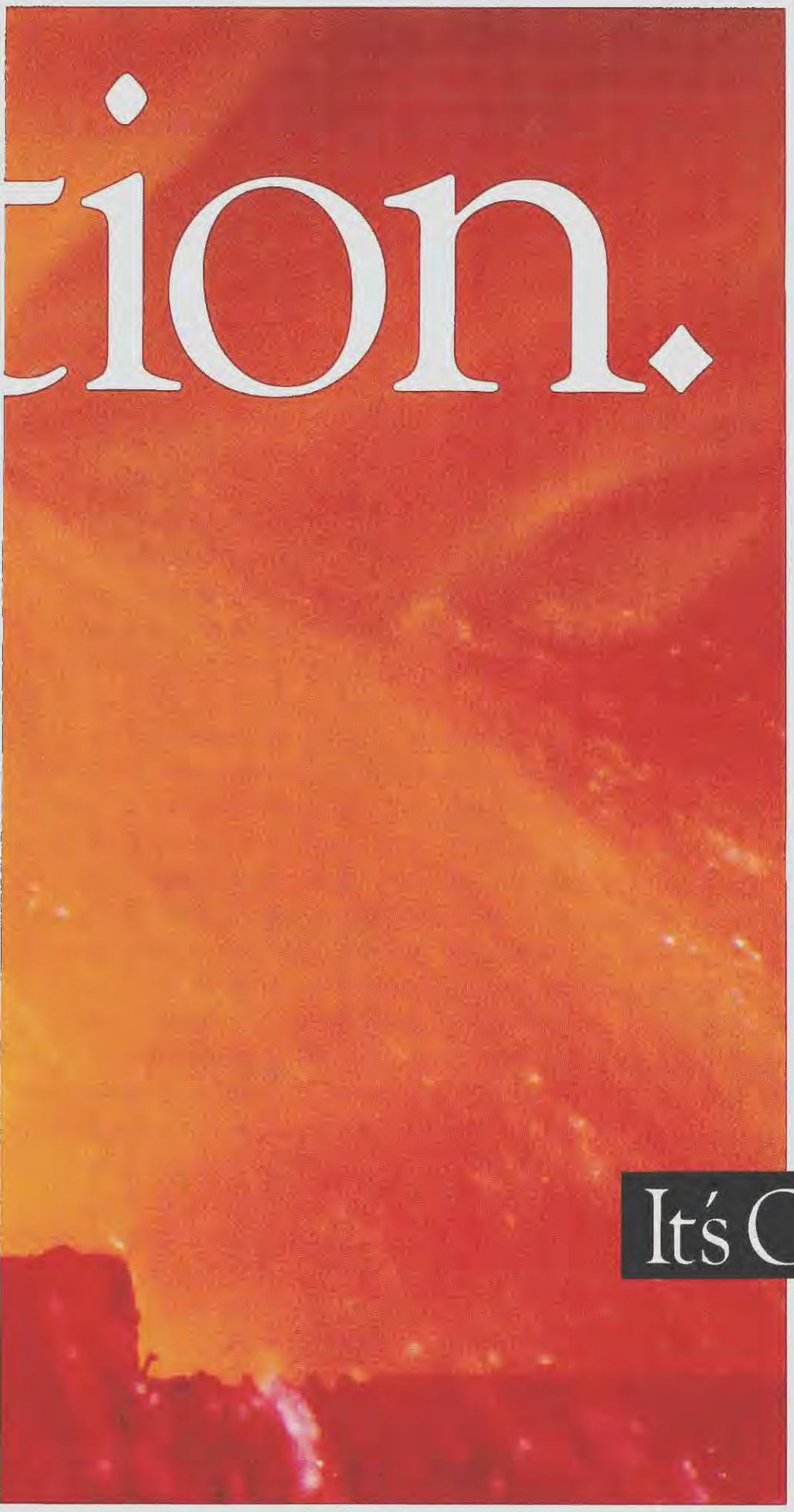
Few sources were willing to discuss specific departments, though they generally praised the larger ones.

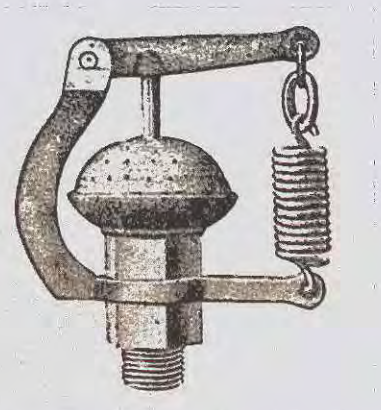
"The Illinois Insurance Department is the best one in the country" because of its deregulation philosophy, Mr. Spector said. "Illinois' regulatory philosophy assumes at its foundation that the market can regulate the market," he said. Regulators' tough approach to solvency regulation and consumer protection ensure that consumers are not hurt, he said.

On the other hand, the New York department has "a very technical philosophy" and its regulators believe government can effectively regulate the market, Mr. Spector said.

Overall, "the states are doing a very, very good job. It's not perfect, but it is getting better," said the NAIC's Mr. McCartney.

The Consumer Federation's Mr. Brobeck urged more frequent departmental reviews of insurers' conduct in the marketplace as well as increased consumer access to toll-free hot lines explaining insurance products and rates. BI





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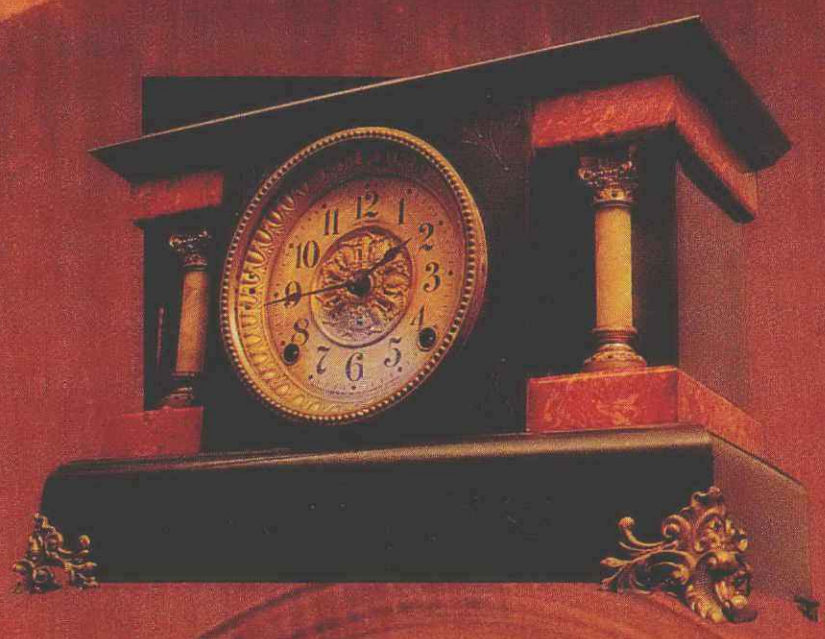

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Insurance regulators: To elect or to appoint?

By MICHAEL SCHACHNER

How an insurance commissioner attains office can be more critical to the direction of a state insurance department than the qualifications of the person who dons the regulator's hat, many observers say.

Those who favor appointing regulators say an appointment makes the commissioner a member of an administrative team and allows the regulator to make decisions without worrying about how they will influence future elections.

And, elected regulators' pro-consumer agendas—like keeping rates low—can hinder insurer solvency, they say.

Those who oppose appointing commissioners, though, say that regulators who are not elected are not compelled to keep in touch with consumers' concerns.

A third faction of insurers, risk managers and regulators say they see no historical evidence that either type of commissioner is better than the other.

Regardless of how regulators attain office, "We deal with them all the same," summed up Paul Brown, director of government and public affairs for the Risk & Insurance Management Society Inc. in New York.

Commissioners are appointed in an overwhelming majority of states —38. The top insurance regulator is elected in California, Delaware, Florida, Georgia, Kansas, Louisiana, Mississippi, Montana, North Carolina, North Dakota, Oklahoma and Washington.

Those who oppose electing commissioners say elected regulators take consumer-oriented stances that preserve low premium rates, which appeases voters but jeopardizes insurers' ability to remain solvent.

"Some elected commissioners have a hard time balancing the voters' needs with marketplace reality," said C. Richard Peterson, executive vp with broker Sedgwick James Inc. in New York.

"Insurance companies aren't endless deep pockets, and it isn't necessarily the commissioner's job to keep rates artificially low," Mr. Peterson said.

An insurer attorney offered an even harsher view of elected insurance commissioners: "Elected commissioners pander to the public's desire to knock out insurance companies, which in the long run, is to the detriment of us all," said George Bernstein, an independent attorney in Washington.

"We end up going from a healthy, competitive market to a situation where insurers pull out of markets because they can't compete," he said.

Cynthia Maleski, acting insurance commissioner for Pennsylvania, where the regulator is appointed, believes that appointed offices attract better qualified candidates than elected posts.

And, appointed regulators generally are more effective regulators, she said. "Appointment allows the commissioner to follow through with the administration's agenda, which in most states includes solid regulation of insurance."

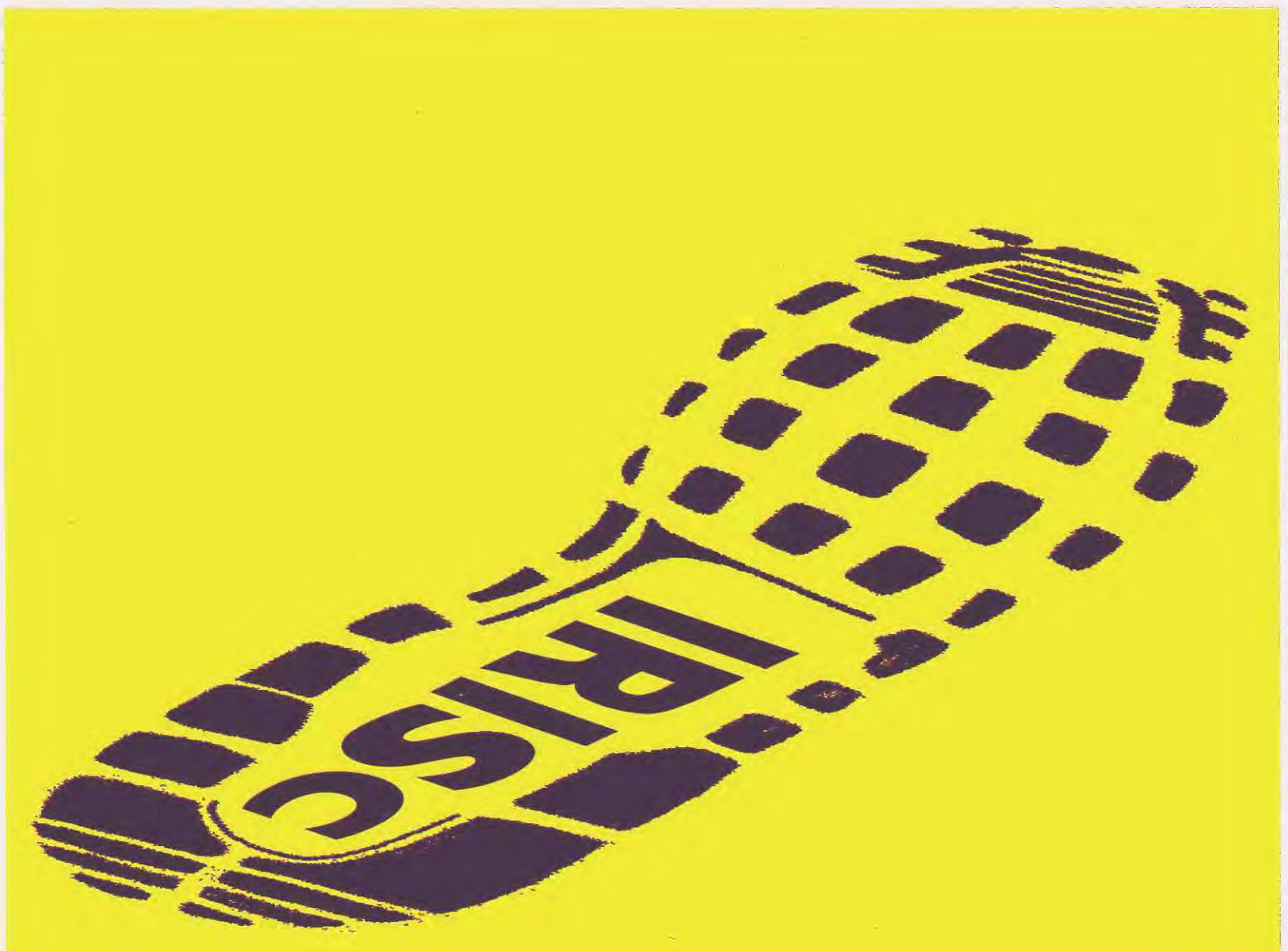
But, others believe that electing commissioners makes them more accountable for their decisions and guarantees that insurance buyers' needs are placed ahead of the insurance industry's quest for profits.

"If the public is sensitized to insurance issues, I favor electing the commissioner, because insurance is really for the people," said J. Robert Hunter, president of the National Insurance Consumer Organization in Alexandria, Va.

Commissioners say it is no coincidence that states with elected commissioners are the most "pro-consumer."

"The issues we deal with have a greater direct economic impact on people than any other issue controlled by a government office. Therefore, the public deserves the

Continued on page 16



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Regulators

Continued from page 14

right to have a say in who regulates the business of insurance," said Georgia Commissioner of Insurance Tim Ryles, who was elected to his post.

"My primary responsibility is to the individual buyer of insurance, not to the corporations that make money in our state. On this stance, I don't waver one bit," Mr. Ryles said.

"Because appointed officials don't have to campaign, they're not forced to be in touch with the public," said Jim Long, insurance commissioner for North Carolina, which has elected its commissioner since the position was created in 1899.

"But I have to be responsive to 6 million people, not one governor who appointed me. In that sense, I'm pro-consumer," Mr. Long said.

John Garamendi, who became California's first elected commissioner in November 1990 (*BI*, Nov. 12, 1990), promised in his campaign that he would hold down insurance rates. He has devoted much time to implementing regulations for Proposition 103, the 1988 ballot initiative that mandated a 20% insurance "charge" rollback and subjected insurers to prior rate approval.

A third group of observers says that each regulator must be measured by what he or she accomplishes while in office.

"There's nothing apparent from history that would indicate that one system of choosing a regulator produces better commissioners," said George Mulligan, senior vp-state affairs with the American Insurance Assn., a Washington-based insurer trade group.

"Generally, elected officials are strong leaders that genuinely want to accomplish something. But they normally want a higher elected position sometime down the road. If this desire controls one's decisions, we then have a major problem."

But, appointment is no guarantee that insurance regulation will be handled correctly, Mr. Mulligan said.

"It's good to have the commissioner as part of a team, as long as the person is experienced. But appointments that are made without regard for talent or knowledge are wrong," he said.

"I'm hard-pressed to identify any marked differences" between elected and appointed commissioners, said Patrick J. McNally, senior vp-general counsel with the National Assn. of Independent Insurers in Des Plaines, Ill.

"Some are experienced and some aren't. Some are good and some aren't," he said.

Overall, "elected officials seem to be as good or as bad as appointed officials," said Mr. Brown of RIMS.

"From RIMS' perspective, appointed commissioners are preferable because they implement more uniform regulation and operate without catering to special interest groups," he noted.

However, "My personal view is that there are pros and cons to both," he said. "I would think that appointed commissioners have fewer special interests to play to, while elected commissioners theoretically speak for the people."

The "true test" of a good regulator is "not whether he's appointed or elected, but whether he has the Legislature's support on staff, budget and appropriate rate levels," Mr. Long said

Many commissioner—regardless of whether they are elected or appointed—face similar challenges.

For example, Pennsylvania's Ms. Maleski downplayed the notion that appointing a commissioner takes politics out of the job. "Appointment may insulate us from politics, but it certainly doesn't isolate us," she said. "You're still in the political forum when you're a member of the governor's administration."

Ms. Maleski is an example of how an appointed commissioner can become embroiled in a game of political football.

Recently, Pennsylvania legislators, who support a higher workers compensation insurance rate hike than Gov. Robert Casey favors, told him they would not approve his appointment of Ms. Maleski as permanent insurance commissioner unless he compromised on a rate increase. But, the Legislature emphasized that its handling of the situation had nothing to do with Ms. Maleski's performance.

Georgia's Mr. Ryles agrees that politics is part of any government job. "People are always saying that removing the position from campaigns and elections will take politics out of the job, which is pure hogwash. It's political no matter how you slice it. It just depends on whether you prefer people politics or bureaucratic politics."

Observers also question whether elected commissioners cater to special interest groups any more than appointed regulators do.

"Pressure comes from a variety of directions. I don't see one type of regulator being more responsive to lobbyists, though an elected official who is a true politician will often allow his agenda to be influenced by outside pressures," said Jim Garrison, risk manager for the city of Phoenix and president of the Public Risk Management Assn.

But Mr. Hunter, the consumer advocate, said all commissioners respond to special interest groups, especially insurance industry lobbyists.

In states where commissioners are appointed, "the large insurers lobby the governor to get their person appointed," he said. In states where regulators are elected, "the insurers contribute to the candidate of their choice."

"What we need most is elections with restrictions on campaign funding," Mr. Hunter said. BI

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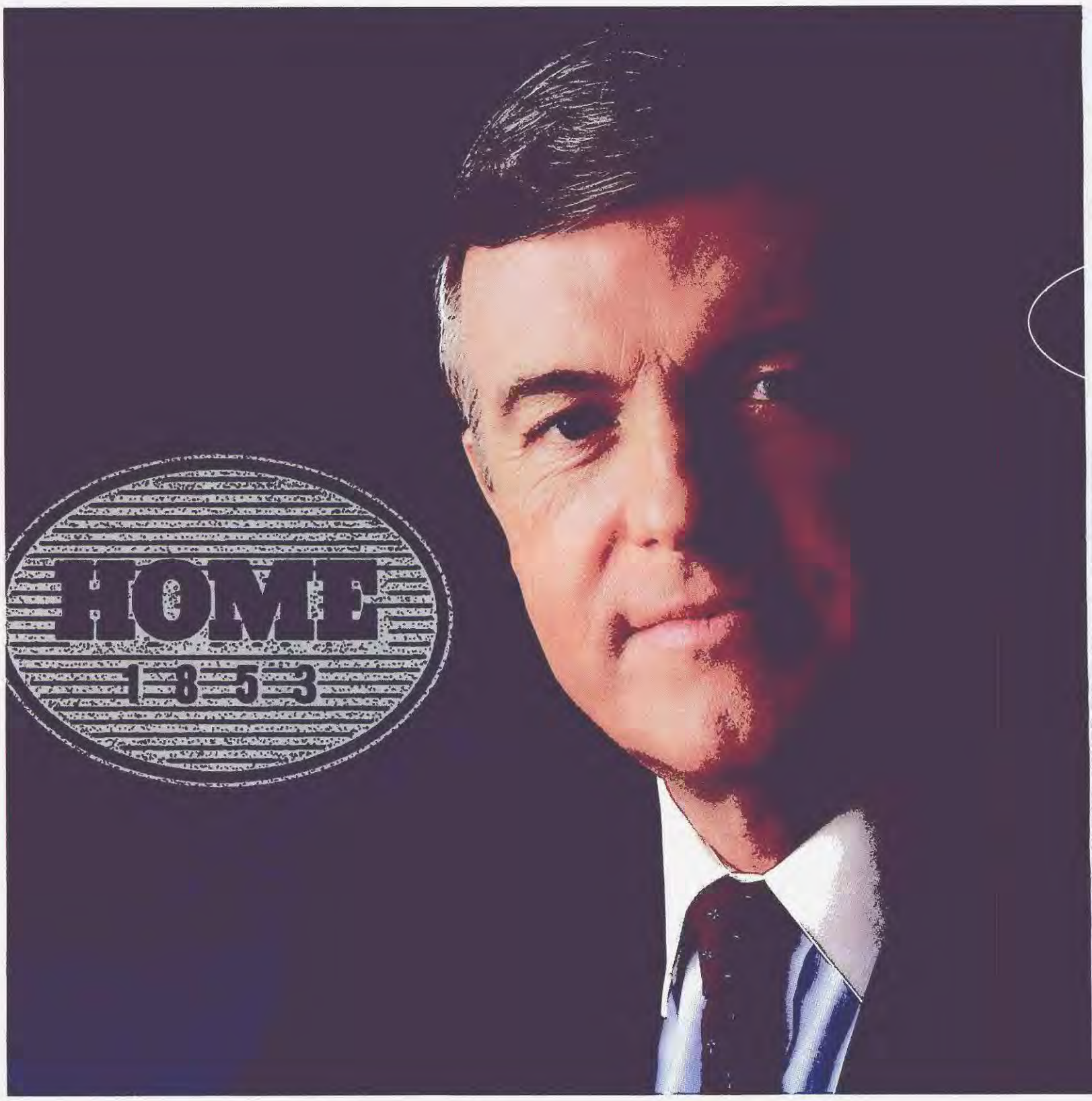

OLD PROS ON

More states setting sights on NAIC accreditation

Additional designations may be granted this week as review process is refined

By MEG FLETCHER

An unprecedented number of states are trying to meet insurance department accreditation requirements.

Fourteen states now hold National Assn. of Insurance Commissioners accreditation, and 25 to 30 others are seeking accredited status. Regulators may consider accrediting some of the other states during the NAIC meeting this week in Atlanta (see map, page 18).

"If we never get another state accredited, the program will have been an overwhelming success," said William McCartney, Nebraska insurance director and NAIC president.

But, accreditation is not without its critics. On the one hand, the NAIC program is faulted by federal officials for being merely voluntary; on the other hand, business-oriented groups fault the NAIC plan for planning to penalize insurers in non-accredited states.

Insurers located in the 14 states accredited to date write more than 96% of all U.S. life insurance premiums and more than 88% of all U.S. property/casualty insurance premiums, according to the NAIC.

Accreditation probably has encouraged all states to change their operations, especially those now on the verge of qualifying, said Mr. McCartney.

Three areas are evaluated during the process: laws and regulations; regulatory practices and procedures; and organizational and personnel policies.

The accreditation process itself is being refined. Currently, documentation is becoming more important, as the self-evaluation guide that state departments can use is expanded, and reviewers are required to follow a written set of principles and produce three reports on each candidate for accreditation.

Originally, only one person was responsible for the accreditation reviews. Now the staff has been increased to three, one of whom does preliminary reviews before the review team visits a state.

In other developments, the NAIC clarified two model acts a state is required to adopt for accreditation.

The group is expected to expand the range of allowable interpretations of "extraordinary dividends" under the NAIC Model Holding Company Act (*BI*, Oct. 5). In addition, the NAIC revised a model law, the Business Transacted with Producer-Controlled Property/Casualty Insurer Act, to give brokers due process protection by specifying that a court—and not a regulator, as specified under the old model—should determine whether a broker contributed to the insolvency of an insurer it controlled (*BI*, Dec. 9, 1991).

The National Assn. of Insurance Brokers supported the latter change and is targeting eight states that passed the original act—Arizona, Georgia, Kentucky, North Carolina, North Dakota, Tennessee, West Virginia and Wyoming—to replace it with the revised version, according to Robert L. Sanford, chairman of the NAIB's State Affairs Committee.

Meanwhile, many risk managers, insurers and other observers are concerned about NAIC proposals to impose sanctions on unaccredited state insurance departments.

For example, after December 1993, accredited states will not accept reports of insurer examinations from unaccredited states except under limited circumstances.

As a result, an insurer domiciled in a non-accredited state may have to undergo—and pay for—examinations by more than one state, and it could face some obstacles to selling its products nationwide.

At least one regulator wants much greater obstacles. Salvatore Curiale, the New York insurance superintendent, is urging Congress to limit the interstate sale of insurance to insurers domiciled in accredited states after a reasonable transition period.

Other regulators say that such a restriction is highly unlikely, but different states could respond differently.

Once Nebraska is accredited, "a company domiciled in a non-accredited state will have a much tougher row to hoe" when seeking admission to Nebraska's marketplace, Mr. McCartney said.

Meanwhile, the federal General Accounting Office and National State Auditors Assn. are critical of the NAIC accreditation program's lack of documentation and voluntary nature,

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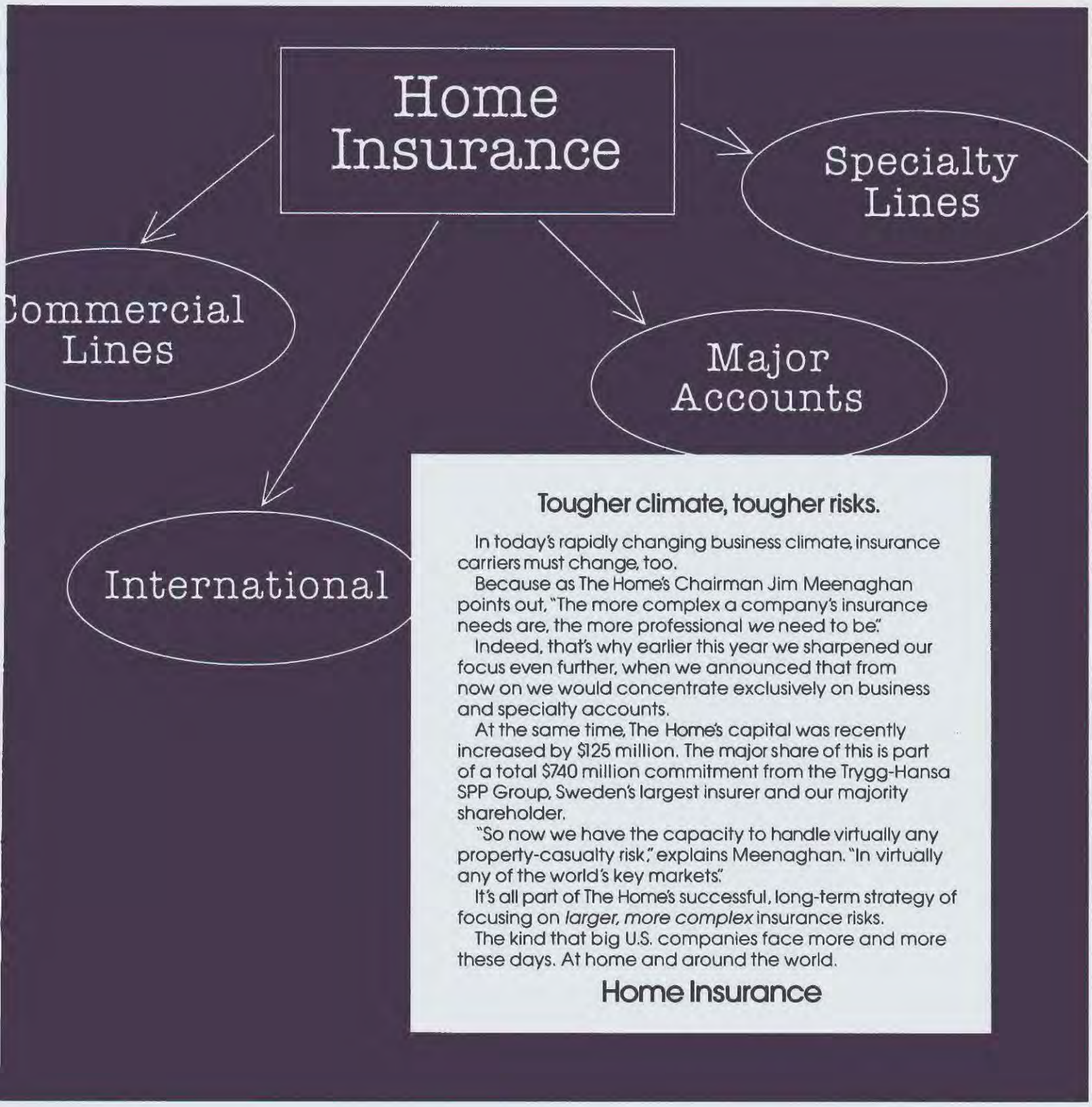
E TODAY



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A NEW TEAM

Accreditation

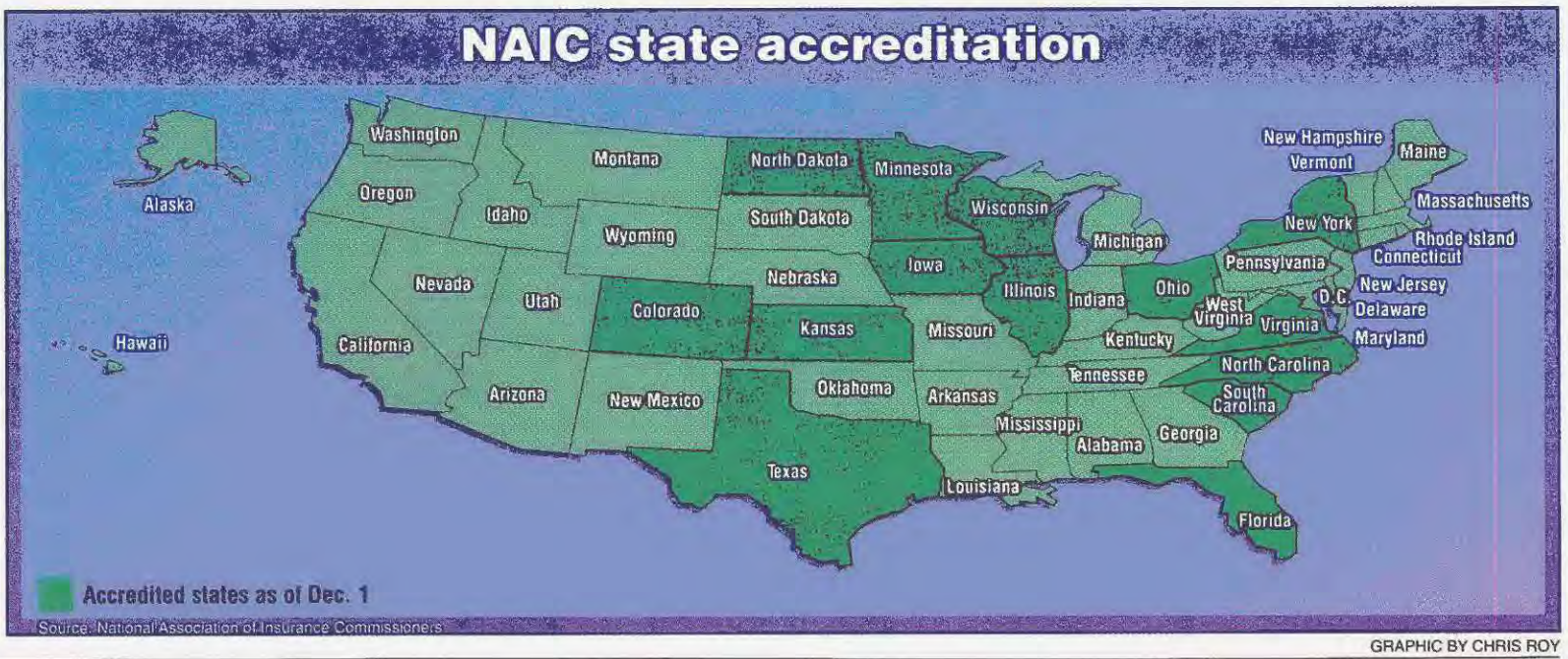
Continued from previous page
among other things.

Both groups generally favor greater federal involvement in accreditation.

"Time will tell" if the accreditation program is a success, said Lenore Marema, vp-legal affairs for the Alliance of American Insurers in Schaumburg, Ill.

It will be well into 1994 before it is known whether the accreditation program has improved the quality of state solvency regulation, said Paul Brown, director of government and public affairs for the Risk & Insurance Management Society Inc. in New York.

RIMS is concerned that the sanctions may make it more difficult for corporations to purchase insurance. BI



GRAPHIC BY CHRIS ROY

Agents and brokers may get a break on licensing by states

By MICHAEL BRADFORD

Agents and brokers may be closer to finding some relief from multistate licensing regulations that they have long complained are onerous and expensive to meet.

For years, intermediaries have sought to streamline the paperwork and cut down on the time involved in meeting different regulations in all the states in which they operate. In calling for a uniform licensing system, agents and brokers have seen some proposals fall by the wayside while others offer some optimism.

"There continues to be a great deal of concern by brokers, particularly those with multistate operations," said Carl Modecki, president of the National Assn. of Insurance Brokers. "Every state is completely different, and that is a concern to us."

"The system in place now is excessively bureaucratic and is primitive in comparison to other financial services fields," agreed Joel Wood, vp of government affairs at the National Assn. of Casualty & Surety Agents.

"Many of our members are having to hire their own personnel divisions solely for maintaining individual producer licenses in all the states," said Mr. Wood. "That is simply unnecessary."

He said while states should be able to make "reasonable requests" of agents and brokers with regard to regulations, "there has to be a test of that reasonableness."

To that end, NACSA helped develop a proposal for a self-regulatory licensing system for agents and brokers that was contained in insurer solvency legislation, H.R. 4900, proposed by Rep. John Dingell, D-Mich., chairman of the House Energy and Commerce Committee (*BI*, April 20).

Under the proposal, an organization—the National Assn. of Registered Agents & Brokers—

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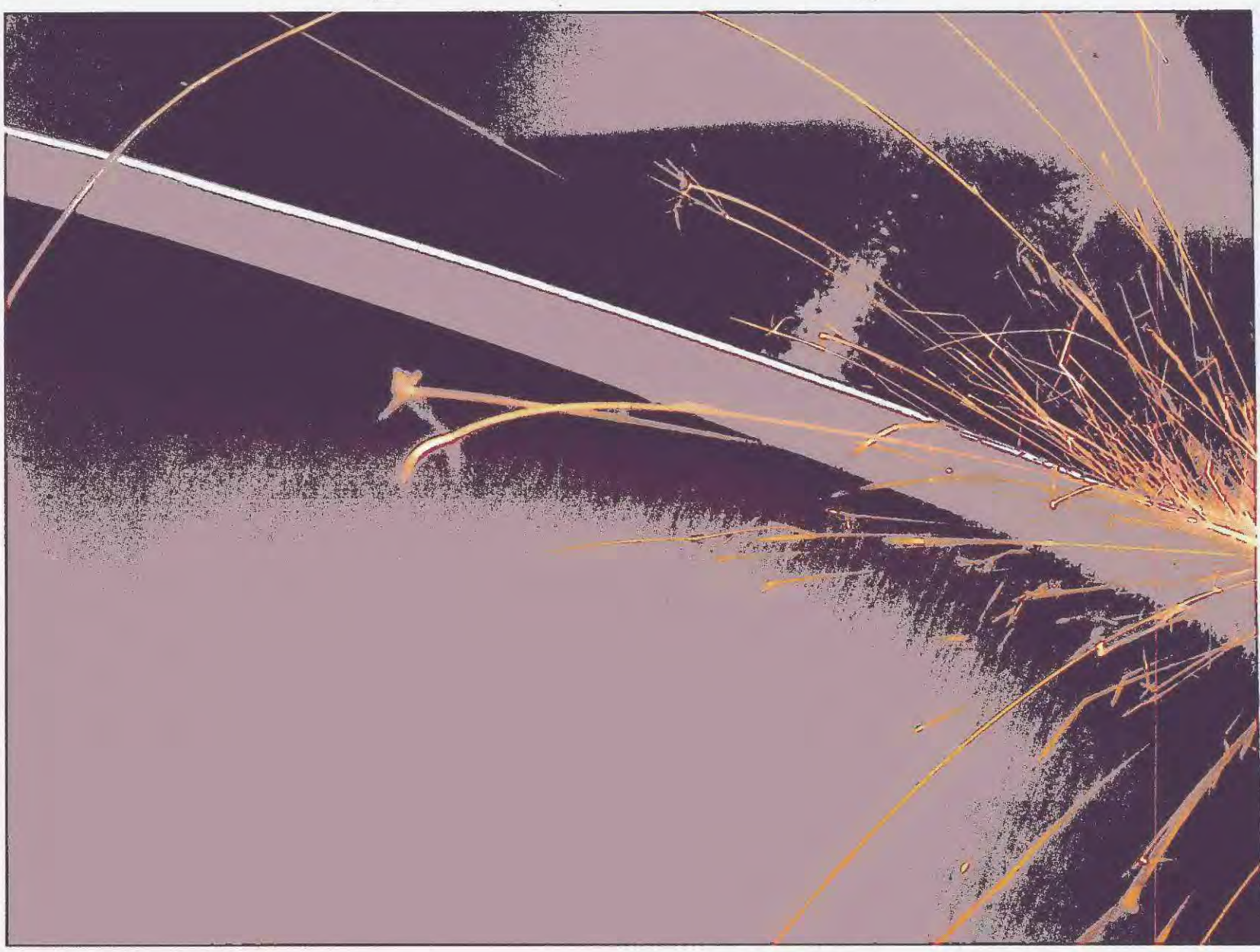

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would be created to operate a clearinghouse that issues uniform applications and license renewals on behalf of multiple states.

The states would continue to regulate agents and brokers, and could deny or revoke licenses, but states would not be able to impose additional requirements in areas under NARAB regulation.

NARAB would establish membership criteria that defines the integrity, personal qualifications, education, training and experience of members, according to a description of the Dingell bill.

The proposal also calls for the development of a national data base to monitor insurance intermediaries' activities and to centrally collect information on regulatory violations.

NARAB would fall under the supervision of the Federal Insurance Solvency Commission, another agency that would be created under Rep. Dingell's proposal.

NARAB would be funded by assessments on its members and would operated by a seven-person board composed of representatives of member companies.

"We back the Dingell bill, which is not to say we don't have some concerns with it," said NACSA's Mr. Wood. Regarding the uniform licensing proposal, he added that "we have unbridled enthusiasm for it. It is the most significant rallying point for our members on Capitol Hill."

Mr. Modecki of the NAIB called the proposed legislation "a first step," but added that it could use some enhancements.

'We have unbridled enthusiasm for NARAB,' says Joel Wood, vp of government affairs for the National Assn. of Casualty & Surety Agents. 'It is the most significant rallying point for our members on Capitol Hill.'

For example, the central data base that gathers information on regulatory violations should also describe how the violations are resolved, he suggested.

Mr. Modecki said the NAIB currently meets with state insurance regulators to convey its concerns with agent licensing practices.

The association's aim is "not to avoid licensing regulations," but to ensure they meet regulators' needs and don't generate an undue burden on producers, he added.

On another front, the National Assn. of Insurance Commissioners is analyzing its options for creating a data base that could eventually be developed into a national intermediary licensing system.

At first, an NAIC system would not have the capability of issuing licenses to intermediaries but would be a central information source for state regulators.

The system could contain intermediaries' continuing education credits, regulatory violations and other data, according to Lewis E. Melahn, the Missouri insurance commissioner and chairman of the NAIC market conduct and consumer affairs committee.

Mr. Melahn said the data base might be tied to other regulatory or quasi-regulatory data bases to track individuals who might try to enter the insurance business after having violated regulations in other professions.

He said the NAIC currently is trying to determine "how we can put together a centralized system" and how to fund it.

The panel studying the feasibility of a data base will present its findings at the NAIC's December meeting this week.

"They will say, 'Here are the things we have come up with. Pick the ones you want to work on next,' " Mr. Melahn predicts.

Ultimately, a data base could be turned into a full-fledged licensing system, Mr. Melahn said, because a central licensing system would require the same information that the NAIC data base might contain.

"It could come to that down the road" if such a system could be shown to benefit the industry and regulators and there was funding for it, he said.

Mr. Melahn pointed out, though, that if Rep. Dingell's proposal is passed and the NARAB system is put in place, "it would be an absolute waste to have two systems."

And, he maintains, that is what the NARAB proposal would do by itself because it leaves licensing decisions to the states if a broker only operates in one state.

"It makes no sense to do it for part of the industry and not for all of it," said Mr. Melahn. "The licensing system under the Dingell bill would end up as a dual licensing system. It would ultimately be more expensive and complex than the system we have now."

One proposal for a uniform agent licensing system that never got out of the gate was put forth by Centralized Insurance Services Inc., a unit of the Life Office Management Assn.

The system, called the State Licensing Network, would have allowed insurance regulators to use personal computers to tap into a mainframe system in Atlanta.

Regulators could use the central system to license agents and brokers and keep tabs on intermediaries who lost their credentials or breached professional conduct.

Among the system's other offerings were a method of keeping up with continuing education credits; the ability to receive license applications and issue licenses; and the ability to reproduce accounting reports, audits and additional reports that agents and brokers are required to file.

The proposed system suffered a fatal blow when the NAIC failed to endorse it at its December 1991 meeting (*BI*, May 25).

"I suspect it is a dead issue," said Lynn G. Merritt, president of Atlanta-based LOMA.

"I think it was a very good idea," said Mr. Merritt, but regulators were unable to agree on the concept and instead decided to pursue formation of their own data base. BI

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'Fundamental' health care changes sought

Clinton may reduce costs, but at a price: Benefit specialists

By LOUISE KERTESZ

ANAHEIM, Calif.—Three out of four employee benefits specialists surveyed say the health care cost and access problems are so bad that the "basic structure" of the U.S. health care system needs a "fundamental alteration."

On the question of whether Clinton administration proposals will eventually lead to national health insurance, benefit specialists at a symposium put on by the International Society of Certified Employee Benefit Specialists were much more evenly divided.

Thirty-seven percent of the 336 surveyed consultants, benefit managers and others predicted a national health insurance program; 35% said the Clinton program would not lead to national health insurance; and 29% said they were uncertain.

Overall, a majority of those surveyed said Gov. Bill Clinton's proposals would effectively control costs, but at a price.

Fifty-three percent said the Clinton plan to control costs by using spending budgets and setting rates would be "somewhat" or "moderately" effective. Another 37% said his plan would not be very effective.

But a similar number—55%—said Gov. Clinton's plans would hurt the quality of health care.

Not surprisingly, play-or-pay plans were widely unpopular with the benefits specialists, though most said the employers they are associated with would continue to provide health benefits.

Three out of four of those surveyed agreed with the statement that a "play-or-pay system will inevitably fall prey to adverse selection, leaving taxpayers with the financial burden of an underfunded government health insurance plan."

Yet 63% also said that their employers would continue to provide health benefits through a company-sponsored plan. Only 20% said their employers would drop the benefits if a play-or-pay plan were adopted; 17% were uncertain.

Results of the survey were reported at a session at which nine panelists responded to questions on the health care crisis and reform. The questions came from Carson E. Beadle, managing director at William M. Mercer Inc. in New York, as well as from the audience.

"Do we need government to solve our health care problems?" Mr. Beadle asked. "Or, how much government do we need? Would you be ready to turn health care over to the government?"

Cathy A. Dobbe wouldn't be. "Being a utility, we are already regulated," answered the administrator of benefits at Wisconsin Electric Power Co. in Milwaukee. Further regulation would mean "additional inefficiency to our industry."

"Medicare has not been a tremendous success. . . .Don't model the private sector on public sector failure," argued Ted Carlson, chief operating officer at Memorial HealthNet Inc., a claims administration firm in Houston.

The focus in health care should be shifted "to keeping people well," and benefit plans should reflect that focus, he added.

Ann K. Dudero also argued against giving the government as much control of health care as, say, the Canadian government has. "We just don't have the same confidence in our government to take care of us," said the employee benefits manager at Jostens Inc. in Minneapolis. "I don't think they would do a good job of running (the system)."

Besides, under government control, the U.S. health care system might lose its leadership in technical innovation in medicine, she added.

"The private sector has a better chance of rectifying the (health care) problem than the government," agreed Karen L. Kendall, manager of welfare benefits at Compaq Computer Corp. in Houston.

But Ms. Kendall also favored government controls on capital investment to slow the spread of advanced and expensive medical technology.

"We don't need government control for that," countered Anne Marie Fourre, benefits manager at The Chronicle Publishing Co. in San Francisco.

"Redundant" services—including hospitals—could be eliminated "without government intervention," she said.

"It's going to get down to what the people demand," observed Michael J. Dooley, vp of health care management in St. Louis for Prudential Insurance Co. of America. For example, advertising for a product, like nicotine patches, "makes demand for the product soar."

"A critical aspect" of the health care crisis "is consumer education, (people) taking responsibility for their own health," he asserted.

Consumer expectations are "critical," Ms. Kendall agreed. "We expect every hospital to have all the modern equipment. We don't want to drive five minutes (to another one). We're part of the problem."

"The idea of people taking responsibility for their own health" should be emphasized, agreed Vera Miller, fund administrative manager at the Connecticut Bricklayers Pension & Health Funds in New Haven.

Not all the blame was placed on consumers. "Doctors and hospitals should have some backbone" when it comes to providing unneeded services, "instead of caving in to the patient," said Robert E. Molloy, president of a Dallas consulting firm that bears his name.

Jostens' Ms. Dudero said that she favored government intervention in curbing the operations of "vested interests," such as

Continued on page 22

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IBF CONFERENCES

Track health care results to gain efficiency

But evaluating treatment outcomes becomes more complex

By LOUISE KERTESZ

ANAHEIM, Calif.—Variation in the results of health care treatment "costs millions" and, if these results could be controlled, rationing of medical services would become unnecessary, an expert contends.

"Outcomes measurement" means different things to different people, explained Dr. Paul W. Frankel, a partner and national medical director at Coopers & Lybrand in New York. But, he said, it focuses essentially on "the result of care."

Though the results of care have been measured for many years—for example, in observing that penicillin cures strep throat—outcomes are now being measured more comprehensively, he said.

Dr. Frankel spoke at the annual employee benefits symposium of the International Society of Certified Employee Benefit Specialists, held here last month.

In evaluating the quality of care a patient receives, one must consider objective, subjective and economic outcomes, Dr. Frankel said.

Objective outcomes include results of physical and mental exams, test results, complications of treatment and—the most severe outcome—death.

Benefit managers 'should be insisting on measuring outcomes,' Dr. Frankel says.

There are various ways for payers to compare objective outcomes of treating a given illness at a group of hospitals, Dr. Frankel said.

He urged benefit managers to use these tools but to keep in mind that simple comparisons can be misleading because some hospitals or doctors serve more critically ill patients.

"You should be insisting on measuring outcomes and making comparisons," he said. "(But) you have to realize that the field is a little soft."

Subjective outcomes are focused on patient satisfaction with health care treatment and include a patient's perceptions of his or her health, satisfaction with life and satisfaction with medical care, Dr. Frankel explained.

Patient satisfaction also can be measured in various ways. One is by a "health status questionnaire" that asks patients about their health in general; physical, emotional, role and social functioning; pain; and energy and fatigue.

But there is some concern that subjective measurements might prompt providers to change their practice patterns "inappropriately," Dr. Frankel warned.

Economic outcomes measurements must consider the total cost of care, the total savings resulting from that care, the cost of poor quality and the cost of inappropriate care, he said.

For several years, economic outcomes have been used to create profiles of providers, he noted.

Some "first generation" profiles, Dr. Frankel cautioned, were "very simple" and "not

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CEBS survey

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doctors referring patients to their own diagnostic facilities.

Responses were just as pointed to another question from Mr. Beadle: Should insurers be required to offer a reasonable plan that would cover everyone?

"It sounds really nice and idealistic. But I don't think it will work," Ms. Dudero said. Insurer competition is the key to keeping premium costs down, she added.

Play-or-pay proposals came in for widespread criticism.

The burden of such a system would fall on small business, asserted Alan P. Cleveland, an attorney with Sheehan, Phinney, Bass & Green in Manchester, N.H. "The jobs will be lost. . .All the new jobs added in the last 15 years have been in small business."

By implementing a play-or-pay system, "we're jeopardizing the country's economic potential," he added.

The problem is that 'people are all working on their own agenda,' says Mr. Carlson of Memorial HealthNet.

An audience member stated that the government should require businesses to provide health care or be taxed to provide it. Let some businesses fail, if they must. "Let the market work," he argued.

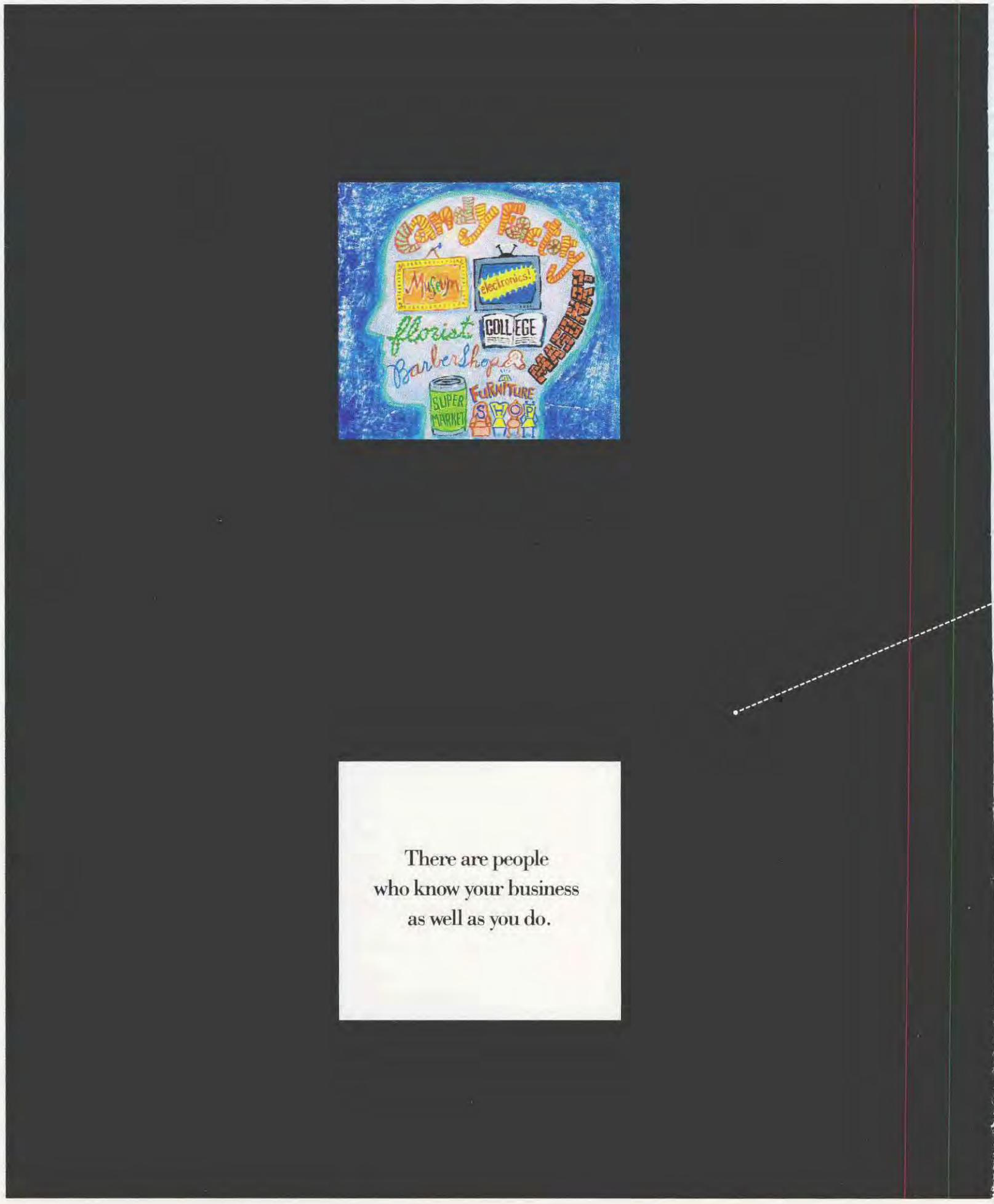
Another attendee, who identified herself as "a liberal Democrat," said that businesses are already paying for the uninsured. "The money's coming out of our pockets anyway. A mandate would give us more control over the uninsured using the system as a last resort."

"How do we make sure as many people are covered as possible, without damaging the whole system?" Mr. Beadle asked.

The government should provide incentives to "develop unique arrangements" among all those involved in the health care system, Mr. Carlson said. The problem is that "people are all working on their own agenda."

Under a play-or-pay system with an 8% payroll tax on businesses that don't provide health benefits, some firms would opt for the tax, several panelists said.

"We spend 11% to 12% of payroll on our benefit plan; 8% looks good," said Ms. Kendall. "Given the current environment, I think (opting to pay the tax) would be seriously looked at," she said. BI



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very useful in improving the quality of care." They were basically financial analyses of dollars spent on certain medical services per patient per plan year.

Doctors balked at being measured and compared in this manner. Their reaction was essentially, " 'This is irrelevant to the practice of medicine,' " said Dr. Frankel.

Second-generation economic outcomes studies measured utilization of services by patients with certain diseases. For example, he said, doctors were compared to their peers on the basis of the number of laboratory tests they ordered per office visit for certain illnesses.

Such measurements were "somewhat more useful to doctors," said Dr. Frankel. But most still balked, saying, " 'You're still watching me. The care I'm giving is just the right amount.' "

A third generation of economic outcomes measurements is now emerging.

Dr. Frankel expects them to be both more comprehensive and more acceptable to doctors.

These measurements will consider standards of care, identify inappropriate care, measure the efficiency of care and account for a provider's case mix, said Dr. Frankel.

These latest measurements consist of "patterns of treatment" standards. These standards spell out "the maximum expected frequencies of services provided by or ordered by a physician for treatment of a specific condition of a patient," he said. Actual doctor performance is then compared to these treatment standards.

Doctors claimed early measurements were 'irrelevant to the practice of medicine,' says Dr. Frankel.

But in considering whether a physician is providing too much care, it is necessary to perform an "episode of care analysis." An episode of care is "the sum of all services provided by or attributable to a single responsible physician for treatment of a specific condition of a patient," he said.

For example, in treating a certain condition, a physician may appear to have provided a minimum of care to a patient in his or her own office. But upon further examination, that physician may have extensively referred that patient for consultation and tests for the same condition, Dr. Frankel explained.

"Efficiency of care" must also be considered in evaluating individual providers. Care must be "not too little and not too much," he said.

And in evaluating an individual provider's practice patterns, it is necessary to consider his or her case mix, because certain providers treat more serious conditions of the same illness, he said.

Payers should insist that vendors use such measurements to evaluate their networks, Dr. Frankel asserted.

The best providers are those that rank high in both objective and subjective outcomes, he said.

In attempting to change the practice patterns of providers, those that rank high in objective outcomes and low in subjective outcomes "are the fun ones," Dr. Frankel quipped.

For example, a hospital with an excellent emergency room by objective outcomes might allow a patient with a sore throat to be placed in a bed next to the victim of a gunshot wound. That would result in low patient satisfaction, which is a subjective outcome.

That situation could be easily corrected, Dr. Frankel pointed out. But a physician that's "lousy except for a great bedside manner"—providing a great subjective outcome but low objective outcome—is "not encouraging," he said.

And doctors with low subjective and objective outcomes are "the dregs of medicine," Dr. Frankel asserted.

"Don't spend any time trying to make them" into ideal doctors, he said. BI

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Upjohn to offer LTC plan in 1994

But better products sought from insurers

By LOUISE KERTESZ

ANAHEIM, Calif.—Though many employers are still only considering offering long-term care benefits, The Upjohn Co. plans to begin making LTC coverage available to employees in April.

"More and more people need" a long-term care benefit, said Peter J. McCauley, manager of corporate pension and savings plans at the Kalamazoo, Mich.-based pharmaceutical company.

But most employees don't have such a benefit, and most insurers don't offer long-term care insurance, he observed.

Mr. McCauley spoke at a session during the annual employee benefits symposium sponsored by the International Society of Certified Employee Benefit Specialists last month.

Insurers now "have to listen to the customer," asserted Mr. McCauley, who said that long-term care products from most insurance companies "are not flexible enough."

However, he added, many insurers are seeing long-term care as "the benefit of the '90s" and "are putting long-term care packages together."

Upjohn compared the long-term care programs of 10 insurers before selecting an insurer, said Mr. McCauley, who declined to identify the insurer.

Upjohn employees will pay the entire premium for the program, he said.

Companies today are interested in benefits that "will not cost the company any money" but "will affect (employees') perception of the company," he said.

Upjohn's long-term care program will cover employees and their spouses, retirees and their spouses and parents and parents-in-law. It will provide a daily nursing home benefit of

Continued on next page

Long-term care

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between $50 and $150, depending upon the premium paid, with home health care covered at 50% of nursing home benefits.

The lifetime maximum is 2,000 times the daily benefit, or $100,000 to $300,000.

Long-term care insurance is an important benefit because "(employee) stress affects the bottom line," Mr. McCauley said. For example, when employees need to take time off to care for elderly parents, productivity is affected, and absenteeism increases. Requests for leaves of absence also multiply, he said.

On the other hand, Upjohn believes the availability of long-term care insurance will boost employee morale and job satisfaction and will help the company in recruiting, especially in recruting scientists. "Their perspective of you as a company has to do with the benefits you offer," he said.

Long-term care benefits are needed because of "changing demographics—the aging of America," Mr. McCauley said. By the year 2000, 13% of the U.S. population will be between the ages of 65 and 95, he said, up from 9.8% in 1970 and 12.6% in 1990. At the same time that more Americans will require long-term care, "Medicare does not cover long-term or custodial care," he noted.

Also, "Medical plans cover the cost of treatment for specific medical conditions; most do not cover assistance for everyday medical problems," he said.

The cost of nursing home care can be prohibitive—running to $50,000 a year, and home health care can cost $15,000 per year, he said. Consequently, the burden of care often falls upon "informal caregivers" like family or friends, he said.

Many large employers that self-insure medical benefits are choosing to offer a fully insured long-term care benefit, Mr. McCauley explained. "A partnership is really critical" between the employer and the insurer, which should market the program "for maximum enrollment," he said.

Since the benefit may be paid to the employee and his or her dependents 20 to 30 years into the future, an employer should carefully assess the financial stability of the long-term care insurer, Mr. McCauley observed.

In comparing potential insurers for the program, a company should develop benefit specifications for all prospective bidders, including daily benefit amounts. Insurers should have opportunities to discuss any variances to the specifications they wish to suggest, he said.

Requirements for an insurer's support services should also be specified, such as long-term care resource and referral systems, administration, claim processing, care and case management, enrollment services and employee communications.

Upjohn required its insurer to accept certain impairments that would qualify a covered person to receive long-term care benefits. A beneficiary must be unable to perform two to three of the following:

- Dressing, including putting on braces and artificial limbs.
- Toileting, including "associated personal hygiene."
- General mobility, including walking, using a wheelchair, and moving between a bed and a chair.
- Organizing and taking prescribed amounts of medication at prescribed times.
- Eating without assistance.

Long-term care insurance is an important benefit because '(employee) stress affects the bottom line,' Mr. McCauley says. When employees need to take time off to care for elderly parents, productivity is affected, and absenteeism increases, he says.

Upjohn required its insurer to recognize cognitive impairment as a separate criterion for receiving long-term care benefits. Cognitive impairment is defined as "deterioration of the insured's intellectual capacity which requires significant supervision, because behavior poses a significant health and safety threat to the insured or others."

Cognitive impairment can include Alzheimer's disease, dementia, manic depression and schizophrenia.

Eligible facilities and services under Upjohn's program include skilled nursing homes, intermediate care, home health care, respite care, adult day care, foster home care, hospice care, alternative care, informal caregivers like family and friends, and licensed and non-licensed caregivers.

The services of informal caregivers—such as a teenager taking care of a grandparent—are "of primary importance," Mr. McCauley said. Charges for these services are negotiated through the insurer's care manager, he added.

Upjohn believes that the program will prove successful if 10% to 20% of its employees enroll in coverage during the first year. Also, "You're educating employees on a concern they should have," Mr. McCauley added. BI

Annual meeting attracts 420

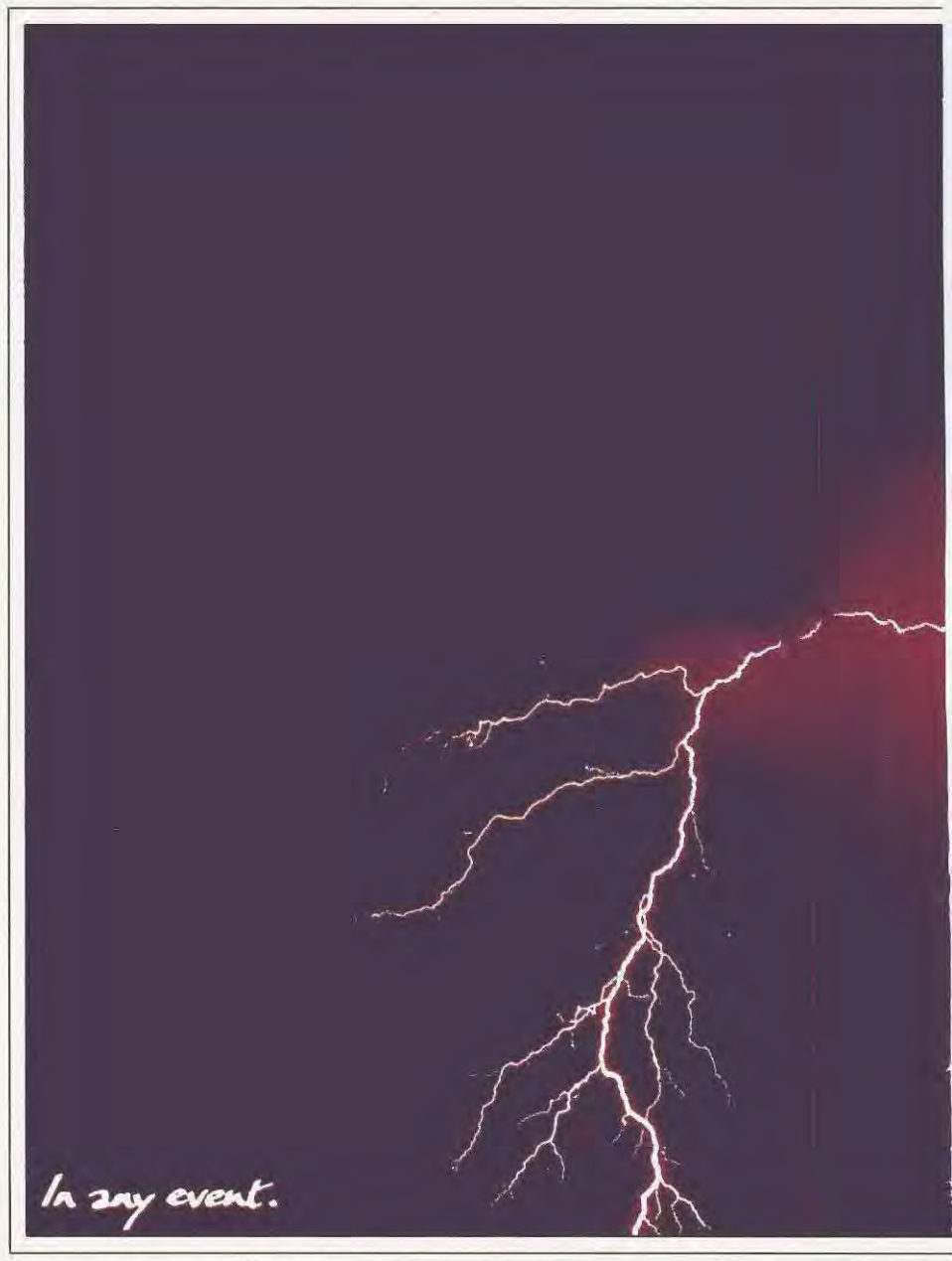
ANAHEIM, Calif.—The International Society of Certified Employee Benefit Specialists held its 11th annual employee benefits symposium Nov. 15-18 at the Disneyland Hotel.

Attendance was 420, up from 368 last year.

At a "Town Hall Meeting on Health Care Reform," attendees learned the results of a post-election poll on Bill Clinton's health care proposals, which was taken at the conference (see story, page 20).

Next year's meeting will be Sept. 12-15 in Washington.

For more information on the ISCEBS or next year's meeting, contact the International Society of Certified Employee Benefit Specialists, 18700 Bluemound Road, P.O. Box 209, Brookfield, Wis. 53008-0209; 414-786-8771.



Info

• A comprehensive **glossary of terms and expressions used in the managed care industry** is now available from United HealthCare Corp. It includes an alphabetical listing of common abbreviations and acronyms. Copies of "The Managed Care Resource—The Language of Managed Health Care" are $10.95 each from United HealthCare Corp., Mail Route 8003, P.O. Box 1459, Minneapolis, Minn. 55440-1459.

• The Assn. of Engineering Firms Practicing in the Geosciences has published **"The 1992 Directory of Consultants Who Provide Services Associated with Preliminary Site Assessments and Underground Storage Tanks."** The 40-page directory lists offices in Canada, Guam, Mexico, Puerto Rico, Switzerland and the United States. The directory is available at no charge from The Assn. of Engineering Firms Practicing in the Geosciences, 8811 Colesville Road, Suite G106, Silver Springs, Md. 20910.

• **"How to Choose a Group Legal Plan"** has been published by Midwest Legal Services Inc. The 48-page guide discusses why a group legal services benefit plan is a good addition to a benefit package and provides a checklist of questions to ask when considering a plan. The book is available free of charge from Midwest Legal Services Inc.; 515-246-1200 or 800-247-4184.

• The Health Insurance Assn. of America has released a new guide that explains the newly standardized private Medicare supplement insurance. **"The Consumer's Guide to Medicare Supplement Insurance"** includes tips on what to look for in a Medicare supplement policy, a list of expenses not covered by Medicare and a chart of 10 standardized supplement insurance plans. The guide also describes other private coverages. Free copies are available from the HIAA, P.O. Box 41455, Washington, D.C. 20018; 202-223-7783.

• The Life Insurance Marketing & Research Assn. Inc. has published a brochure of 1993 conference and meeting dates and locations. **"1993 LIMRA Conferences"** outlines the purpose, content and format of each meeting. For a free copy of the brochure, contact LIMRA's customer service unit at 800-235-4672.

• **"Insurance Policies Covering Long-Term Care Services in New York State,"** a consumer guide on long-term care insurance, is now available from the New York Insurance Department. The guide discusses the cost of long-term care and factors to consider before purchasing the insurance. A list of insurers licensed to sell individual and group long-term care policies in New York State is also included. The booklet is free from the New York Insurance Department's Publications Unit, Agency Building 1, Empire State Plaza, Albany, N.Y. 12257.

• A new booklet discusses **how annuities work, why people purchase them and what types of annuities are available.** Single copies of "A Consumer's Guide to Annuities" are free. Send a postcard to the American Council of Life Insurance, Consumer Department, 1001 Pennsylvania Ave. N.W., Washington, D.C. 20049-2599.

• **"What Every Senior Citizen Ought to Know About Taxes, Benefits, Health Care and Estate Planning Basics,"** a new booklet published by Commerce Clearing House, provides an overview of some major programs and choices available for older Americans. The 64-page booklet discusses Social Security, Medicare, Medicaid, pensions, income tax issues and insurance. Single copies are $5; quantity discounts are available. Contact CCH, Cash Item Department, 4025 W. Peterson Ave., Chicago, Ill. 60646; 800-248-3248.

• The adoption of **seismic-resistant building codes for new buildings and retrofitting existing buildings can significantly reduce earthquake damage**, suggests a new study. "Physical Damage and Human Loss: The Economic Impact of Earthquake Mitigation Measures" reports on the lives and property that could be saved in the Los Angeles and Memphis, Tenn., areas if mitigation measures were in place before a major quake hits. The study also discusses the costs that would be incurred by the changes. Copies are available from the Insurance Information Institute for $17.50. Fax requests to 212-791-1807.

• Tips to avoid unnecessary settlements are provided in a **"Product Liability Guide for Manufacturers."** The 20-page publication provides tips on things to do and say, as well as what to avoid. It includes a litigation checklist, suggestions on working with the insurer and a glossary. Booklets are $3 each. Include payment with request. Hand Tools Institute, 25 N. Broadway, Tarrytown, N.Y. 10591.

• The American Society of Safety Engineers' revised brochure, **"Careers in Safety and Safety Engineering,"** identifies the fastest growing areas within the safety field. In addition, it lists career opportunities, offers suggestions for college preparation and describes basic safety functions. Free copies are available from ASSE Membership Services Department, 1800 E. Oakton St., Des Plaines, Ill. 60018-2187; 708-692-4121, ext. 28 or 30.

• The third edition of an **"Employee Benefits Resource Guide"** has been published by the International Foundation of Employee Benefit Plans. The guide lists source materials relating to employee benefit plans and includes a directory of addresses and phone numbers for the Department of Labor, Internal Revenue Service, Pension Benefit Guaranty Corp. and the field offices of the Pension and Welfare Benefits Administration. Copies are available for $20 to IFEBP members, and $24 for nonmembers. Include payment with order. IFEBP, 18700 W. Bluemound Road, P.O. Box 69, Brookfield, Wis. 53008-0069; 414-786-6700.

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MERCANTILE & GENERAL
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Insider Trading

Aetna Life & Casualty Co.: John P. Donahue, director, sold 19,971 shares of common stock at $42.38 per share on Nov. 3. Mr. Donahue also indirectly sold 10,957 common shares at $42.38 per share the same day. In addition, he disposed of by gift 1,485 common shares at an unreported price per share from Sept. 28 to Oct. 22. He now directly and indirectly holds 408,853 common shares.

Aetna stock was trading at $44.25 per share on Nov. 25.

Alexander & Alexander Services Inc.: John A. Bogardus, director, disposed of by gift 240 shares of common stock at an unreported price per share on Sept. 28 and now directly and indirectly holds 94,240 common shares.

A&A stock was trading at $26.25 per share on Nov. 25.

American International Group Inc.: Maurice R. Greenberg, chairman, disposed of by gift 476 shares of common stock at an unreported price per share from July 9 to July 11 and now directly and indirectly holds 7.49 million common shares.

AIG stock was trading at $114.13 per share on Nov. 25.

Chubb Corp.: Several Chubb executives exercised common stock options on Sept. 8 at $43.25 per share:

- Percy Chubb, officer and director, exercised an option for 576 common shares and now directly owns 277,563 common shares.
- David S. Fowler, vp, exercised an option for 200 common shares and now directly holds 5,469 common shares.
- Henry G. Gulick, officer, exercised an option for 100 common shares and now directly and indirectly holds 5,547 common shares.
- Thomas V.A. Kelsey, vp, exercised an option for 578 common shares and now directly and indirectly holds 39,224 common shares.
- Robert A. Marzocchi, vp, exercised an option for 515 common shares and now directly holds 1,869 common shares.
- Joseph A. Morein, vp, exercised an option for 578 common shares and now directly holds 1,078 common shares.
- Robert Rusis, vp, exercised an option for 200 common shares and now directly holds 5,276 common shares.
- Henry B. Schramm, vp, exercised an option for 578 common shares and now directly and indirectly holds 6,045 common shares.
- John F. Swope, vp, exercised an option for 578 common shares and now directly holds 24,878 common shares.
- Dean R. O'Hare, chairman, exercised an option for 578 common shares and now directly and indirectly holds 43,872 common shares.

In addition, Donn H. Norton, vp, exercised an option for 2,722 common shares and sold 1,144 shares at between $35 and $43.25 per share from Sept. 8 to Sept. 28 and now directly and indirectly holds 6,116 common shares.

Glenn A. Montgomery, vp, exercised an option for 919 common shares at between $24.50 and $28.63 per share on Sept. 25 and now directly holds 2,240 common shares.

Chubb stock was trading at $88.63 per share on Nov. 25.

Continental Corp.: Richard D. Osborne, director, purchased 400 shares of common stock at $25 per share on Oct. 2 and now directly holds 600 common shares.

Francis M. Colalucci, vp, exercised an option for 2,050 common shares and sold 2,050 common shares at between $28.75 and $33.63 per share on Aug. 11 and now directly and indirectly holds 1,262 common shares.

Continental stock was trading at $27.75 per share on Nov. 25.

Arthur J. Gallagher & Co.: James W. Durkin, vp, exercised an option for 20,800 shares of common stock and sold 14,100 common shares at between $13.74 and $27.75 per share on Oct. 26 and now directly holds 8,407 common shares.

Gallagher stock was trading at $27.63 per share on Nov. 25.

General Re Corp.: Graham O. Harrison, director, disposed of by gift 300 shares of common stock at $108.19 per share on Oct. 19 and now directly holds 2,300 common shares.

Andrew W. Mathieson, director, disposed of by gift 404 common shares at $115.43 per share on Oct. 27 and now directly and indirectly holds 4,791 common shares.

General Re stock was trading at $110.75 per share on Nov. 25.

Marsh & McLennan Cos. Inc.: Richard H. Blum, director, exercised an option for 22,000 shares of common stock at between $33.19 and $91 per share on Oct. 28 and now directly and indirectly holds 64,697 common shares.

Robert Clements, president, exercised an option for 5,000 common shares and sold 5,000 common shares at between $33.19 and $91 per share on Oct. 23 and now directly and indirectly holds 24,850 common shares.

Douglas C. Davis, vp, exercised an option for 2,000 common shares and sold 2,000 common shares at between $49.38 and $91.38 per share on Oct. 22. In addition, he exercised an option for 3,000 common shares and sold 3,000 common shares at between $49.38 and $83.94 per share from Sept. 2 to Sept. 10. He now directly and indirectly holds 4,112 common shares.

Frank J. Tasco, director, exercised an option for 55,000 common shares at between $24.38 and $33.19 per share on Oct. 30 and now directly and indirectly holds 55,187 common shares.

Gregory F. Vangundy, officer, sold 321 common shares on Oct. 27 and now directly and indirectly holds 32,696 common shares.

Adele S. Simmons, director, disposed of by gift 300 common shares at an unreported price per share on Sept. 29 and now directly holds 85,149 common shares.

John M. Regan, director, acquired by gift 660 common shares at an unreported price per share on Aug. 11. In addition, Mr. Regan sold 16,200 common shares at between $85 and $99 per share between Sept. 24 and Sept. 29. He now directly holds 101,562 common shares.

M&M stock was trading at $92.25 per share on Nov. 25.

NAC Re Corp.: John P. Birkelund, director, sold 5,000 shares of common stock at $35.50 per share on Oct. 19 and now directly holds 21,921 common shares.

NAC Re stock was trading at $38.75 per share on Nov. 25.

Poe & Associates Inc.: William F. Poe, chairman, indirectly sold 30,000 shares of common stock at between $13.50 and $13.75 per share from Oct. 23 to Oct. 26 and now

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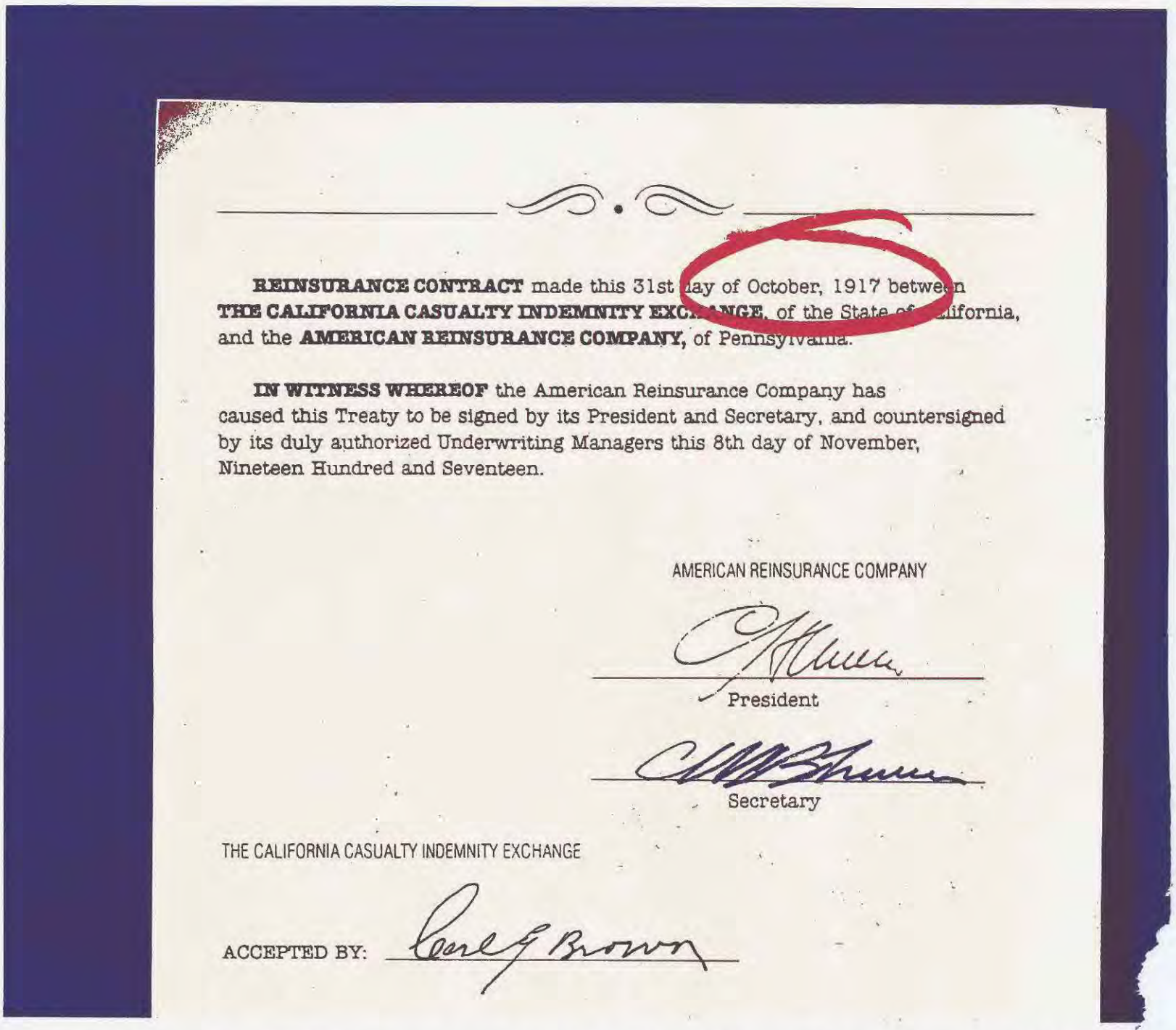

REINSURANCE CONTRACT made this 31st day of October, 1917 between **THE CALIFORNIA CASUALTY INDEMNITY EXCHANGE**, of the State of California, and the **AMERICAN REINSURANCE COMPANY**, of Pennsylvania.

IN WITNESS WHEREOF the American Reinsurance Company has caused this Treaty to be signed by its President and Secretary, and countersigned by its duly authorized Underwriting Managers this 8th day of November, Nineteen Hundred and Seventeen.

AMERICAN REINSURANCE COMPANY

President

Secretary

THE CALIFORNIA CASUALTY INDEMNITY EXCHANGE

ACCEPTED BY:

It took 75 years of dedicated writing

In 1917, we first put our pen to this treaty. In 1992, after seventy-five years of a mutually beneficial relationship, they've renewed with us again. In fact, over half of our clients have been with us 20 years or longer. Formed to underwrite Workers' Comp for coal miners in Central Pennsylvania, we are now a multi-line, multi-national corporation with assets over $ 3.8 billion.

It takes enduring quality to maintain financial strength and client relationships through hard and soft markets.

In 1985, when capacity got tight, we didn't close offices or reduce coverage. Our record of constancy helped our clients through the tough times. Some reinsurers didn't make the same constant commitment; some didn't make it at all.

Along with stability, we offer innovation. Systems and services especially designed to meet our clients' needs. We bring together specialists from across divisional, corporate and geographic lines to provide customized solutions for our clients. We have actually restructured

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directly and indirectly holds 1.2 million common shares.

W.F. Poe Syndicate Inc., beneficial owner, sold 30,000 common shares at between $13.50 and $13.75 per share from Oct. 23 to 26 and now directly holds 384,969 common shares.

Poe & Associates stock was trading at $15.50 per share on Nov. 25.

RLI Corp.: Gerald D. Stephens, officer, director and beneficial owner, sold and disposed of by gift 13,600 shares of common stock at between $19.75 and an unreported price per share from Sept. 2 to Sept. 25. Mr. Stephens also indirectly acquired by gift 200 common shares at an unreported price per share on the same day. He now directly and indirectly holds 407,550 common shares.

RLI stock was trading at $23.38 per share on Nov. 25.

SAFECO Corp.: Robert S. Cline, director, purchased 300 shares of common stock at between $52.63 and $53.63 per share from Oct. 13 to Oct. 19 and now directly holds 300 common shares.

James W. Cannon, director and officer, exercised an option for 15,300 common shares at between $28.13 and $29 per share on Sept. 10 and now directly holds 60,580 common shares.

SAFECO stock was trading at $56 per share on Nov. 25.

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

Alyeska Pipeline settles litigation from Valdez spill

By JOANNE WOJCIK

ANCHORAGE, Alaska—The operator of the trans-Alaska pipeline has agreed to pay the state and federal governments $32 million to settle litigation related to the 1989 Exxon Valdez oil spill.

The settlement, filed Nov. 25 in U.S. District Court in Anchorage, would resolve the government's allegations that Alyeska Pipeline Service Co. had failed to maintain sufficient oil spill response capabilities on Prince William Sound.

Alyeska, a Delaware corporation owned by a consortium of oil companies, is responsible for initial containment and cleanup of oil spills caused by vessels loaded at the terminal in the city of Valdez.

Approximately 11 million gallons of crude oil was spilled when several of the Exxon Valdez's cargo tanks ruptured after the ship was grounded on a reef in the sound (*BI*, April 3, 1989).

Exxon Corp. resolved federal and state claims last year when it agreed to pay more than $1 billion in civil and criminal penalties under a settlement approved by the U.S. District Court in October 1991 (*BI*, Oct. 14, 1991; March 18, 1991).

However, under terms of the settlement, both the federal government and the state reserved the right to seek civil damages from Alyeska for losses related to the grounding of the Exxon Valdez, the resulting oil spill, the containment or cleanup of that spill and Alyeska's preparedness in responding to an oil spill, explained Stuart M. Gerson, assistant attorney general in charge of the U.S. Justice Department's civil division in Washington.

The settlement requires Alyeska to provide a restoration project by purchasing forestry land for the state park system and to finance several projects that can be used to combat future oil spills.

Alyeska did not admit any wrongdoing as part of the settlement.

Alyeska will not tap the Trans-Alaska Pipeline Liability Fund to pay the $32 million settlement. The fund, which is financed by a 5-cent-a-barrel levy on oil pumped through the pipeline, has a balance of more than $300 million (*BI*, April 30, 1990).

Alyeska will not tap the Trans-Alaska Pipeline Liability Fund to pay the $32 million settlement.

Instead, each of the pipeline's owners will contribute. Alyeska is owned by Amerada Hess Pipeline Corp., ARCO Pipe Line Co., BP Alaska Pipelines Inc., Exxon Pipeline Co., Mobil Alaska Pipeline Co., Phillips Alaska Pipeline Corp. and Unocal Alaska Pipeline Co.

"The settlement provides redress for the damage the governments allege Alyeska has caused," said Mr. Gerson in announcing the pact. "But, more importantly, we have put in place preventive measures and the capacity to protect the environment and avoid such damage in the future."

Under terms of the settlement, Alyeska will pay:

- $14.5 million to construct storage facilities and boat response docks in Prince William Sound.
- $7.5 million to purchase forestry land.
- $6 million to construct an access road project to a deep water port that will serve as a response staging area in the event of future spills.
- $1.6 million to reimburse the U.S. Coast Guard for cleanup expenses.
- $1.5 million to reimburse municipalities for Alaska Fisheries Tax payments lost when businesses were closed due to the spill.
- $200,000 to equip the government sections of the response command post in the Valdez Emergency Operations Center to respond to future oil spills in the sound.

Alyeska also firmly commits in the agreement to build the center in the city of Valdez at an estimated cost of $14 million. BI

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Jobs satisfy public risk managers

By SARA J. HARTY

The educational backgrounds of public risk managers vary widely, as do the types of entities they work with, the size of annual budgets and their salaries.

And, on the whole, these risk managers plan to stick with their chosen profession, found a recent survey by the Public Risk Management Assn. of Arlington, Va.

Of the PRIMA survey's 519 respondents, 45.2% were employed by cities, 25.1% worked for counties, 11.3% for school districts and the remainder for various other public entities.

Most held the title of risk manager, though some safety managers, insurance coordinators, human resource directors and others were included.

The average salary was $47,054, calculated from 491 respondents who answered questions about salary levels.

Average salaries were highest in the West at $51,327; followed by the Northeast at $50,025; and the North Central region at $44,461. The South had the lowest average salary, $43,754.

By entity, respondents working for a state had an average salary of $56,102; county employees reported the lowest average salary, $44,931.

Not surprisingly, respondents under the age of 30 earned the lowest average salary, $31,719; while those over 60 had the highest, $53,374.

Similarly, more educated people had higher average salaries. Respondents with doctoral degrees earned almost $60,000 on average, while those with only a high school diploma averaged $39,637.

Job satisfaction appears to be high: 89.6% of those in the PRIMA study said that they plan to remain in public risk management.

The field is still dominated by men; only 29.4% of the respondents were female.

And, on average, men earned almost $4,000 a year more than the women respondents, the study found.

Nearly a third of the respondents, 32.2%, have budgets between $100,000 and 499,000; 20.2% have budgets greater than or equal to $500,000; 11% have budgets between $50,000 and $99,999; 8.1% have budgets less than $25,000; 6.4% have budgets between $25,000 and $49,999; and 22.2% did not answer the question.

Almost half of those surveyed hold a bachelor's degree as their highest academic credential; 32.5% have a master's degree; 14.1% have only a high school diploma; 3.7% hold law degrees; and less than 1% have a doctoral degree.

One-fourth of the women hold a master's degree, compared to 35.4% of the men.

In addition to academic degrees, 24.1% have an Associate in Risk Management designation and 6.4% hold the Chartered Property & Casualty Underwriter designation.

Claims handling was also covered in the PRIMA poll. About a quarter of the risk managers reported that a combination of an insurer, third-party administrator and in-house handling handle their claims. Nearly a fifth, 19.5%, used a TPA alone; 17.1% used a combination of a TPA and in-house handling; 11.3% used an insurer; 11.3% handled all claims in-house; 8.9% used an insurer and TPA; and 8.6% used an insurer and in-house handling.

•

Copies of "Public Risk Management: 1992 State of the Profession" are available to PRIMA members for $35 and to nonmembers for $50. Contact PRIMA, 1117 N. 19th St., Suite 900, Arlington, Va. 22209; 703-528-7701.

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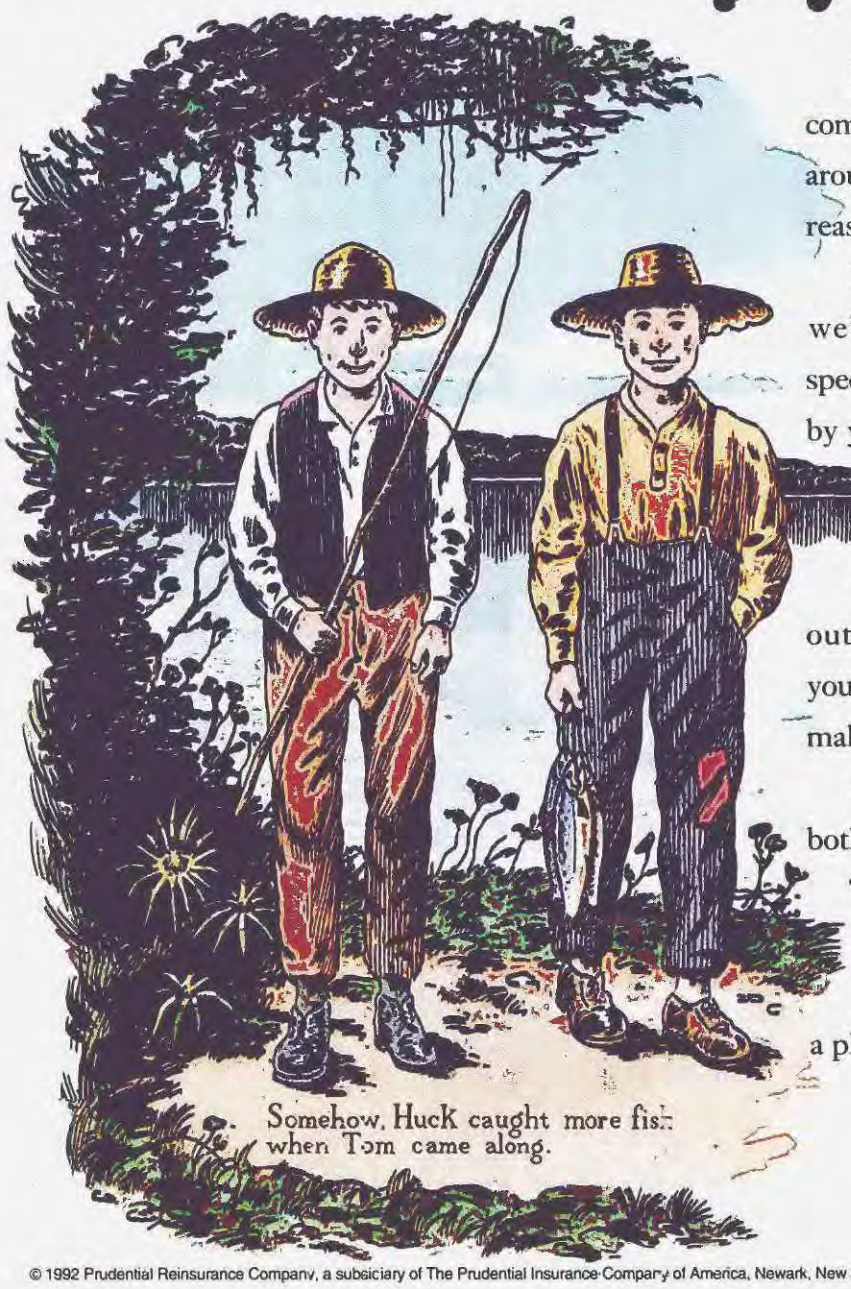

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Agent/Broker Topics

A monthly editorial section sent exclusively to agents and brokers

Merger initiative stymied

Fallout from PIA showdown: rancor, minor changes, no deal

By LAURA MAZZUCA

LAKE BUENA VISTA, Fla.—The fireworks exploding over the Walt Disney World Dolphin Hotel last month weren't just provided by the nearby Epcot Center or Magic Kingdom amusement parks.

Pyrotechnics of another sort were set off by a pitched proxy battle at the 61st annual National Assn. of Professional Insurance Agents convention.

Fourteen PIA state affiliates—many of them consolidated or considering consolidation with local chapters of the Independent Insurance Agents of America—used member proxies in an attempt to ram through a referendum requiring the PIA to conduct a membership survey, through an impartial third party, to determine if the rank-and-file favor national consolidation with the IIAA.

Merger talks between the two agent groups broke off in September at the behest of the PIA national board (*A/BT*, Oct. 5).

But the national PIA leadership countered with 885 proxies of its own, and the survey referendum was defeated 4,035 to 2,218.

The pro-consolidation forces did score a victory with the passage of several resolutions.

One, an amendment to the PIA bylaws, requires a membership vote before admitting any direct writer agents as members. This amendment was added to a bylaw change on "section membership," which will admit customer service representatives, non-licensed accounting personnel, and other non-agents to PIA membership.

Another resolution calls for the PIA and the IIAA to work together on several of the main issues facing the independent agency system, including federal legislative and insurer relations issues.

And, a change to PIA bylaws will allow agents to be direct members of the national association. This permits them to retain membership and PIA-provided insurance if a state affiliation is disenfranchised or quits (see story, page 28E).

A month of behind-the-scene machinations culminated in the proxy battle at the November convention. On one side were the 14 state associations that solicited member proxies on national consolidation; on the other side was the national PIA, the leaders of which viewed the movement as a conspiracy between the IIAA and the consolidated state associations.

In an Oct. 28 letter to the consolidated state affiliates, Daniel J. Blum, the outgoing PIA president, accused the national IIAA and the merged chapters of creating a "Trojan horse" by seeking the proxies to disrupt the national business meeting. The merged chapters deny that the effort was led by the IIAA.

Mr. Blum also chastised the members for going ahead with consolidation after the PIA warned against it.

"When the national negotiations broke down, the state leaders who jumped the gun and consolidated with their IIAA counterparts now find themselves hanging nigh and dry," Mr. Blum wrote in a letter to members of unconsolidated PIA chapters.

"Their best hope is to get the rest of the PIA to pull their chestnuts out of the fire by merging with the IIAA at any cost. But this is a problem of their own doing. Your national leadership repeatedly advised your state leadership not to consolidate until the outcome of the national negotiations became clear. Your leadership chose to ignore it and that's why they now have problems."

The letter included an officially sanctioned PIA proxy dealing specifically with three proposed bylaw changes.

Some PIA members who attended the closed-door business meeting at the convention feel that in spite of the failure to pass the referendum, the meeting was a success.

"The direct writer issue was taken off the table, and I think everybody walked away happy that that happened," said William Hartnett, president of the PIA of Rhode Island, which joined four other New England states in soliciting member proxies.

Although Mr. Hartnett and others were disappointed that the referendum for the national survey was defeated, the proxy battle allowed the 12 merged chapters to flex their muscles and show the national PIA that "they play too important a part to be ignored," he said.

The New England PIA will continue with its plans to consolidate with its IIAA counterparts, as will other state affiliates, he said. Eventually, a critical mass will be reached, and "at that point, the rules of the game at both nationals will, by force, change," Mr. Hartnett said. "Over time, it's a self-correcting problem."

Illinois PIA will officially merge with the Independent Insurance Agents of Illinois on Jan. 1 in spite of what the national associations do. "What we were doing was for the benefit of the agents in Illinois," said George Boehm, president of Illinois PIA.

And the PIA of Texas, which had set aside its consolidation efforts with its IIAA counterpart for the past two years because "we thought the nationals were going to get together" has decided to go ahead with consolidation talks, said Robert Bentley, president of the PIA chapter. "Our members have pretty well mandated that they want something done."

If the Texas groups do consolidate, it "may cause some people to reconsider," said Mr. Bentley. It would be the largest merger so far: the PIA has 1,200 members in Texas; the IIAA 1,800.

Other state chapters, though, have decided to go along with the national decision to stop consolidation talks.

"Let's put it behind us," said

Continued on next page

Maybe not much —28G

PIA fallout

Continued from previous page

Robert Wallin, PIA national director for Washington.

Both Washington chapters agreed that their members did not want to pay dues to two organizations, so consolidation talks were suspended, Mr. Wallin said. "We're leaving the door open in case anything changes on a national level."

Both state affiliations are still quite congenial—a "day and night difference" from the name-calling campaign on the national level, Mr. Wallin said.

Still other PIA state affiliates, including those in California, New York and Ohio, are opposed to consolidation because most members haven't indicated an interest, said Michael Gruschon, president of the Ohio PIA.

"At this point, we don't see what we'd have to gain," Mr. Gruschon said. Only about 25% of the members in the Ohio chapters belong to both groups, so there has been "no real strong desire" on either side for a merger, he said.

Mr. Gruschon, who voted for the PIA-approved proxies from Ohio members, voted against the consolidation survey referendum. He said the proposal was unclear on the specifics of the survey, beyond the fact that it would be conducted by an impartial third party.

But some members felt that the PIA national's proxy counterattack was unfair and resulted in an unbalanced and inaccurate vote on the merger issue.

'To say it wasn't an unusual meeting would be a lie,' says Mr. Hartnett of the PIA of Rhode Island.

The PIA proxies as written dealt only with proposed bylaw changes, but the same proxies were granted general authority in the business meeting to defeat the survey referendum, charged Gene A. Elliott, director of the PIA of Kansas. According to the PIA, while the proxy was designed to address bylaw changes, it does contain a paragraph granting authority to vote on general issues.

Also, the national PIA would not accept 1,150 proxies from the Insurance Agents Assn. of Minnesota, the first consolidated state group, citing dues that were late by several months.

Steven Micke, president of the Minnesota group, concedes the dues were late, but argues that the PIA is partly to blame.

His group presented both the PIA and the IIAA with an alternative dues structure for reduced rates in September. The IIAA, which is only receiving dues from its 1,152 pre-consolidation Minnesota members, agreed to work with the association on a dues structure. The national PIA, however—which had only 730 members at the time of consolidation and is receiving "windfall" dues from the IIAA members—never responded to Minnesota's request for approval, Mr. Micke said.

When the agent groups in Kansas officially merged in September, members agreed to offer both national associations dues based on previous membership, so neither organization would lose members, Mr. Elliott said. But because the PIA never approved the plan, dues to both groups have been withheld until the plan is approved.

Kansas' proxies were accepted, however, because its dues are fewer than 60 days overdue.

Michigan chapters, which voted to withhold dues from both associations in September, agreed to release the dues a month later, said Art Lee, president of the Professional Independent Insurance Agents of Michigan. "We were hoping this would force the issue, but it didn't work that way," he said.

Dues are not an issue in West Virginia, which amended its affiliation agreement with the PIA to pay dues to both national associations, said Christopher J. Pallotta, president of the Professional Independent Insurance Agents of West Virginia.

But because of the cost involved, the consolidated associations will have to decide which national association to affiliate with in the very near future.

"Membership is going to speak across the board with their dollars," Mr. Pallotta predicted. "So both organizations should be on their best behavior, because we're right on the edge as to what we'll do."

Agents agreed that the proxy battle—and the negative atmosphere in the wake of the consolidation failure—resulted in the most unusual business meeting ever at an annual convention.

"To say it wasn't an unusual meeting would be a lie," said Mr. Hartnett.

Although not "contentious," the meeting was long and "cumbersome" because the national PIA was unprepared for the flood of proxies to be counted on each vote, he said.

It was also "a fairly emotional meeting," said Mr. Hartnett. With Mr. Blum's sharply worded letter to state affiliates and the general tone of the consolidation failure, "there are still hard feelings out there."

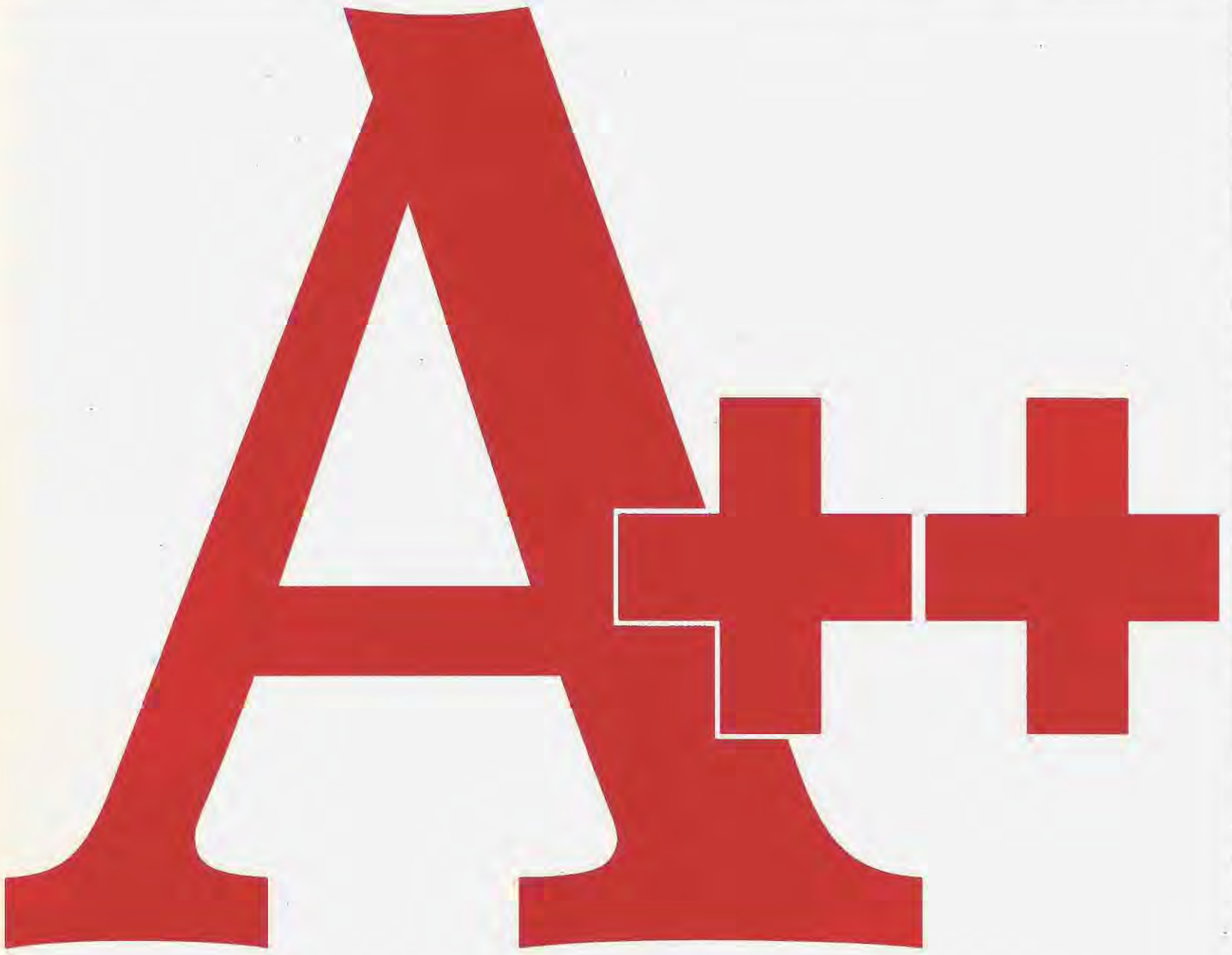
Other delegates, however, felt more strongly about the board meeting.

"We're their customers, and they keep treating us like dirt," said Mr. Micke from the Minnesota association. "I'm done with the fight of trying to get the national PIA back to the table, because they won't go."

Although he expressed some hope that a new task force formed to address problems in consolidated states might help, Mr. Micke and others remain ambivalent about the PIA's motives. "We'll find out by Dec. 10"—the date of Minnesota's next board meeting, he said.

Normally, conventions are a "fun time," and business meetings are productive, said Mr. Lee of the consolidated Michigan association.

But the proxy fight created a "very hostile environment," he said. "I never felt comfortable there. After those four days in Orlando, I feel that they (the PIA) just don't care." BI



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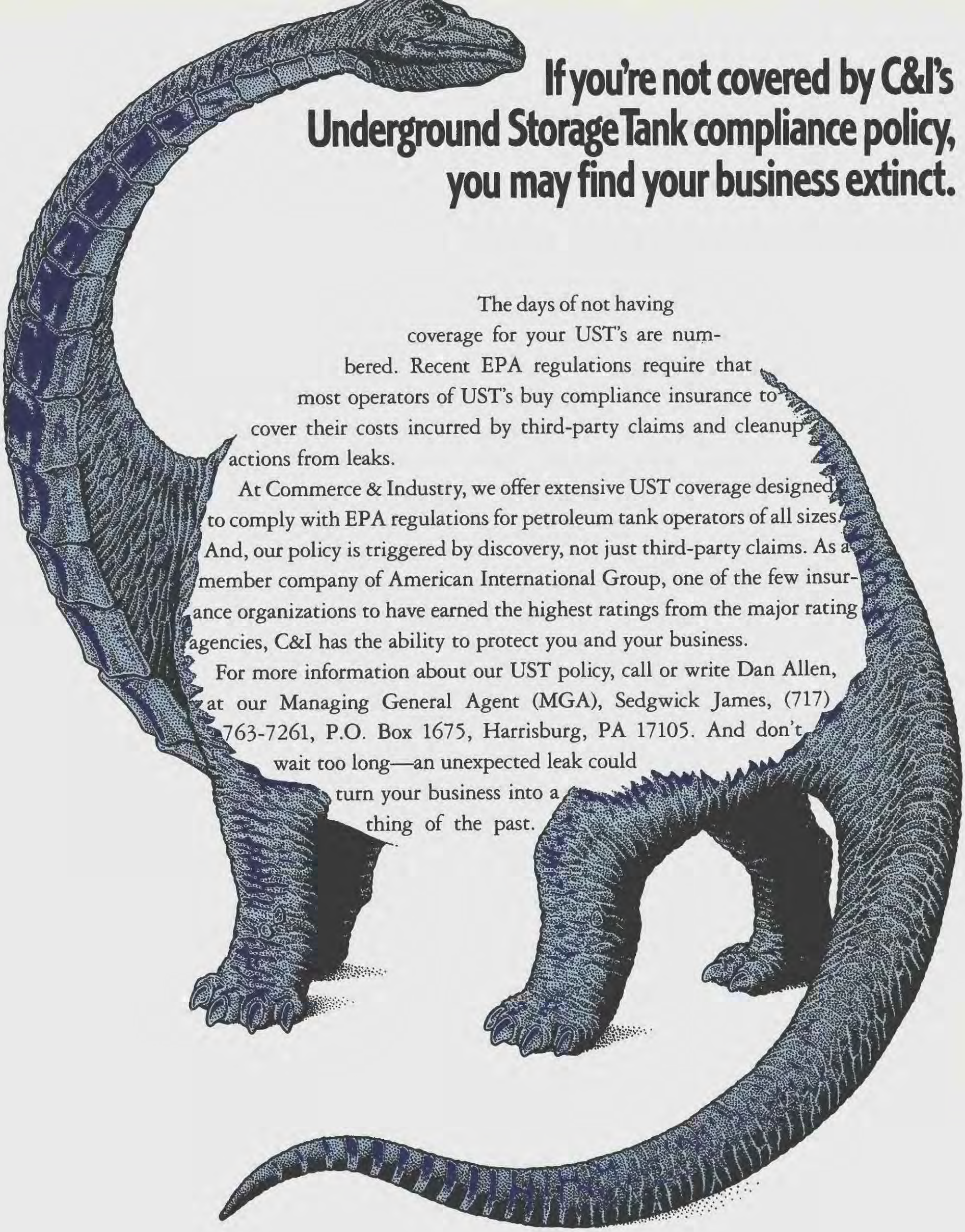

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Agent/Broker Topics

So many contracts, so many hazards

Not just production deals can cause liability problems: Expert

By LAURA MAZZUCA

LAKE BUENA VISTA, Fla.—When the words "agency contract" come to mind, most agents think of the agency-insurance company production contract.

But there are other contracts—with producers, automation companies, even clients—that can become pitfalls for an insurance agency unless they are carefully negotiated.

"The risk management technique of avoidance is the way to treat potential contract pitfalls and their consequences," said Ronald T. Anderson, an agency consultant based in Newport Beach, Calif.

Problems occur most frequently in five types of contracts: agency-insurer production contracts; agency-producer contracts; managing general agent contracts; client contracts; and automation contracts, said Mr. Anderson at the National Assn. of Professional Insurance Agents convention last month.

Both professional and general liability exposures can arise. First come general liability exposures, like slip-and-fall incidents or automobile accidents, which are covered in comprehensive general liability policies, he said.

More serious are professional liability exposures, which arise because the agent, as an insurance expert, is held to a higher standard of professionalism than the average layperson, Mr. Anderson said.

The law defines a contract as a legally binding agreement between two or more competent people. In a contract, both parties agree to certain responsibilities. If only one party has a duty under the agreement, it is not really a contract.

While oral contracts meeting this criterion are just as binding as written contracts, they are more difficult to prove in court, Mr. Anderson said. Additionally, after a written contract is signed, no later oral statements can be used to contradict or alter the written terms, he said.

Statutes of limitation also apply to contract liability. For tort liability, this is usually between one and five years; for contractual liability, between seven and 10 years, he said.

Each type of agency contract contains its own problems, Mr. Anderson said. These include:

• Insurance company representation contracts.

In insurance company representation contracts, agents must beware of hold-harmless agreements, which could affect the agency's errors and omissions coverage, Mr. Anderson warned.

Tort liability, which generally refers to negligence, can crop up with contracts containing hold-harmless clauses, in which one party agrees to hold another party harmless for financial loss due to negligence of either or both parties.

In fact, hold-harmless agreements, which can turn up in virtually any agency contract, are far from foolproof and "are only as good as the party giving it to you," Mr. Anderson said.

Also, some contracts give the insurer the right to defend the agency when both agency and insurer are being sued for negligent acts or omissions. This can create a conflict and should be avoided, Mr. Anderson said.

Tie-in sales provisions are another problem. When sellers require buyers to accept more than the offered item—such as requiring an agency client to buy a homeowner policy with an auto policy, or requiring the agent to make life insurance sales—they may violate local laws, he said.

Agents entering into company representation contracts must also be sure that they retain independent contractor status, ownership of expirations, and have appropriate change/termination/runoff provisions, he said.

• MGA/surplus lines broker contracts.

When negotiating a managing general agent or surplus lines broker contract, agents again must watch for hold-harmless clauses, which can affect E&O coverage, Mr. Anderson said.

Also, some of these agreements are not actually contracts, since they do not bind two or more parties. Instead, he said, they are "invitations to submit risks for consideration."

Such agreements do not address issues like expiration ownership, E&O responsibility, or guarantee of submitted proposal consideration, as in an actual contract, he noted.

Unless promises by both parties are contained in the document, "you have a promotional piece, not a contract," he added.

• Agency-producer contracts.

In traditional agency-producer contracts, producers are dealt with as independent contractors. This means agencies do not have to pay their workers compensation costs or FICA taxes, Mr. Anderson explained.

But making a producer an independent contractor does not relieve the agency of the responsibility for his or her acts in the event of a lawsuit, he warned.

While some producer contracts include provisions to hold the producer responsible for negligence suits stemming from his actions, these often backfire because individual responsibility often is hard to prove, he said. It can also turn the producer into an adverse witness, which would hurt agency morale, Mr. Anderson added.

Another situation to avoid is the use of minority agency ownership as an incentive to the producer. If the relationship goes awry, the producer as minority stockholder —or partner, if the agency is not incorporated—"can trigger an ownership problem rather than an

Continued on next page

The PIA has stopped the consolidation talks— but not IIAA's commitment to the independent agent.

IIAA believes that independent agents should have their own unified, dedicated voice. Not only because it is in the best interest of its members, but also because over 90 percent of independent agents have demanded it.

After two years, PIA chose to end consolidation discussions with IIAA. The reason? Most notably, PIA wants to pursue the impossible task of serving two masters — independent agents and their competitors, the direct writers.

In addition, PIA says it could find "no compelling reasons" to consolidate with IIAA. This flies in the face of the success of those states that have achieved consolidation. Not only have they realized significant savings both in dollars and staff time, but they are also reaping the rewards of a strong, unified voice with consumers, legislators and regulators — a voice that is not fragmented or weakened by unproductive competition.

We "Reject" the PIA Action

On September 13, IIAA's National Board of State Directors unanimously "rejected" PIA's withdrawal from merger negotiations and restated its commitment to creating one organization advocating the unique interests of INDEPENDENT insurance agents.

One thing has not changed: IIAA's commitment to the independent agent. IIAA will continue to be the unrelenting advocate for independent insurance agents. It will continue to strive to give independent agents across the country the power and strength of a unified voice. And it will actively support and assist each of its state associations — merged or unmerged — to ensure the strength and prosperity of the independent agency system...now and into the future.

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Continued from previous page
employee problem," he said.

"The use of an ownership interest to aid in hiring or retaining producers should be based on a great deal of premeditated thought," Mr. Anderson said. "How many people do we know that we are willing to share ownership of our business assets with?"

Non-compete or non-piracy covenants, which prevent the producer from either competing for business against the hiring agency or from developing a separate agency on company time, can also become problems.

The courts are generally not in favor of such restrictive covenants, and may call on the agency to prove that the covenants are necessary to protect the agency, Mr. Anderson said.

- **Agent-client contracts.**

In these consumer-savvy times, client contracts—in which customers stipulate what they believe the agency should do for them—are becoming increasingly common, Mr. Anderson said.

Such contracts can run the gamut "from meaningless to reasonable to ridiculous," he noted.

One lengthy client contract referring to life and health insurance and presented to a property/casualty agent for signature stated that the agent must "make recommendations to eliminate gaps, overlapping coverage, over-insurance, under-insurance, elimination of poor policies and other insurance recommendations which will benefit client."

Some client contracts also contain provisions for dispute resolution, which negates the agency's E&O insurer's duty to defend, and could result in a denial of E&O coverage, Mr. Anderson said.

To avoid such contracts, he suggested that agencies offer prospective clients brochures detailing the services available, which are just as binding on the agency as a written contract.

- **Automation contracts.**

Whether they deal with a computer system, hardware, software, or maintenance, automation contracts frequently contain hold-harmless clauses, which shift liability from the supplier to the agency, he warned.

In general, Mr. Anderson warned agents to "watch what you're signing" by looking for the following:

- A copy of the contract, provided well in advance of signing.
- A general impression of fairness and logic in reading the contract.
- A clear statement of what obligations both parties are undertaking by signing the contract.
- Obligations that are binding on both parties. If this is not the case, you may have an "agreement" instead of an enforceable contract.
- All oral commitments should be included in the written contract, since once an oral agreement is on paper, other commitments are unenforceable.

Mr. Anderson advised avoiding the following:

- Contract wording that creates a responsibility on you for negligent acts of the other party, such as hold-harmless provisions.
- Contract wording that takes rights away from you, such as a clause that gives the other party the right to assume your legal defense if you both are sued for the same matter.
- A contract party who says, "we don't need a written contract since we're good friends." BI

New PIA leader vows to 'cool rhetoric'

Priority: refocus on agents' concerns

By LAURA MAZZUCA

LAKE BUENA VISTA, Fla.—Jerry Hargrove, the National Assn. of Professional Insurance Agents' new president, has his work cut out for him.

A year of emotional peaks and valleys marking the rise and fall of consolidation talks between the national PIA and the Independent Insurance Agents of America have left members of both groups wrung dry from the failed effort—and more than a little bruised on both sides from the slings and arrows of what Mr. Hargrove calls "bad rhetoric."

If that's not enough, insurance agents still face problems that were sometimes overlooked during the tumult of PIA/IIAA consolidation efforts. Those worries include loss of insurance markets, legislative threats to state regulation, proposed changes to the intangibles amortization schedule, and an ongoing erosion of the industry's public image.

He says he will try to heal wounds on both sides, while also fighting off the wolves at the door.

"I knew what I was getting into five years ago when I got on the board," said Mr. Hargrove, president of Northside Insurance Services in Roswell, Ga. "I look at it as a challenge."

His first order of business is to "cool the rhetoric and let some healing happen," Mr. Hargrove said. "I want to get our focus back on agent issues and away from political issues."

To that end, Mr. Hargrove immediately appointed—after the November conference—a task force composed of the presidents of state PIA groups, national PIA board members and representatives from states in which the two trade groups are consolidated. The task force will work with the consolidated agent groups to address questions about dues structuring and collection, definition of membership, examining membership "windfall" from dues of new consolidated members, and pinpointing services needed by the associations.

"I didn't intend to wait until December to make these appointments," Mr. Hargrove said.

Another task force, composed of state leaders appointed in May by outgoing PIA President Daniel J. Blum, has offered suggestions to the PIA's board of directors on

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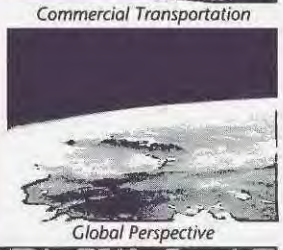
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Agent/Broker Topics

Hargrove

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restructuring the PIA's basic state operations—such as term reductions for PIA officers—and replacing the state affiliation agreement with a "menu of services" and fee schedule.

This would allow affiliates to choose services from the national association such as market access programs and insurance programs like the PIA's errors and omissions and group health coverage, Mr. Hargrove said.

And, a bylaw change approved at the annual business meeting held last month—allowing direct national PIA membership to agents if a state affiliate leaves or is disenfranchised—will make it easier for agents to retain PIA membership and group insurance coverage if a consolidated state agent organization chooses not to affiliate with the PIA.

Unlike Mr. Blum, who was embroiled in the controversial national consolidation efforts, Mr. Hargrove can afford to take a more laissez-faire position on state consolidation.

"I believe an independent state or affiliate has the inalterable right to decide what its membership wants," he said. Problems arise only when the consolidated minority attempts to inflict its opinion on states that prefer the status quo, he said.

And Mr. Hargrove doesn't believe that national consolidation is out of the question, either. Rather, the two agent associations got off to a bad start because they never really had a chance to work together, he said.

Many state associations, especially in smaller regions with fewer resources, have pooled their talents for years, long before consolidation became a watchword.

To remedy this, PIA members at the annual business meeting unanimously passed a resolution to work with the IIAA to jointly address federal legislative issues; technical issues; company relations issues; agency markets; joint rating bureau liaisons; and to make joint presentations to the National Assn. of Insurance Commissioners.

"After 25 months of committed effort in working with the IIAA, we recognize the strengths of their association and of the PIA," the resolution states. "In order that our collective members be best served in these areas, we call upon the IIAA and the PIA to put aside their organizational and position differences and that we cooperatively combine our strengths in agreeing to work together through combined committees."

Mr. Hargrove

Mr. Hargrove has extended "an open invitation" to IIAA President Eric G. Gustafson to join him in fighting for insurance agents on these and other issues.

"Rick and I don't have to deal with all the trash that R.C. (Riley, former IIAA president) and Dan (Blum) had to" during the consolidation discussions, he said.

In his inaugural address, Mr. Hargrove targeted these areas:

- Provide new contracts, markets and profit centers. He specifically cited the PIA's "Business Link" program, which has helped more than 500 members land insurer contracts, as a step in the right direction.
- Strengthen state insurer regulation by opposing legislation that would give the federal government a role in solvency regulation and by supporting increased funding and staffing of state insurance departments.
- Bring more affordable education programs. The PIA plans to regionalize its national education programs, which would reduce travel and other costs.
- Build a positive public image for independent agents. The PIA will conduct national media tours to "to promote the independent agent's unique value," and continue its newspaper columns, now appearing in more than 13,000 newspapers monthly.
- Harness new business technology to improve efficiency and marketing. The PIA recently created a Strategic Business Technology Committee, which will encourage agents' use of new technology, such as pen-based computers and laptops. BI

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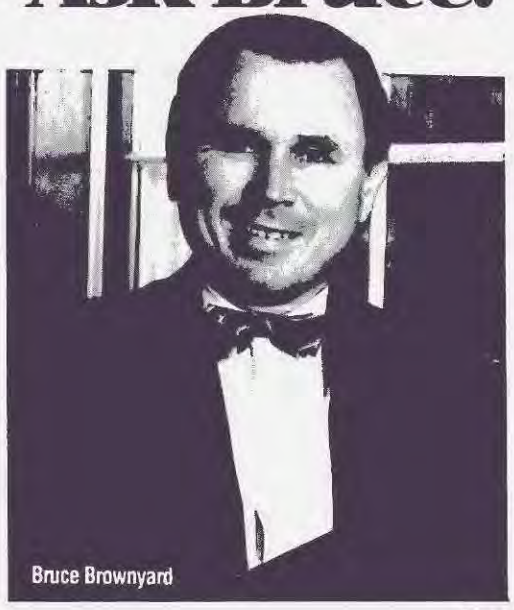
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Business Insurance

He gives some the (slick) willies, but Clinton has agent supporters

By LAURA MAZZUCA

LAKE BUENA VISTA, Fla.—At the National Assn. of Professional Insurance Agents annual convention, agents who walked past the *Business Insurance* booth were met by the smiling face of President-Elect Bill Clinton on the front page of the Nov. 9 issue.

"What do you have *him* on there for?" grumbled one, jerking his head at the picture.

He is hardly alone. Many agents are less than enthusiastic about Gov. Clinton's victory.

They may be apprehensive because they haven't worked with him and don't know his style, said Patricia A. Borowski, vp of government and industry affairs for the PIA.

More to the point, Gov. Clinton's outspoken views on health care reform—and his campaign promise to "take on the insurance companies"—have "raised some eyebrows" in the agent community, she said.

Add to that the fact that he's a "Democratic president with a Democratic House and Senate," and you have the formula for fear and loathing in the agency ranks, Ms. Borowski added.

Then again, maybe it's Hillary. Tina Carpenter, executive director of the PIA's Arkansas affiliate and a Clinton supporter from way back, proudly wore her "The fat lady sang in Little Rock" T-shirt to the director's meeting at the PIA convention. Although responses to the shirt were running about 50-50, most Clinton supporters "were very quiet about it," she said.

Although she speculated that the president-elect's positions on abortion and gay rights might have lost him a portion of the more conservative agents' support, several detractors told her outright that "they just can't stand Hillary," she said.

The new first lady aside, agents say they are justifiably concerned about how a Clinton administration will handle longstanding insurance issues like McCarran-Ferguson reform, federal solvency regulation and the tax treatment of intangible assets.

Among issues of particular interest to the insurance industry, only health care reform was a mainstay of the Clinton candidacy. Solvency regulation came up only once, when Gov. Clinton voiced his support of state oversight.

So "it's pretty much all speculation at this point" on where he will stand on these issues, said Robert A. Rusbuldt, director of federal affairs for the Independent Insurance Agents of America and a stalwart Republican.

With health care reform—"which will impact the whole insurance industry somehow"—and the economy commanding much attention, there is "not enough room on the plate next year" for more peripheral issues, said Ken A. Crerar, executive vp of the National Assn. of Casualty & Surety Agents.

During the campaign, Gov. Clinton took pains to distance himself from the "tax-and-spend," anti-business image that has hurt other Democratic candidates. Many agents are unconvinced.

"There's a tendency in our industry to see Democrats in a certain light, but I think Clinton is going to approach things differently," said Mr. Crerar, himself an unabashed Democrat. "I think he's going to reach out to business."

Health care has many insurance observers on edge.

"My impression is that he (Gov. Clinton) has pretty well defined a program for health care reform that has to be fine-tuned," but it's pretty obvious that the plan will require employers to provide health insurance, Mr. Rusbuldt said. "The question is how it will be financed."

Despite the newfound popularity of health care reform, change may be several years off. Some congressional observers are spe-

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Clinton

Continued from previous page

culating that it might be two years before any legislation is passed, said Ms. Borowski of the PIA.

Taxes are, of course, never far from the surface. Mr. Rusbuldt of the IIAA points out that Gov. Clinton expressed support for raising the corporate tax rate to 36%. This will be "a big issue for small business," he added.

Taxation of intangible assets, like customer lists, is also of considerable interest to agents. Mr. Rusbuldt predicts that Gov. Clinton will follow the lead of Rep. Dan Rostenkowski, D-Ill., who has proposed allowing fixed 14-year amortization of the entire purchase price of a new business, including its intangible assets.

Still, such a proposal, which would be welcomed by agents, could be bundled in a tax bill that might ultimately hurt small businesses, he said.

"Taxes will be the issue next year," including taxes on annuities and investment proceeds on life policies and annuities—items of great interest to agents, said Mr. Crerar of NACSA. While it may not hurt agents, "it sure will keep them busy," he added.

Clinton administration tax policies may not be bad for agents, said Mr. Crerar. "I think we're all going to be paying more taxes next year," but proposed incentives, such as investment tax credits, will be good news for small businesses that want to invest in new technology, he said.

Lobbyists are unsure what the new president will think of a proposal by Rep. John D. Dingell, D-Mich., to set up a dual federal-state regulatory system (*BI*, April 20).

Rep. Dingell's bill was not acted on this year and will probably not be taken up in 1993, said Mr. Crerar. He added one caveat: "Everybody is watching Florida" for solvency problems from Hurricane Andrew, and if insurers fail there, the issue may be given new immediacy.

Other issues of interest to the insurance industry could also confront Gov. Clinton. Among the possibilities are federal flood and crop insurance programs and safety and highway regulation for commercial trucking.

Perhaps the biggest concern for the industry, at least in the long term, is pollution—specifically reauthorization of the Superfund law. Vice President-elect Al Gore, a committed environmentalist, could give this issue a new spin, Ms. Borowski said.

But no matter what the issue is, insurance people who have worked with Gov. Clinton in the past agree he is fair, intelligent and determined when faced with large issues.

"In our experience with him as a governor, he's been fair toward the industry," said Larry Clark, president of the PIA chapter in Arkansas. "He's done a good job with appointments, particularly with the commissioner. Clinton has been supportive to the industry in trying to keep markets in Arkansas."

William H.L. Woodyard III was the Arkansas insurance commissioner from 1976 to 1982 and worked with Gov. Clinton in his first term as governor.

"Clinton's approach to any problem is to insist upon hearing all sides," said Mr. Woodyard, a partner with Mitchell, Williams, Selig, Gates & Woodyard, a Little Rock, Ark., law firm that represents companies in their dealings with state government. "He likes to have well-reasoned commentary from the best people on all sides, and this is good news to anyone who has a position on an issue."

As an example, Mr. Woodyard cites the governor's response to rising auto insurance rates in his first term. Higher rates made the coverage less accessible, but Gov. Clinton avoided "heavy-handed" regulation. Instead, he developed a program to convert prior approval rating to competitive rating. This helped keep insurers in the state.

"We've had a very stable insurance environment in Arkansas, not a particularly litigious state," in part because of how the administration treated insurance, Mr. Woodyard said.

"He is a person who definitely wants to accomplish," added Ms. Borowski, who became familiar with Gov. Clinton's working style when the PIA worked with him and Nebraska Gov. E. Benjamin Nelson in selling other governors on the importance of state solvency regulation.

Gov. Clinton is not anti-business, Ms. Borowski said. During his first term as governor, he used Atlanta's economic incentive plan as a blueprint for Arkansas and enticed new business into the state with beneficial business loans and workers compensation reform, she said.

Gov. Clinton has also expressed an interest in sponsoring a White House conference on small business which would address issues like changing requirements for Small Business Administration loans in order to encourage reinvestment in business, she said.

This hands-on approach is a "very good indication of his working style" and shows how the Clinton presidency may be run.

"He has traditionally tried to look at all the factors involved, so I don't think he'll take a radical approach," said Mr. Clark of the Arkansas PIA.

Which should spell relief for agents who get nervous over that word—"radical." BI

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Insurance in the Philippines

Tighter market control may signal price hikes for buyers

By Robert K. Meyers

International Issues

SINCE THE FALL OF THE dictatorship of Ferdinand Marcos, the Philippines has suffered a number of violent natural disasters while struggling to reconcile competing political and economic interests in a country where the 1990 per capita income was $700 and unemployment hovered above 9% during the same year.

The relationship between the Philippines and the United States—long based on both mutual need and interest—has been altered significantly both by the close of the Cold War and the rise in economic power of other Asian nations such as Malaysia, Singapore, South Korea and Taiwan. Late last month, the two U.S. military bases there were turned over to the Philippine government.

The Philippine insurance industry should be viewed in the context of other Pacific Rim countries and the larger issue of economic development. In the majority of the Pacific Rim and Latin American counties discussed recently in this column, the prevailing trend is toward liberalizing the insurance market. In the Philippines, however, an even more restrictive regulatory process may soon become the norm.

With the election of Corazon Aquino in February 1986, some foreign policy viewers thought that economic development would accompany the new legitimate political regime in Manila. Following two consecutive years of contraction in 1984 and 1985, the economy did experience positive growth from 1986 to 1990.

Including state insurance, premiums written in 1990 for non-life business were $306 million while life premiums were $454. For non-life business, written premium as a percentage of GDP was less than 1% (in the United States, it was 5.1% for the same year); within the Pacific Rim Basin and Asia, this places the Philippines ahead of Indonesia but behind Japan, Malaysia, Singapore, South Korea and Taiwan.

The Philippine private insurance industry is composed of about 128 insurers: 23 life insurance companies, 100 non-life companies and five others. The Philippine market would be considered a tariff market and has been closely regulated. Placing non-admitted coverage in the Philippines is illegal for any risk. Fines are usually minimal, but insurers can face penalties of up to $20,000. The law restricts equity participation for multinational investment in Philippine insurance companies to a maximum of 40%. This requirement may change in the short to medium term, but there have been no firm indications as to when.

The Aquino government's ascension to power was expected to positively impact insurance deregulation. This was to accompany the expected liberalization of the economy in general. However, except for the relaxation of a 25-year ban on new insurance company capitalization requirements, the trend has been quite the opposite. The government has decided to issue licenses to new insurance companies that meet regulatory requirements. This was followed by a Department of Finance declaration addressing foreign ownership, capital and surplus requirements.

The new requirements include:

- For insurance companies, paid-up capital requirements equal to at least 75 million pesos ($2.9 million) and surplus of at least 25 million pesos ($975,000).
- For reinsurers, paid-up capital of at least 120 million pesos ($4.7 million) and surplus of 30 million pesos ($1.2 million).

By raising minimum capital requirements, the Philippine insurance commission is acting in a manner similar to Malaysia: legislating for new, more financially healthy insurers, which thereby lessens the market's reliance on foreign reinsurers and indirectly benefits the national treasury.

Increased competition may cause smaller, less-well-capitalized insurers to drop out of the market, but in the long term, the results should benefit the insurance buyer.

However, the decision to issue new licenses was not the norm. The Aquino administration did not act for deregulation or more equitable distribution among Philippine and foreign joint venture insurance companies. Instead, the administration stipulated that every government corporation or commercial business entity that is either totally or 33% government owned or controlled would be insured by the government social insurance system.

In light of Philippine proposals to turn the former U.S. bases into free-trade zones, foreign investors should know the government's equity stake in a project, if applicable, when structuring their insurance programs.

Another way the Philippine authorities restrict options for insurance buyers is through the Development Bank of the Philippines. The DBP has an insurance pool that in essence acts as a monopoly operator for all project loans secured from or through the DBP.

The insurance industry has seen a number of proposals illustrating an even more active regulatory attitude.

The Philippine Insurance Rating Assn., known as PIRA, is a quasi-government agency empowered to develop, monitor and enforce tariff rates. PIRA formally is an adviser to the Philippine insurance commissioner, though it incorporates members of the insurance industry through annual election to its board of directors. In general, board members are representatives of the non-life insurers. The Philippine Insurance Commission is an agency of the Department of Finance and is the authority behind enforcement of the tariff, regulation of industry legislation, and adjudication of legal or technical issues. The tariff is applicable only to fire and allied perils, auto and surety.

PIRA, under the direction of the insurance commissioner's office, has recently reduced the earnings available to brokers and agents. A recent rule authorizes the reduction in commissions from 35% to 25% on fire and lightning coverages or policies, as well as the decrease from 25% to 15% on property allied perils coverages.

More recently, the PIRA has made several proposals which, if passed, could seriously affect the structure and pricing of multinational corporations' exposures in the Philippines. Among the proposed changes are:

- Long-term policies and discounts would be eliminated for base rates for buildings and contents. Discounts for deductibles would remain, but deductibles would be doubled. This effectively prohibits the insurance buyer from earning discounts for assuming long-term relationships with insurers.
- To qualify for a declaration policy—one that applies to stock in warehouses or storage and that offers the policyholder a discount on the premium—the minimum sum insured has been raised from 1 million pesos ($39,000) to 10 million ($390,000), effectively shutting out the smaller policyholders from the benefits of a declaration policy.
- The scale of allowances—the minimum discount applicable to a tariff rate for each fire protection mechanism at a policyholder's location—has been eliminated. As a result, there is no measuring point as to whether a rate is appropriate for an exposure. It appears that this is now left to the underwriter's discretion.
- An extra rate of 0.05% is proposed to cover spontaneous combustion and/or self-heating. There is still some debate as to whether in these cases, damage from the ensuing fire is already covered under the standard conditions of the policy.
- For buildings under construction, PIRA has proposed that a policy issued at the estimated completed value for the whole period of construction will be charged at the full—rather than half—annual rate, pro-rated. Therefore, the insurer is at risk for the full sum insured only when the building is finished, but the premium payment is based on full value during the construction process. This dramatically increases the original cost to the policyholder's program and unnecessarily benefits the insurers.
- The Allied Perils Tariff rate for typhoon is raised from 0.02% to 0.1%; the rate for flood raised from 0.05% to 0.1%; and the rate for extended cover from 0.01% to 0.02%.

The proposed changes, also known as the Interim Tariff, would portend sharp increases in property program costs to the insurance buyer. Many of the proposed changes would only take effect if statistics support such changes. However, observers believe that should the changes be approved on a temporary basis, it would just be a matter of time before they acquire permanent status. This could happen without the submission of the desired statistics.

There is more bad news for insurance buyers in the Philippines. Since last summer, market capacity has begun to contract both locally and from foreign insurers. There are several causes: loss experience has worsened considerably in the Philippines, which, combined with adverse public perceptions of the local economic situation, has fueled a decrease in insurer capacity. Industrial all-risk policies—those exposures with total values exceeding 2.5 billion pesos ($97.5 million)—have generally become more expensive because they are allowed to circumvent the tariff. Also, insurance availability is decreasing for specialized smaller risks, like garment manufacturers and spinning mills.

A big factor affecting the Philippine insurance industry is the number of natural catastrophes that have struck the island in the last two years. A perennial recipient of violent typhoons, the islands suffered the volcanic eruption of Mount Pinatubo in 1991 (*BI*, June 24, 1991). And in July 1990, an earthquake measuring 7.7 on the Richter Scale struck the main island of Luzon causing as much as $800 million in losses (*BI*, Aug. 6, 1990). The earthquake hurt the London and European reinsurance markets because normal practice among Philippine insurers is to cede as much as possible of the coverage they write.

The catastrophic reinsurance crunch has been extensively discussed in recent issues of *Business Insurance*. Increasingly, insurance buyers are seeing "more for less" in those risks where cat exposures are most significant, especially with earthquake and flood risks. Reinsurers have been hit hard by a disasters, but some think that they could have been hit harder.

Some timely legislation comes to bear on this situation: a new Philippine law relaxes rules for issuing licenses to insurers, with the expectation that more investors may mean less dependence on reinsurance. It is ironic that the Philippines, so severely buffeted by natural catastrophes that have contributed to the dramatic contraction in cat capacity and price increases, should be at the forefront of adapting to this new trend. It appears that the Philippine insurance commission, by way of the proposed changes to the tariff, is acting to ensure that domestic companies will survive and prosper in the changing conditions.

PIRA seems intent to tightly control the market, to the potential disadvantage of the insurance buyer. The impact of these new proposals on is not yet known, but for the insurance buyer or multinational corporation with operations in the Philippines, it seems likely that pricing for risks will increase. BI

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

Recouping health care costs

By Dennis Minichello

THE EVER-ESCALATING COST of medical care has become a hot topic in the popular press. Numerous articles concerning this topic have appeared in newspapers, magazines and on television. Many explanations for these soaring costs have been offered and just as many remedies have been proposed by those who participate in the health care delivery system. But while the topic has been popularized, no consensus has yet been reached as to an overall solution.

The high cost of medical care is hardly a new topic for employers. Employers have directly faced the problem for several years as the cost of providing health care coverage to employees has risen dramatically.

The cost of health care coverage is an ever-increasing drain on companies' profits. Whether the company self-insures its medical benefits or pays insurance premiums for insured programs, these costs continue to rise disproportionately compared with other operating expenses.

As costs continue to escalate, employers are looking to minimize or recover a portion of those costs. This is especially true where an employee or a covered dependent is injured as the result of a third party's negligent act. Because the employer pays for the medical care necessitated by that negligence, it makes good economic sense for the employer to try to recover those costs any way possible.

The law recognizes the right of an employer to recover amounts it has expended as a result of third-party negligence in the doctrine of subrogation. This doctrine applies in all instances in which one person not acting as a mere volunteer or intruder pays a debt for which another party is primarily liable, and which in equity and good conscience should have been discharged by the other party.

The doctrine is designed to place the ultimate responsibility for a loss on the responsible party—the one who ought to reimburse the innocent party who is compelled to pay.

Subrogation is particularly applicable when any employee or covered dependent is injured from the negligence of a non-employee third party, and when the employer is legally obligated to cover the injuries under its group health care. The doctrine

Subrogation allows recovery of costs from third parties

permits the employer to proceed directly against the third party to recover the medical benefits paid to the employee or, alternatively, permits the employer to exercise a lien against any recoveries made by the employee directly against the third party for injuries sustained.

Most health care plans plans provide for subrogation by inserting a provision in the plan contract. This important but often overlooked provision of group health and disability insurance plans is known as the "subrogation assignment and lien" provision.

Under that provision, the employer may institute a lawsuit directly against the third party for recovery of the injured party's medical costs. Alternatively, the employer can participate in a lawsuit filed by the employee against the third party by asserting a contractual lien on any recovery made by the employee. Either way, the employer may recoup some or all of the medical benefits paid under its health care plan.

The right to subrogation has been recognized in all states and has typically been asserted by insurance companies to recover money paid out in accordance with insurance policies issued to policyholders.

Until recently, though, there were conflicting court decisions regarding state restrictions on contractual subrogation provisions contained in self-insured benefit plans. However, in 1990 the U.S. Supreme Court decided in *FMC Corp. vs. Holliday* that the Employee Retirement Income Security Act of 1974's pre-emption provision precluded state judicial or statutory limitations on subrogation provisions in self-insured employee benefit plans.

While the FMC Corp. decision does not seem to cover insured plans, and while some state courts may look for exceptions to the Supreme Court's decision, it is true that medical subrogation clauses in insurance contracts are generally enforceable.

FMC Corp. had a self-funded employee welfare plan that provided health benefits to FMC employees and their dependents. In the case, the daughter of an FMC employee was seriously injured in an automobile accident, and FMC paid a portion of her medical expenses under the plan's health provisions. The employee brought a negligence action on behalf of his daughter in a Pennsylvania state court against the driver of the automobile in which she was injured. That claim was settled.

FMC then sought reimbursement of the amount it had paid for the daughter's medical expenses from the amount of the settlement. The employee refused, relying on a Pennsylvania state statute that it alleged precluded subrogation by FMC.

The U.S. Supreme Court ruled that ERISA's pre-emption provision precluded application of the state statute and permitted FMC to seek reimbursement from the employee's settlement.

An employer should keep in mind several important factors when pursuing its rights of subrogation:

- First, be mindful of any statute of limitations for the filing of lawsuits against third parties or the assertion of liens on the recoveries made by its employee against third parties.
- Second, it is important that the medical plan have a written subrogation clause and that clause be clearly and precisely drafted so that there is no doubt about the extent of the subrogation right.
- Third, remember that the right of subrogation extends to amounts paid for both injuries and death no matter how small the amount.
- Finally, the amount recovered may be limited by the contributory negligence of the employee in his or her own injury even in a situation involving a third party. The employer will stand in the shoes of its employee and can assert no better claim against the third party than is available to the employee.

The doctrine of subrogation can be a very valuable cost recovery tool. By identifying those instances where the clause is appropriately exercised and by diligently using available legal remedies, an employer can offset the medical costs it has incurred when an employee or covered dependent is injured. BI

Dennis Minichello is a partner with the national law firm of Keck, Mahin & Cate in Chicago.

No comp cover for death during jury duty

An employee's accidental death while serving as a juror or during his journey from the courthouse to his job site was not covered by the Workers Compensation Act, according to a decision of first impression in Washington issued by the Court of Appeals of that state.

Woodruff Belnap, an employee of The Boeing Co., was summoned for jury duty from Oct. 2-31, 1985. Boeing's policy was to allow time off with pay for jury duty. On Oct. 24, Mr. Belnap traveled from his home to the courthouse where he reported for jury duty at 9 a.m. At noon, the court excused him for the remainder of the day. He then drove to work intending to complete the remainder of his shift, which was in compliance with Boeing's stated policy.

En route to work, he stopped for gasoline and while exiting the service station his vehicle was broadsided by another vehicle. He died shortly thereafter from his injuries. His widow filed for a survivor's pension but was

Legal Briefs

denied. She appealed to the courts and lost again in the trial court.

On appeal, Mrs. Belnap argued that by paying Mr. Belnap's regular salary while he served as a juror, Boeing was furthering its own corporate policy of encouraging its employees to be responsible citizens and by so doing enhanced its corporate image in the community. Thus, she contended, Mr. Belnap was at all times acting in the course of his employment while serving as a juror.

But, the court said that Boeing exercised no control over Mr. Belnap's service as a juror and serving as a juror was not part of his job description. Furthermore, the court noted that Boeing was not in the business of administering justice, by way of jury trials or otherwise.

Belnap vs. Boeing Co., Court of Appeals of Washington, Feb. 10, 1992 (*BI*/02/N.-$10).

Retirement benefit fraud claim

A fraud suit brought by an employee in a state court alleging that the level of his retirement benefits was misrepresented to him was pre-empted by the Employee Retirement Income Security Act of 1974, according to a federal appellate court.

Roger Olson was employed with the Range System product line of General Dynamics Corp. from 1955 to 1986 when the line was sold to Amex Systems Inc., a subsidiary of Allied Signal Inc. At the time of sale, Mr. Olson was advised that he would be offered a job with Amex that would be equal to or better than his present position. Mr. Olson accepted a job with Amex. In 1988, Amex sold the line to SAIC Range Systems, where Mr. Olson worked until his retirement in June 1988. Mr. Olson participated in the employee benefit plans while employed at all three companies.

Mr. Olson brought this suit in state court alleging fraud, claiming that the benefits he received from SAIC were less than he would have received had he retired from General Dynamics. The case was removed to federal court, which ruled for the employers on the ground that Mr. Olson's fraud claim was pre-empted by ERISA.

The appellate court noted that ERISA supersedes any and all state laws insofar as they "related" to any employee benefit. The court concluded that Mr. Olson's fraud claim did have a connection with and made reference to a benefit plan; thus, the state fraud claim was pre-empted by ERISA.

Olson vs. General Dynamics Corp., 9th U.S. Circuit Court of Appeals, Dec. 20, 1991 (*BI*/01/N.-$10). BI

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

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GREENWICH HARTFORD CHICAGO SAN FRANCISCO

Collecting claims from British insurers

Be aggressive in pursuing lawsuits, London insurance attorneys advise

By EILEEN P. GUNN

NEW YORK—There's blood on the streets of London—particularly Lime Street.

That's not news to American policyholders who have watched Lloyd's of London syndicates and other London insurers fall into insolvency or simply grow skittish about paying the onslaught of U.S. claims.

But policyholders need to be more aggressive in pursuing their claims, contends Paul Wordley, a London solicitor. He and several other insurance lawyers spoke about the Lloyd's situation at the recent second annual Corporate Insurance Policy Institute, sponsored by Anderson Kill Olick & Oshinsky, a New York law firm.

Several London insurers have gone out of business and others are reeling from the recent series of U.S. disasters. Still, "there are billions of dollars in assets (in London), and Americans want to be there when they are given out," said Mark Keenan of Anderson Kill Olick & Oshinsky in Washington.

Collecting on claims from a British insurer in liquidation proceedings can be difficult for Americans for four reasons, said Andrew Wilkinson, a solicitor with Clifford Chance in London:

- Estimating claims is often a contentious procedure because of its complexity.
- Liquidators do not want to pay out anything until all liabilities have been determined.
- Much American coverage is reinsurance or excess coverage, which can be especially difficult to recover.
- Liquidation procedures in Britain are governed by rules originally created for manufacturers that do not always cover issues that arise in insurance insolvencies.

For companies in provisional liquidation—the step before actual liquidation—a scheme of arrangement can sometimes be drawn up as an alternative to liquidation. These "remarkably simple" informal or formal court-approved agreements between insurers, creditors and policyholders are similar to Chapter 11 reorganizations in the United States, Mr. Wilkinson said.

Although they are a "major step forward for the London market in dealing with insolvencies," he cautioned that schemes of arrangement are "not a universal panacea."

If an insurer has gone into provisional liquidation and is in ancillary receivership in the United States, policyholders can do several things to protect outstanding claims, said Mr. Keenan.

- Review policies and determine what coverage was or could be lost.
- Team up with other policyholders in the same situation to increase clout during the proceedings.
- Move for a modification of interim stay orders and then prosecute a coverage action up to judgment in a U.S. court.

This will bind the London company to a judgment or settlement that will provide the policyholder with a liquidation claim. With that, a policyholder can proceed through the "proof of claim" process in London at fairly low costs.

- File the proof of claim in London even if no deadline for liquidation proceedings has been established.
- Monitor proceedings.
- Pursue other remedies if there are any.

More and more U.S. policyholders are suing London insurers because they need to tap for the first time the excess and umbrella policies placed in London.

Seth Schafler, a partner at Anderson Kill, discussed the ins and outs of litigating against London insurers for first timers.

Policyholders can pursue litigation against Lloyd's and other London insurers in U.S. courts. A standard "service of suit" clause in policies binds the London insurer to the policyholder's choice of forum and choice of substantive law to be applied to the case.

But what if no possible U.S. jurisdiction looks favorable? Policyholders may be able to have the case heard in London if they can establish jurisdiction and prove a sufficient relationship between the jurisdiction and the business conducted, said Mr. Schafler.

For example, if the policy was written in London or claims were sent there to be processed, there would be a sufficient relationship, said Mr. Wordley.

When developing a litigation strategy, policyholders should also be aware of the "gang of six," which is a group that now comprises about a dozen U.S. law firms that regularly represent the London market in environmental cases, according to Mr. Schafler.

"The London market is a specialized market and is represented by specialist lawyers," explained Mr. Schafler.

Policyholders have to be prepared to match this expertise, he said, and their lawyers should know the London market and judicial process as well as the insurers' lawyers to effectively gather discovery materials and testimony.

A placing slip, something the policyholder typically does not see, can be critical to later litigation. The slip is an underwriter's agreement to issue a policy in accordance with the terms on the slip. In addition to being evidence of coverage, it is a shorthand insurance agreement effective in its own right before the policy is issued, Mr. Schafler said.

The placing slip is particularly critical when the claim is on a long-tail policy that has been lost.

London or Lloyd's brokers hold the placing slips.

But brokers are often unforthcoming with placing slips and

Continued on next page

Continued from previous page
other critical records such as placing files and claims files. This is because of "dual agency" —a uniquely British practice in which brokers provide some services and maintain some records for the insurer as well as the policyholder.

If the broker, or an essential third party, withholds documents or testimony, the American court hearing the case can put a "letter of request" into the British court, which will then compel depositions or production of documents.

Finally, policyholders should be warned that unlike in the American discovery process where a "class" of documents can be requested, British rules require that requests be specific. Follow-up requests may be necessary to gather all the desired evidence. BI

Beware of pollution exposure in buyouts: Wall

By EILEEN P. GUNN

NEW YORK—Environmental liability exposures can be the "deal breaker" in company mergers or acquisitions, a risk management consultant says.

"Be aware of any liability the company has, because you inherit it," cautioned Barron S. Wall, a managing associate with Insurance Consulting Associates in South Hackensack, N.J.

Risk managers must thoroughly search for any potential environmental liabilities they may acquire in a merger or acquisition, Mr. Wall stressed during the second annual Corporate Insurance Protection Institute, sponsored by New York law firm Anderson Kill Olick & Oshinsky on Nov. 18.

In a buyout, the purchaser can inherit hidden liabilities like those stemming from the acquired company's failure to comply with a variety of environmental laws and regulations or a high rate of incidence of occupational disease, Mr. Wall pointed out. Those liabilities can "cost you in the long run."

In the first phase of the acquisition process, the property of the company being acquired should be closely inspected, he advised.

In addition, environmental liability issues should be discussed, and information about them should be gathered from three sources:

- Interviews with the current and previous owners of the property, as well as tenants and neighbors.
- Public records that may contain information about current and past use of the property. Such records may be filed with federal agencies like the Environmental Protection Agency, the Department of Transportation, the Occupational Safety and Health Administration and the Food and Drug Administration.
- In-house information about the company's operations, like methods of waste disposal and the use of any toxic materials.

Of particular importance for the purchaser is obtaining records on past and current environmental litigation in which the company that is being acquired has been involved.

The purchaser also should obtain information on environmental conditions that government agencies have on file about the company that is being acquired. The federal Freedom of Information Act allows access to such information at federal agencies, he said.

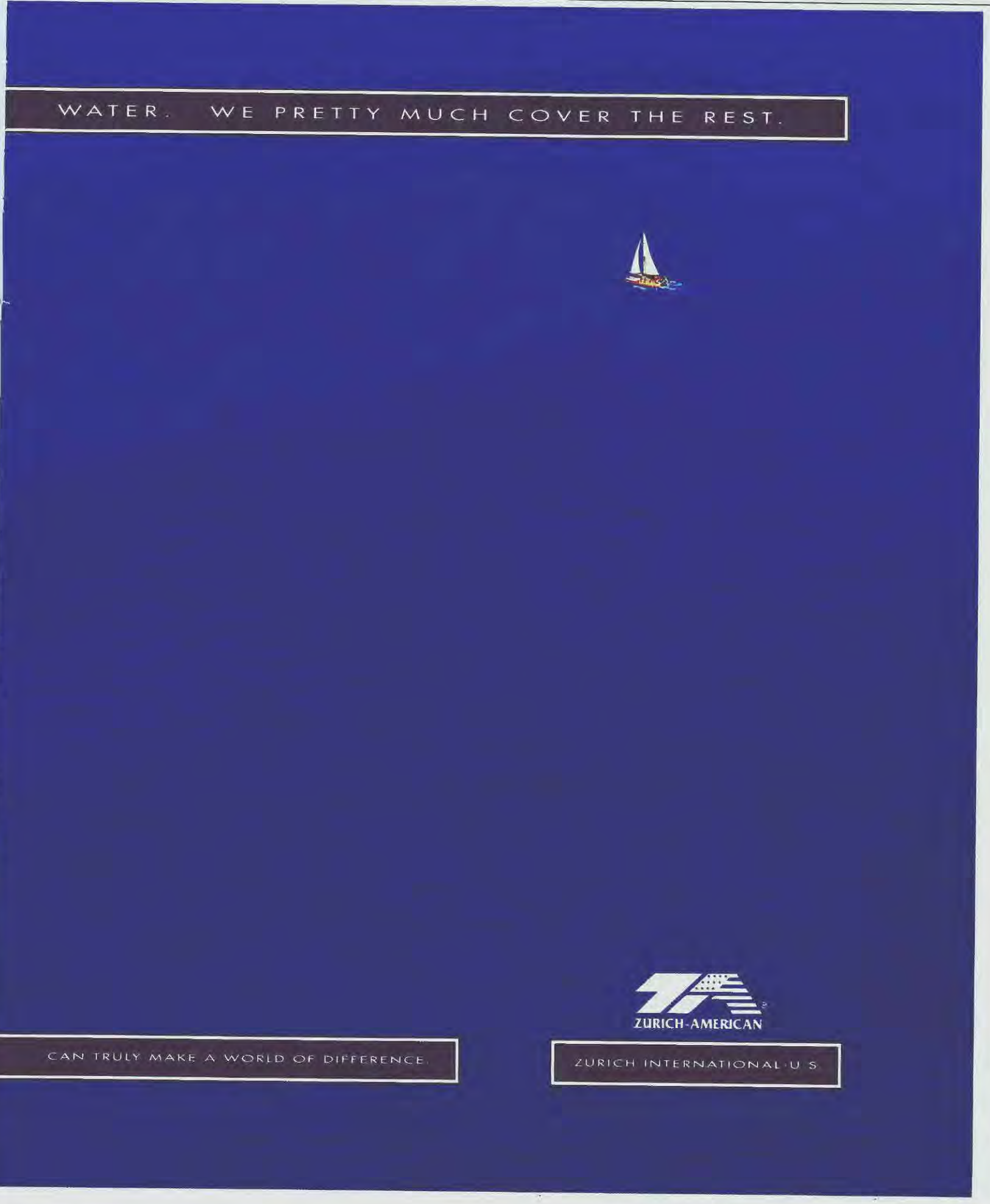
In phase two of the acquisition process, there should be "heavy-duty analysis" of existing ground, water or noise pollution on the company's property, Mr. Wall said.

If problems are uncovered, the purchaser can decide before the deal is finalized what can be done to solve those problems and how much it will cost. Those expenses then can be factored into the deal.

Another crucial inspection for the purchaser should be the target company's old insurance policies, which are often overlooked in an acquisition, Mr. Wall said.

Because of the long-tail nature of so many environmental claims, risk managers should obtain old policies as well as information about old brokers and agents up front, Mr. Wall strongly urged.

Mr. Wall also stressed that risk managers should go through all of these procedures "concurrently with legal and financial review." BI



Study finds work comp optimism

WESTBOROUGH, Mass.—There is a "powerful" consensus among employers that their workers compensation problems are within their control, says a recent survey by a workers compensation consulting firm.

The optimism among a majority of the 135, mid-size employers who responded to the survey appears directly related to their belief in the effectiveness of using cost containment tools and procedures, reports Lynch, Ryan & Associates Inc. of Westborough, Mass.

The employers appear prepared to take specific steps toward cost-control, including holding safety orientations for employees, notifying the insurer at the time of injury, actively managing claims, establishing a relationship with a medical provider, maintaining contact with out-of-work injured employees and using modified duty to speed return-to-work.

In addition, a majority of respondents also said that workers compensation fraud was not a problem in their own companies but may be more a problem in their industry or other industries.

"It's gratifying to see that employers don't feel powerless in the face of this issue, and that they see a distinct management role in resolving this crisis," said Lynch, Ryan & Associates President Thomas C. Lynch. "You wouldn't have seen that five years ago, or perhaps even two years ago," he commented.

—By Meg Fletcher

Marziano promoted at Continental Insurance

Fredric G. Marziano has been named president of Continental Insurance Cos. in New York. In addition to retaining his executive vp title and overseeing the company's agency and brokerage group, Mr. Marziano will now head Continental's insurance operations in Canada.

Also at Continental:

Adrian M. Tocklin was promoted to executive vp from senior vp. Ms. Tocklin joined the company in 1974 as supervising adjuster and held claims management positions in various field offices.

James P. Flood was appointed to senior vp of the corporate claims division. Mr. Flood was previously vp of environmental claims.

Comings & Goings: Industry

Sarah M. Dore recently joined Continental's health care division as vp and director of underwriting at its newly expanded Chicago office.

Other insurer changes:

SAFECO Corp. in Seattle announced two appointments: **James W. Ruddy** was promoted to a senior vp from vp and general counsel; and **Daniel E. Wolfe** was promoted to vp.

David N. Hafling has been promoted to senior vp and actuary for American States Insurance Co. and its units, all subsidiaries of Lincoln National Corp. in Indianapolis.

James S. Kemper III was elected executive vp in charge of the commercial lines group of the Kemper National Insurance Cos. in Long Grove, Ill. Mr. Kemper succeeds **R. Keith Like**, who is retiring.

James E. Moore has been promoted to senior vp from vp at Connecticut Speciality Insurance Co., an Orion Capital Corp. unit in Farmington, Conn.

H. Peter Stolz was named director of underwriting for the commercial insurance division of the Zurich-American Insurance Group in Schaumburg, Ill.

Robert G. Bright has joined RLI Corp., which is headquartered in Peoria, Ill., as director of claims litigation. Formerly, Mr. Bright was vp and general counsel at Bliss-McKnight Insurance Co.

Selective Insurance Group Inc., which is headquartered in Branchville, N.J., announced two new appointments: **Debra P. Carter** has been promoted to vp of two of its units—Selective Insurance Co. of America and Selective Way Insurance Co.; and **Donald E. Williams** has been named senior vp of the parent and those two units.

Marilee Roller was named president and chief operating officer of Pacific Corinthian Life Insurance Co., a Pacific Mutual Insurance Co. unit in San Diego.

Agents/Brokers

Roland H. Graham-Helwig has been named CEO of Willis Corroon Corp.'s office in San Jose, Calif. Prior to the appointment, Mr. Helwig was senior vp for Willis Corroon International Americas in San Francisco.

David M. Glantz has been promoted to executive vp of Rollins Burdick Hunter of Illinois Inc.

Robert K. Meyers has been appointed manager of the international department at Johnson & Higgins in New York.

Thomas G. Piegari has been appointed managing vp of the Alexander & Alexander Inc. corporate specialty office in Lyndhurst, N.J. He had been director of new business production.

Reinsurance

B. Grant Fraser has been named senior vp of U.S. RE Corp. in New York.

General Reinsurance Corp. of Stamford, Conn., announced several promotions: **Dallas W. Luby** was promoted to executive vp from manager of the treaty marketing and claims departments; **Brian E. Flynn** and **Garick R. Zillgitt** promoted to vps in New York; and **Susan R. Johnson** promoted to vp in Chicago.

Frank C. Bonner Jr. has been appointed vp in domestic insurance company operations/bond division of American Re-Insurance Co. in Princeton, N.J.

Other suppliers

Dr. Robert J. Ailes has been appointed vp and chief medical officer of Blue Cross and Blue Shield of New Jersey Inc.

Dr. F. Warren Tingley has joined Travelers Corp. of Hartford, Conn., as national medical director and will be responsible for medical policy and medical management of Travelers' managed care system.

Reed A. Keller has been appointed vice chairman of the human resource advisory group of Coopers & Lybrand of New York. He had been vice chairman of the actuarial, benefits and compensation consulting group.

Glen Pehl has been appointed president and CEO of NcNeary Insurance Consulting Service Inc. in Charlotte, N.C. Mr. Pehl succeeds **William C. Moore** who is now chairman.

Robert G. Pitts has been appointed senior vp and director of the Columbus, Ohio, division of PENCO, a loss control consulting unit of Willis Corroon P.L.C. Mr. Pitts is replacing **Gene Roche** who is retiring at year end.

James O. Hepner has been appointed a consultant for the national health care division of Alexander & Alexander Inc. in St. Louis.

George K. Riley joined International Environmental Services as vp and senior environmental consultant in Rolling Meadows, Ill. He had been director and senior environmental consultant of Allstate Insurance Co.

Tom Logan was named regional manager in Woodland Hills, Calif., for C.E. Heath Compensation & Liability Insurance Co. He is responsible for risk management consulting and account services for workers compensation clients. BI

Rowland

Continued from page 1

doesn't necessarily mean there will be a glorious solution. It certainly means you understand each other a great deal better in searching for it.

So what will you do when you finally get into the chair on Jan. 1?

It's very important that the roles of the chairman, chief executive and chairman of the regulatory board (which will enforce Lloyd's self-regulatory system) are defined so that we operate efficiently in everyone's best interests. I have said to Peter Middleton, however, that while we can have headings of responsibility, I want to see that those roles are actually defined once we have some experience of actually working together. I am determined that the three of us should be as complementary as possible, and it's quite difficult to do that theoretically.

It will be quite a task translating the governance of Lloyd's into a framework.

I am absolutely sure that we will make some mistakes, so it's important to be flexible during that time to experiment, to endeavor to get it as right as possible and then to change quickly if you see you've done some things foolishly.

My job is to help make the whole thing work properly.

Some people supported your nomination as chairman and some strongly objected to it. How will you satisfy both camps?

Clearly, no single person can have the support of every single person at Lloyd's. That would be ridiculous. It would be a denial of everything that makes Lloyd's strong, which is diversity of attitude and view, and competition. So I wouldn't want total support. That would be ludicrous.

I was encouraged by the fact that in terms of votes, I did receive a substantial mandate. If someone is given that kind of mandate by the majority, then those who didn't support it will say, 'OK, let's give it a go. We support whoever's in office.'

You've said you will be closer to the market, including moving the chairman's office from the 12th floor down closer to the market on the first four floors. Can you elaborate?

I have been used all my life to working where the door is always open—not just physically, but mentally as well. If there isn't physical access, then you create it by getting in amongst the people you're working with. Lloyd's is a market and if you lose the feel for that, you lose touch with what the reality of the business is.

The style and orientation (of the ornate offices on the upper floors of the Lloyd's building) means you have to make a very special effort to keep in touch with the market. It's easy to come into those offices without going through the market at all.

I would ideally like every visitor to the chairman or the chief executive to walk through the market because it's enormously impressive. Regardless of what people may read in your columns and others, they get an impression of Lloyd's that is not necessarily at all like it is.

It's great to have a wish like that. The achievement of it is certainly not going to come about by the expenditure of money at the moment.

Do you think that some of the suggestions in the task force report are as viable today as they were in January? Critics, for example, disagree that Lloyd's capacity should expand to 17 billion pounds ($26.4 billion) as was recommended.

One would be a very sterile person if he wrote something at the end of 1991 and a year later said, 'I agree with everything that's in it.' Indeed, to some extent, I expected more controversy to exist around the task force report. Some of the targets in there were as much to provoke—to make people think—as they were real targets.

So, of course, I have different views now. I hope quite a lot of the report was sensible. . .there are other (parts) now which I would write differently. But looking back on it, I'm still pleased with a large majority of it.

(As for Lloyd's capacity), I think the report says that Lloyd's should have sufficient clout in its chosen field to dictate terms. Lloyd's must be a leader, not a follower. If you're going to get superior returns in any market, it's extremely difficult as a follower.

Our view then was that it was necessary that Lloyd's (capacity) be of a certain size to fulfill that and to allow people with old losses to trade out of their situation. If Lloyd's downsizes to a certain level, it's extremely difficult to cope with the institutional framework and the problems of the past. This led us to say there must be targets ahead.

If we were doing it again, I'm sure we'd set different targets. But there would certainly be targets, in my view, of expansion of the market and not contraction beyond a certain size. Being realistic about it, we've got many problems to overcome before (the targets) can be achieved.

The task force recommended corporate capital be allowed into Lloyd's. Critics say this shouldn't happen, while those in the market are encouraging it. What is your view now?

I will certainly want to continue exploring vigorously the possibilities. It would be wonderful if Lloyd's could continue forever with the source of capital it has had in the past. There are many merits in that system.

But rational people looking at it would say, 'With the record you've had and the problems to be dealt with, there is no certainty that it will be forthcoming.' So you've got to explore something else.

No capital will come into the market unless it believes that the market is competently managed; there are superior returns; and the upside outweighs the downside in risk expectations.

The task force also suggested that agencies should be allowed to keep their syndicates open. But this is now the single biggest problem at Lloyd's, with 102 syndicates keeping 168 accounting years open.

The problem isn't the recommendation, but the cause of keeping the syndicates open. The problem is equity between names. . .it is a very, very fundamental problem at Lloyd's. (Runoff reinsurer) CentreWrite Ltd., which will accelerate its activities, will provide a means by which members can escape—or at least be offered a chance to escape. CentreWrite and Chairman Robin Jackson will be an increasingly useful arm in this.

There is no magical source of money that is going to be produced other than from the membership, from successful trading in time ahead, in order to bear the losses of the past.

It's coming up to year end and policyholders are wondering whether they should come to Lloyd's.

Of course they should come to Lloyd's, for the very best of reasons—because Lloyd's offers them a product that they can't buy anywhere. Lloyd's is a risk-bearer in a real sense, and many corporate buyers understand that. Lloyd's pays claims—not always as quickly as we would like but sometimes very well—and it offers security that even in today's world is regarded by buyers across the world as being as good as anyone anywhere else in the insurance market.

But they're questioning Lloyd's security.

Yes, but so too are they questioning the security of every other insurer in the whole wide world.

Lloyd's 'will survive. I'm absolutely sure it will. I don't know what form it will actually take. But there will be some recognizable characteristics of the present institution because it has some very special things to offer,' says Mr. Rowland.

But they're seeing the capital base of Lloyd's rebel, which is different than any other U.K. or U.S. insurer.

Of course the people are severely disquieted because of all the noise, of the suffering and the litigation. Clearly, confidence in Lloyd's will not be fully restored until there's confidence in the way in which it's managed—the belief it can operate properly and efficiently—and the suffering is resolved in some way.

Until that happens, we have to reassure people as best we can by the way in which we conduct ourselves; the way in which we pay our claims; the way in which we show them the security which underlies the policy. It won't be perfect. But it's still a hell of a lot better than that which exists in many other places in the world.

A lot of people are asking—even people who have supported Lloyd's for a very long time—whether Lloyd's is going to survive.

They'd be stupid if they didn't. It will survive. I'm absolutely sure it will. I don't know what form it will actually take. But there will be some recognizable characteristics of the present institution because it has some very special things to offer.

Lloyd's developed a system by which insurance was transacted more efficiently, more simply, than anywhere else in the world. Underwriters underwrote. Brokers transacted. The clients bought. It's a very simple system and isn't mirrored anywhere else in the world yet.

Our job is to get it working as well as it did in the past—better than it did in the past.

But, of course, people will go on questioning the future of Lloyd's. Why am I going to do the job? I wouldn't be doing the job if it was easy. BI

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Court rules against rehabilitator

Decision conflicts with New York ruling

By MARK A. HOFMANN

CHICAGO—Illinois insurance regulators plan to appeal a recent court ruling that a ceding insurer—not the rehabilitator of an insolvent reinsurer—has the right to sue the reinsurer's parent for allegedly misrepresenting the reinsurer's financial condition.

The Illinois Appeals Court's decision runs counter to a New York court's decision in a similar case, which could lead to confusion when the issue is taken up in other states, warns a reinsurance legal expert.

At the center of the Illinois case are Hartford Fire Insurance Co. and several of its units and the Illinois Department of Insurance.

Hartford had been reinsured by Centaur Insurance Co., an insolvent subsidiary of Chicago-based manufacturer Borg-Warner Corp. Hartford says Centaur owes it at least $31 million.

Centaur was declared insolvent in 1987, and the state director of insurance was appointed Centaur's rehabilitator (*BI*, Sept. 7, 1987).

The 1987 order of rehabilitation authorized the director to "sue and defend for the company, or for the benefit of the company policyholders, shareholders and creditors."

A simultaneous, separate order enjoined all suits against Centaur's directors, officers and stockholders. But, that order was rescinded Jan. 27, 1988.

That same day, Hartford sued Borg-Warner in federal court. Hartford charged, among other things, that Borg-Warner misrepresented Centaur's financial condition and therefore should pay all of Hartford's claims filed with Centaur.

The court declined to hear the case, citing the federal doctrine of abstention, under which U.S. courts can relinquish jurisdiction to state courts to avoid conflict with that state's handling of its own affairs.

Hartford then filed a similar suit in Cook County Circuit Court in October 1990.

"Borg-Warner abused Centaur's corporate structure to such an extent that Centaur was merely Borg-Warner's alter ego, which justified the piercing of Borg-Warner's corporate veil," Hartford said in the suit.

Hartford also alleged that Borg-Warner "fraudulently misrepresented Centaur's policyholders surplus" and "recklessly misrepresented" Centaur's financial condition.

In addition, the complaint alleged that Borg-Warner was prevented by its own acts "from denying responsibility for Centaur's obligations."

In May 1991, the rehabilitator asked the circuit court to dismiss Hartford's suit, claiming that he alone had the power to pursue Hartford's claims against Borg-Warner.

Hartford countered that the rehabilitator had no standing to pursue its claims because Centaur could not have brought those claims against its parent company before it was placed into rehabilitation.

The trial court ruled on Oct. 17, 1991, that the rehabilitator lacked standing to pursue Hartford's claim that Centaur was Borg-Warner's alter ego. However, the court ruled that the rehabilitator could pursue Hartford's claims of fraud and reckless misrepresentation claims against Borg-Warner.

Both parties appealed.

The three-judge appellate court panel on Nov. 5 unanimously ruled for Hartford on every count in a decision written by Justice David Linn.

Citing the lower court's reasoning regarding the alter ego issue, Justice Linn wrote that "under the alter ego doctrine, a subsidiary corporation cannot piece its own corporate veil to reach a parent corporation." Since that action could not be taken by Centaur, it could not be taken by the rehabilitator, Justice Linn wrote.

In addition, the rehabilitator could not pursue Hartford's fraud and misrepresentation counts, the court ruled. The law "requires each of these parties to prove that its reliance was justified on the particular facts that each possessed or should have possessed. In other words, each party's claim is presumptively personal," Justice Linn wrote.

"The issue of whether Hartford justifiably relied on Centaur's erroneous reports prepared by Borg-Warner is personal to Hartford. Since Centaur cannot maintain a fraud claim and a reckless misrepresentation claim on behalf of Hartford, neither can the rehabilitator," he wrote.

State regulators have asked the Illinois Supreme Court for permission to appeal the decision.

Insurer attorney Lawrence I. Brandes, a partner with Miller, Singer, Raives & Brandes in New York, agreed with the Illinois court's ruling.

Mr. Brandes recently represented a group of reinsurers in their successful attempt to rescind their contracts with Union Indemnity Insurance Co. because the failed Frank B. Hall & Co. Inc. unit had fraudulently misrepresented its financial status (*BI*, Nov. 16).

But, he noted that the decision went directly against the decision rendered by a New York court in 1989 in a very similar case.

"The case involved the same issues and the exact same statutory scheme as was involved in *Corcoran vs. Frank B. Hall*, and the Illinois court came down exactly opposite," Mr. Brandes said.

In the 1989 New York decision, the state's appellate court ruled that then-Insurance Superintendent James F. Corcoran had the sole authority to act on behalf of Union Indemnity's policyholders and creditors (*BI*, Sept. 7, 1989). Those policyholders and creditors, though, had the right to appeal any settlement the superintendent reached with Hall.

Hartford attorney James Rubin, a partner with Butler, Rubin, Newcomber, Salterelli, Boyd & Krasnow in Chicago, said he thought the Illinois decision could considerably influence other courts because many jurisdictions have rehabilitation statutes similar to the Illinois statute.

He said the decision is good news for other insurers in Hartford's position. "The creditors, who have the greatest incentive to pursue claims, now have the right to pursue those claims against those who are responsible for this insolvency. I think ultimately, it makes it more likely the creditors will be made whole."

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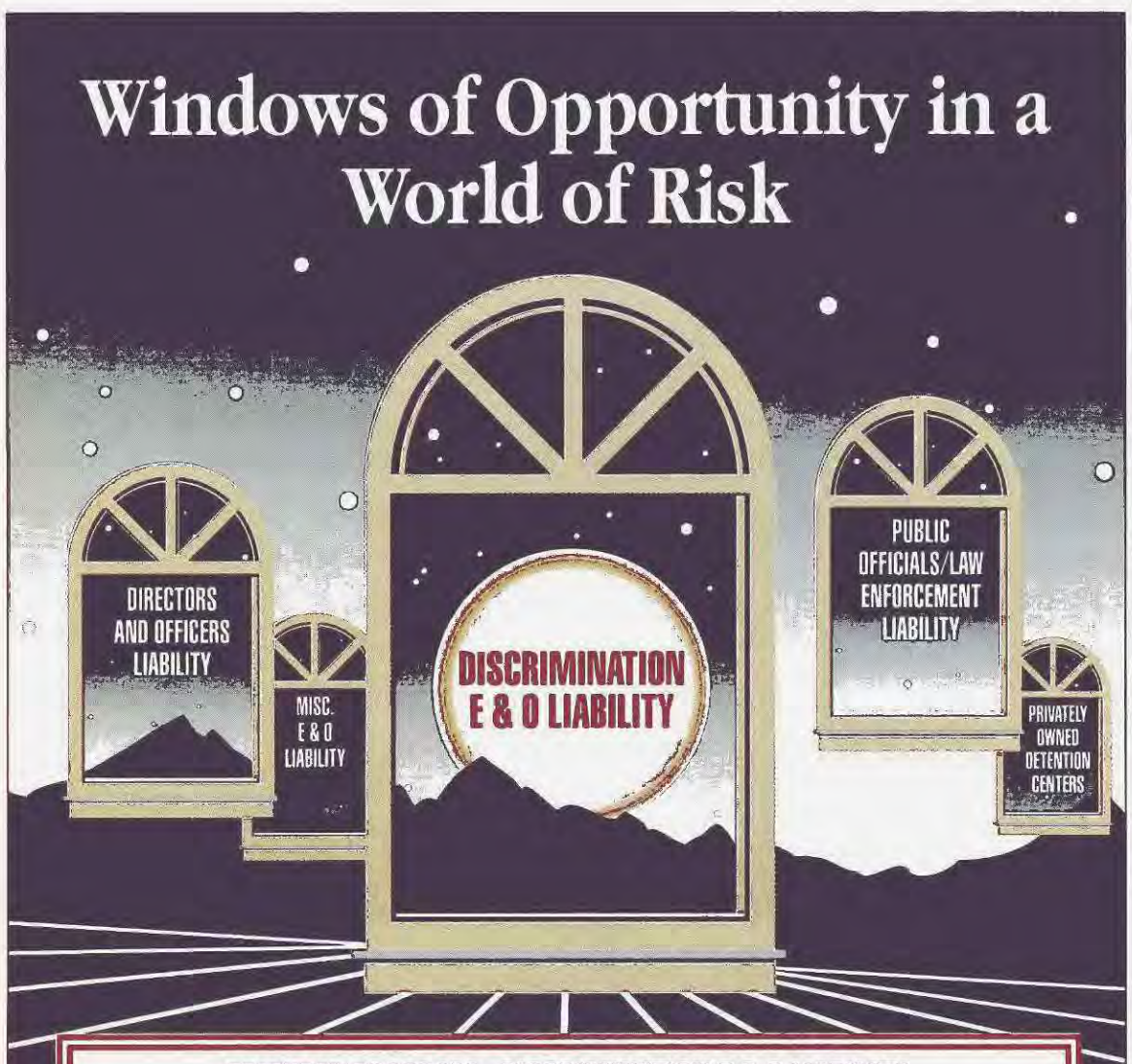
In the matter of the rehabilitation of Centaur Insurance Co.: Stephen Selke vs. Hartford Fire Insurance Co., et al., Illinois Appeals Court, 1st District, 4th Division; No. 1-91-3757.



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ALLIED Mutual Insurance Company

has exchanged 1,827,222 Common Shares of

ALLIED Group Inc.

for a like number of Preferred Stock
with an aggregate par value of

$52,075,827

The undersigned acted as financial advisor to The Coordinating Committee of the Board of Directors of ALLIED Mutual Insurance Company and rendered a fairness opinion in connection with this transaction.

Conning & Company

Retirees suing McDonnell to block medical benefit cuts

By JOANNE WOJCIK

LOS ANGELES—A group of McDonnell Douglas Corp. retirees are suing their former employer to block its novel plan to eliminate retiree medical benefits for non-union workers.

McDonnell Douglas' plan would replace retiree health care programs with an employee-pay-all plan financed by surplus defined benefit pension plan assets over a four-year period. The plan was praised as "ingenious" by consultants who said the strategy will help the company soften the blow of Financial Accounting Standard 106 (*BI*, Oct. 19).

However, retirees assert that McDonnell Douglas' plan violates the Employee Retirement Income Security Act of 1974.

By forcing retirees to begin paying for their own medical insurance, McDonnell Douglas "is reneging on its promise to provide basic retiree health care benefits for the remainder of plaintiffs' and their spouses' lives," asserts the suit filed last Monday in U.S. District Court in Los Angeles on behalf of more than 8,000 former employees.

The "modification and elimination of salaried retiree health care benefits violates the terms of the applicable employee welfare benefit plans, the contracts between MDC and plaintiffs and the members of the class, federal common law and ERISA," the suit asserts.

In addition to the suit, a motion has been filed for an injunction to block the health plan change, which is scheduled take effect in January for 20,000 former salaried employees, said plaintiffs' attorney James S. Cahill of Rossbacher & Associates in Los Angeles.

A spokeswoman for St. Louis-based McDonnell Douglas would not comment on the litigation last week since the company had not yet been served with the suit.

In their suit, McDonnell Douglas retirees said the company "repeatedly extolled salaried employees with the purported virtues of its salaried retiree health care benefits program," frequently reminding them that its health care benefits "were and are among the best and most comprehensive offered in the aerospace industry."

These benefits "were an integral part of the plaintiffs' compensation," the suit points out.

As a result, many employees remained with the company until retirement, rejecting other employment offers, the suit contends.

In October, McDonnell Douglas announced that it would offer to retirees a one-time pretax pension supplement of $18,000 that can be used only to prepay the cost of health care coverage for the next four years. Those retirees who reject the offer would get no payment and will lose their retiree health benefits. Employees had until Nov. 20 to decide.

The four-year period was chosen because the company "felt four years was a solid length of time to give retirees assurance that their medical benefits would be paid for," a spokeswoman said at the time.

However, some observers suggested that the company may be counting on the federal government to set up a universal health plan within the next four years.

But even if a universal health plan is not implemented, McDonnell Douglas has no plans to restore retirees' benefits.

"We will not return to company-funded (retiree) health care after 1996," the spokeswoman said.

To finance the pension supplements, McDonnell Douglas plans to withdraw about $300 million from retirees' overfunded defined benefit pension plan, which had a $2.2 billion surplus at the end of last year. The amount is roughly equivalent to the cost of retirees' health care benefits under the old company-funded plan.

Workers who retire within the next four years would be eligible for a pro rata payments from the pension fund to finance retiree health care coverage. Active workers who do not retire within four years would not be guaranteed retiree health care benefits under the plan. BI

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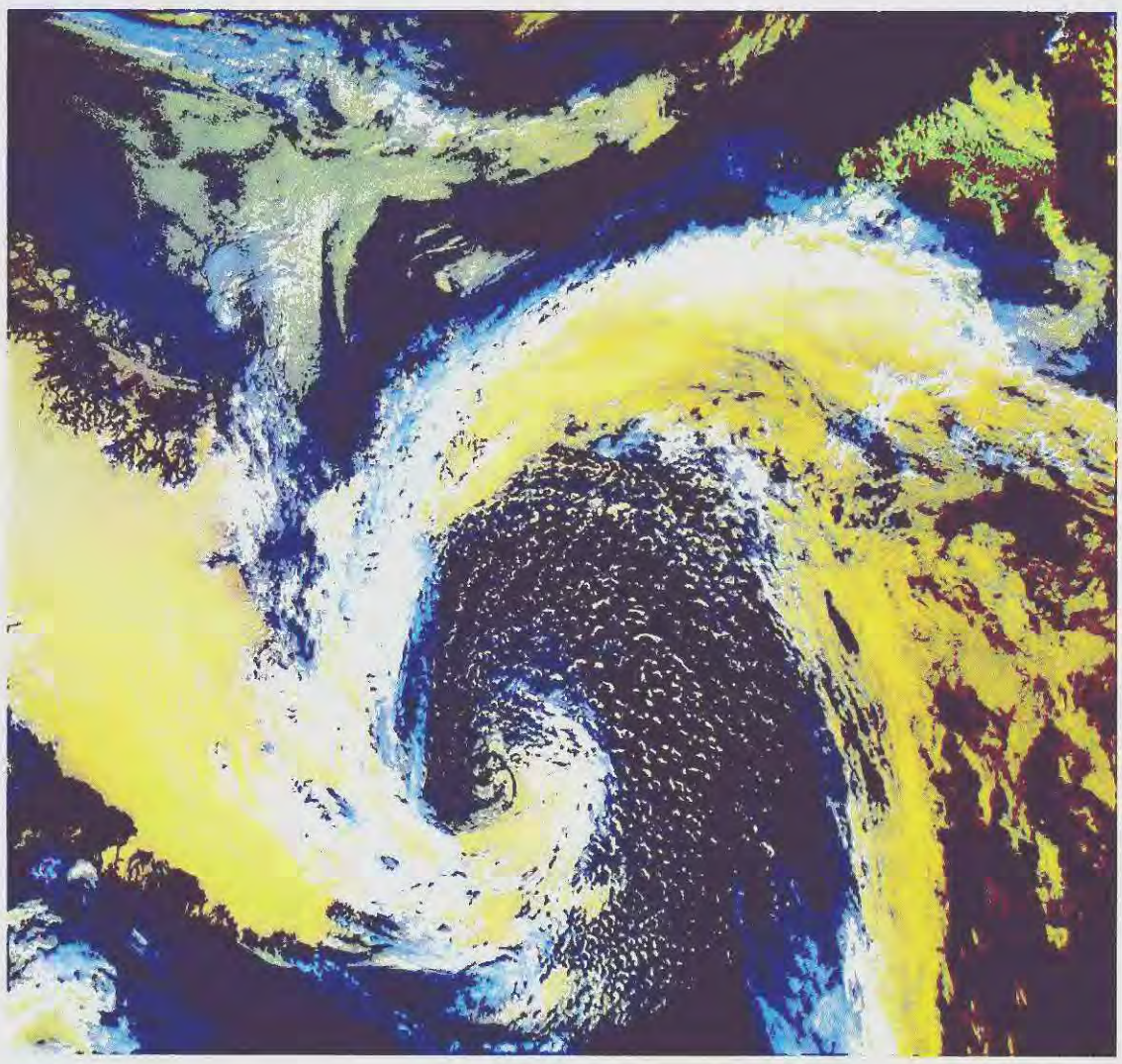

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Robinson Memorial Foundation reaches $200,000 in funding

WESTPORT, Conn.—The Angus Robinson Jr. Memorial Foundation has reached more than $200,000 in funding following a fall charity event.

More than 100 members of the insurance and reinsurance business participated in an October golf tournament at the Burning Tree Country Club in Greenwich, Conn., with 23 foursomes competing for the Angus Robinson Trophy.

Golf was followed by dinner, with the day's event raising nearly $28,000 for the foundation.

The winning foursome was sponsored by Wexford Underwriting Managers Inc. in New York, which won the trophy for the second consecutive year. Foursomes sponsored by Alexander Reinsurance Intermediaries Inc. and Sullivan Payne Co. tied for second place.

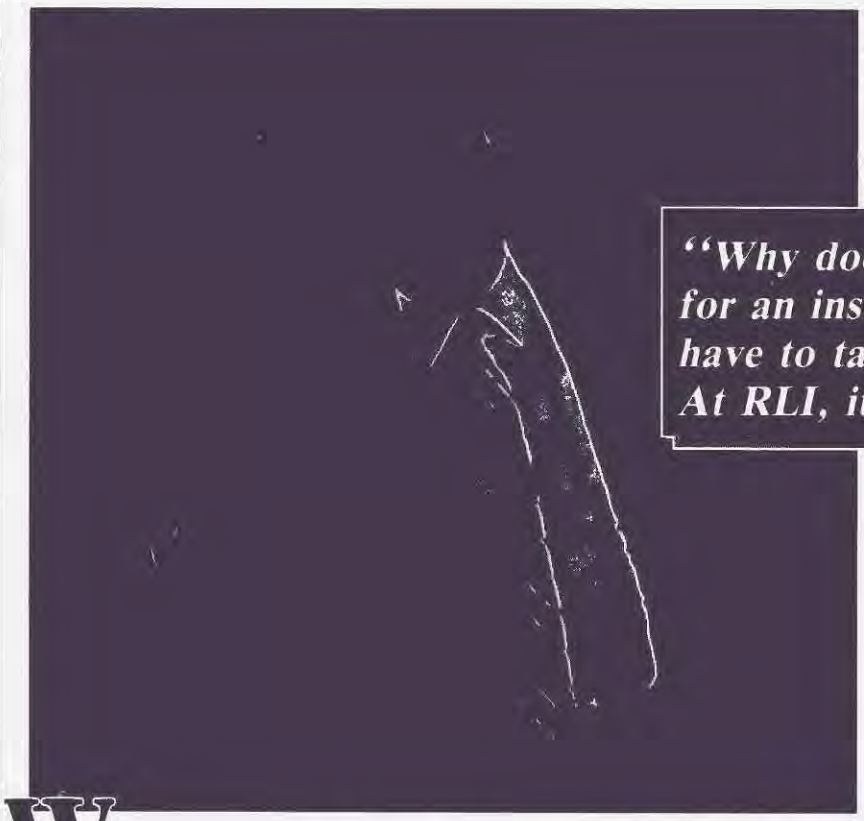
The foundation was created to honor former Chartwell Reinsurance Co. President Angus Robinson Jr., who died in April 1990 at the age of 43.

The foundation is dedicated to providing financial assistance and practical experience to qualified students pursuing degrees in the fields of insurance, reinsurance, risk management and actuarial science.

Eleven scholarships will have been granted by the foundation by the end of the first quarter of 1993.

A third golf tournament is planned for mid-September 1993 at the Burning Tree Country Club.

For more information on the foundation, write the Angus Robinson Jr. Memorial Foundation, 4 Wake Robin Road, Westport, Conn. 06880.



Gerald D. Stephens, CPCU
President & CEO, RLI Corp.

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Where does this misperception come from? And more importantly, what can we do to change it?

I think the answer to both of these questions boils down to one word: *service.* It's service, or the lack of it, that causes consumers to be disillusioned and it's service that can change that disillusionment into satisfaction.

When I take off my hat as "insurance company president" and put on my "insurance consumer" hat, I'm appalled by what I see. I buy a commercial policy and it takes three or four months to get it. When I get it, my college education isn't enough for me to wade through the confusing verbiage. It's about time we started doing something about consumers' problems. It's time we started to demonstrate our care and compassion through our service. At RLI, that's just what we're doing. And we begin with fast service. There's no reason policy turnaround should be as high as 90 days. Our underwriters consistently succeed in making that figure fifteen days. Why can't other insurance companies do the same?

Speed isn't the only thing we're concerned about at RLI. Compassion and caring are what this business is all about. We need to be there, showing our support when our customers' business or home burns down. We need to work to change the 300 year old tort system that ends up making the insurance company the ultimate loser. We need to let the public know what the insurance industry does for their safety and well-being. Work with RLI in making the changes we need to make. I challenge you to be the best you can be.

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For the Record

National Re plans to register shares

STAMFORD, Conn.—National Re Corp. plans to register at least 3.3 million of its 8.1 million shares of restricted common stock with the Securities and Exchange Commission by year end.

The announcement by National Re Corp., which is the parent of property/casualty reinsurer National Reinsurance Corp., both of Stamford, Conn., stems from an April 1990 agreement with two investors. The agreement allows Keystone Inc. and Acadia Partners, L.P., both of Fort Worth, Texas, to demand registration of their 3.3 million combined shares.

Those two investors intend to use the shares as collateral for loans, rather than sell them, a National Re spokeswoman said. However, their intentions could change at any time, she noted.

In addition, National Re said it has notified other holders of restricted stock that they should contact the company within 30 days if they want their stock included in the registration statement.

Guaranty fund to pay claim without a policy

LOS ANGELES—California's guaranty fund must pay claims under a workers comp policy that an insolvent insurer never issued but was prevented from denying because of its agent's error, a California Court of Appeals judge decided.

Blue Jay Enterprises Inc., an automobile repair shop, in 1988 appealed the California Insurance Guarantee Assn.'s rejection of its claim. Blue Jay claimed the guaranty fund was responsible for an injured employee's workers comp claim that was covered by the insolvent Homeland Insurance Co.

Homeland, however, had no record of any policy and Blue Jay admitted never receiving one.

The owner of Blue Jay said that the Factory Insurance Service Inc. agent who wrote out the policy assured the company that it had coverage, even though no policy was ever received. Factory is an authorized agent of Homeland.

The Factory agent took a $500 deposit from Blue Jay and deposited it in Factory's trust account, according to court papers. The agent then later placed two memoranda to Homeland in outgoing mail baskets requesting that it issue Blue Jay's workers comp insurance. Homeland, though, claimed it never received any memoranda or policy.

A workers comp judge determined Homeland was estopped from denying coverage to Blue Jay. As a result, CIGA was responsible for payment of Homeland's obligations that had been created by the estoppel.

Under estoppel, a party is prevented from denying a fact or benefit because of its own actions or conduct to the contrary.

CIGA petitioned for a review with the California Court of Appeals contending, among other things, that covered claims CIGA is obligated to pay on behalf of insolvent insurers do not include

Continued on next page

to Mr. Ostuw.

Continued from previous page
claims created by estoppel.

Rejecting that argument, the judge determined that the term "covered claims" included those created by estoppel.

CIGA may petition an additional review with the California Supreme Court, said Robert C. Hayden, a partner with Lewis, D'Amato, Brisbois & Bisgaard in Los Angeles.

Earthquake Project taps cable bill lobbyist

WASHINGTON—Jack F. Weber, a lobbyist who promoted the passage of the cable television regulation bill, has been named the first executive director of the Earthquake Project.

The property/casualty insurance industry-supported Earthquake Project seeks to create a federal reinsurance facility for catastrophic earthquake risks. Although the project was launched in 1987, Mr. Weber, a former deputy director of media relations for the Reagan White House, is the group's first executive director.

Franklin W. Nutter, chairman of the Earthquake Project and president of the Washington-based Reinsurance Assn. of America, said that Mr. Weber's "experience, credentials and know-how" will be critical in meeting the group's goals in the 103rd Congress, which convenes next January.

Mr. Weber said that the heightened public awareness of the need for disaster preparedness wrought by Hurricane Andrew has resulted "in a tremendous opportunity for a coordinated approach to the issue of disaster response."

Mr. Weber served as a consultant to the broadcaster-consumer coalition that successfully pushed the Cable Television Consumer Protection Act of 1992 through Congress.

President Bush vetoed the bill, but Congress overrode his veto. It was the only override among the 34 vetoes cast by the president during his four-year term in office.

Workers comp funds decry Alliance report

PHOENIX—The American Assn. of State Compensation Insurance Funds describes as "misleading" and "inaccurate" an insurer trade organization's recent report criticizing state workers comp funds.

A new report by the comp fund group describes a recent report by the Alliance of American Insurers as "another in a series of continuing efforts. . .to discredit state workers compensation insurance funds and stem the ever-growing popularity of the state fund movement."

Five states—Louisiana, New Mexico, Rhode Island, Tennessee and Texas—have established state funds during the nearly three years since the Alliance issued the first of three reports critical of state funds, the AASCIF said.

Among the allegations the Alliance made this summer in its third report was that eight workers compensation state funds have become "insolvent" since 1984 and that the financial condition of several others has deteriorated over the same period (*BI*, Aug. 24).

The state fund group dismisses those charges as "misleading and based upon incomplete information or skewed and/or erroneous data." No state fund has ever been declared insolvent, the group said, though a few face problems due to inadequate reserving or poor investment decisions.

In addition, the Alliance implies that state funds should meet the same surplus and reserve standards as private insurers, though state funds are typically nonprofit entities that are required by law to return all excess income to policyholders in the form of lower rates or dividends, the report explains. AASCIF also defends its members' practice of discounting of loss reserves, which is acceptable to regulators.

"Workers compensation systems today are fraught with problems but we don't believe that state funds are part of these problems. They are, however, part of the solution," said Jerry N. LeCompte, president of the state fund group. Steps are being taken to develop solutions with the Alliance, he added.

Texas work comp fund to lower rates in 1993

AUSTIN, Texas—Employers that purchase insurance from the Texas Workers' Compensation Insurance Fund will pay less for coverage next year.

The amount of the rate decrease is based on employers' loss experience. Those with the best experience will see a 10.5% reduction from the benchmark rate set by the State Board of Insurance in 1990.

Employers that buy coverage from the fund and have a "good" loss experience will see a 7.5% reduction from the benchmark and accounts with a poor loss experience will continue to see rates set at 12.5% above the benchmark.

Lower rates were made possible by state workers comp laws passed in 1989 and 1991, according to Jack Floyd, president of the fund. "The effects of the reform are obvious," he said. "We believe these cost savings should be passed along to the employers of Texas."

The competitive fund, which became operational in January, has written more than $160 million in workers comp premiums for about 5,800 employers.

The state board has not yet acted on commercial insurers' request for workers comp rates hike next year. BI

Conference to offer managed care update

SAN DIEGO—About two dozen experts from the managed care, group health insurance, and benefit consulting fields will outline major developments in and challenges facing managed care at the Winter Health Care Management & Cost Containment Conference.

The conference, sponsored by *Business Insurance* and The International Business Forum Inc., will be held Jan. 13-15 at the Hotel del Coronado in San Diego.

The conference will feature speakers representing employers, health care providers, managed care companies and employee benefit consultants.

Speakers will address the latest developments in health maintenance and preferred provider organizations; direct contracting; integrating preventive care into benefit programs; and applying managed care techniques to contain workers compensation costs.

"Nearly everyone agrees that the United States is embarking on health care reform, and managed care will play a big role in whatever solutions are adopted," according to James M. Bucke, editor of *Business Insurance* and one of the conference's co-chairmen.

"The more employers can learn about the promise that managed care holds—as well as the pitfalls in implementing managed care programs—the better prepared they will be to deal with health care reform," he said.

The conference kicks off Wednesday evening, Jan. 13, with a cocktail reception hosted by The Upjohn Co.

Panel discussions will begin Thursday morning when three experts discuss managed care's impact on health care delivery and financing and the range of managed care options now available to employers. The panelists will be Larry Goelman, president and chief executive officer of Cost Care Inc.; Chip Sharkey, senior vp-national marketing of CIGNA Corp.; and Ed Zalta, chairman and CEO of CAPP CARE Inc.

At the other Thursday morning session, two health care experts will share their perspectives on managed care's future and the implications for health care purchasers. The experts are Joseph W. Duva, a partner at Ernst & Young, and Dr. Jacque J. Sokolov, president of Sokolov Strategic Alliance.

At lunch, Stephen M. Wilder, assistant treasurer-risk management at The Walt Disney Co., will discuss how to control workers compensation insurance costs and how employers can influence workers comp reform legislation.

The luncheon is hosted by John Hancock Financial Services.

After lunch, registrants can select one of two concurrent sessions.

A session on direct contracting will focus on selection criteria, negotiating the deal and case studies. The speakers are Linn J. Baker, director-public employees health program for the state of Utah; Nancy Hughes, group insurance manager for Safeway Inc.; and Dr. Arnold S. Milstein, managing director of William M. Mercer Inc.

Panelists at the other session will discuss using managed care techniques to contain workers comp costs. The speakers will be Charles Jacobs, president of InterQual Inc.; Jerry A. Miccolis, vp and workers compensation practice leader for Towers Perrin; and Ed Zutler, president of FHP Insurance Group.

The final session of the day will update attendees on health care coalitions. Debra Hubers, director of marketing at The Alliance, a Denver coalition, will discuss how employers can purchase health care based on value. Patricia E. Powers, executive director of the Bay Area Business Group on Health, will outline the group's current projects.

A cocktail reception will be held Thursday evening.

Leading off Friday's schedule is a presentation on Digital Equipment Corp.'s response to the HIV/AIDS crisis. Paul A. Ross, corporate manager of HIV/AIDS programs, will describe the strategies Digital has implemented to increase productivity, maintain employee relations and contain health care costs.

Integrating preventive care into employee benefit programs will be discussed in the next session by Michael Fox, managing consultant at A. Foster Higgins & Co. Inc.; Lynn Gilfillan, community wellness development coordinator at Coors Brewing Co.; and Allen Iampaglia, risk manager for the city of Glendale, Ariz.

Registrants then may select one of two concurrent sessions.

One session will focus on new directions in flexible benefits administration and options for retirees. The topic will be discussed by Larry Atkins, manager of human resource systems for Barnett Banks Inc.; Sally Gottlieb, manager of benefits administration for Apple Computer Inc.; and Thomas J. Grass, national leader of the group and flexible benefits consulting practice for The Wyatt Co.

The other session, which will focus on balancing quality and cost in prescription drug benefit plan design, will feature James Heenan, director-corporate accounts sales for The Upjohn Co., and Norrie Thomas, president and CEO of Clinical Pharmacy Advantage.

At Friday's lunch, Frank McArdle, a partner in the Washington office of Hewitt Associates, will discuss the prospects for health care reform during the Clinton administration.

The luncheon is hosted by FHP Inc.

Dr. Robert M. MacMillan, executive director health-insurance division in Ontario's Ministry of Health, will lead off the afternoon sessions, taking an in-depth look at the Canadian health care delivery system.

The conference will conclude with a debate over the Canadian health care system between Anthony R. Masso, vp-managed care and insurance products at the Health Insurance Assn. of America, and Howard Weizmann, vp for the Aetna Benefits Consulting Practices division of Aetna Life & Casualty Co.

The conference includes a tabletop exhibit area for publications and software demonstrations.

The conference fee is $795, which includes lunches, refreshments, receptions and the conference workbook.

To register for the conference, contact The International Business Forum Inc. at 50 Charles Lindbergh Blvd., Suite 400, Uniondale, N.Y. 11553-3619; 516-229-2375; fax 516-229-2386.

Information concerning table exhibits or sponsorship is available from Julia Tarsi at IBF at the same number. BI

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Business Insurance

INTERNATIONAL

GLOBAL BRIEFS

Zech leaving Cologne Re for post with Gerling Group

COLOGNE, Germany—Juergen Zech is leaving his post as chief executive of Cologne Reinsurance Co. to join Gerling Group.

Mr. Zech says he will immediately assume a position on Gerling's board of directors and will replace Anton Weiler as chief executive of Gerling-Konzern Allgemeine Versicherungs-A.G., the group's lead insurer. Mr. Weiler retired from the company.

Earlier this year, Gerling Group Chief Executive Adolf Kracht announced a major overhaul in the company's leadership. Gerling, which is Germany's largest commercial insurer, has suffered deteriorating results in recent years, which Mr. Kracht blames on a series of exceptionally large claims and high administrative expenses.

Mr. Zech is expected to play a key role in rejuvenating the company, Mr. Kracht said.

Mr. Zech had been chief executive of Cologne Re since 1987. The board of directors of Cologne Re will meet Dec. 10 to determine his successor.

Peter Luetke-Bornefeld, currently a board member, is seen as the most likely candidate.

—By Don Lewis Kirk

UAP buys insurer stake

PARIS—French state-owned insurer Union des Assurances de Paris is acquiring a 37.4% stake in German insurer Nordstern Allgemeine Versicherungs A.G. from Swiss insurer Winterthur Schweizerische Versicherungs-Ges.

In return, Winterthur will gain a 3% stake in UAP.

The deal, announced Dec. 2, marked a change in UAP's efforts to gain a foothold in Germany. It followed the collapse of talks with French financial group Cie. de Suez to buy a controlling stake in Germany's Colonia Versicherungs A.G.

Suez announced Nov. 27 that it had suspended talks with UAP regarding Colonia. UAP had sought direct control of Colonia in exchange for its 34% stake in Suez's French subsidiary, Groupe Victoire, which controls Colonia. The talks broke down over problems in valuing UAP's stake in Colonia.

UAP acquired the stake in 1989 for 14 billion francs ($2.61 billion at current exchange rates). But those shares were valued at only 11 billion francs ($2.05 billion at current exchange rates) in UAP's 1991 bal-

Continued on page 48

Pollution liability limit to increase outside U.S.

By GAVIN SOUTER

LONDON—Oil pollution liability limits for shipowners and insurers outside of the United States are set to increase more than fourfold to 59.7 million special drawing rights ($82.5 million) after an international agreement reached late last month.

And total oil pollution limits for compensation paid by shipowners, insurers and the International Fund for Compensation for Oil Pollution Damage could more than double under the agreement to 135 million SDRs ($186.6 million).

Despite the increased cap on liability, protection and indemnity insurers welcome the agreement. They say it will bring needed certainty to oil pollution compensation in most major oil importing countries outside of the United States. Under the Oil Pollution Act of 1990, oil spills in U.S. waters have no liability cap (*BI*, Aug. 27, 1990).

Protection and indemnity insurers said they will raise rates to reflect the increased liability caps if the agreement is ratified.

Meanwhile, the International Group of P&I Clubs has warned members that the U.S. oil spill law imposes new liabilities on shipowners that are not covered by P&I clubs.

The new international limits were agreed upon at the London headquarters of the International Maritime Organization, a United Nations agency concerned with maritime safety and pollution prevention.

Representatives of 55 countries met to update the limits imposed by two earlier agreements.

The first agreement is the Civil Liability Convention, which was adopted in 1969 in the aftermath of the oil spill caused by the grounding of the Torry Canyon off the English coast in March 1967.

Under that convention, shipowners' liability is limited to 14 million SDRs ($19.3 million).

Beyond that limit, costs up to 60 million SDRs ($82.9 million) are paid by the International Oil Pollution Compensation Fund, which was established in 1978. The fund is run by an international organization consisting of representatives of 44 governments.

Beyond 60 million SDRs, costs are paid by the nation that suffered the pollution damage.

The limits under the CLC and IOPC have long been regarded as outdated. However, earlier attempts to increase the limits were abandoned when it became clear that the United States would not agree to li-

Continued on next page

Open accounts to cost over $8 billion: Chatset

By STACY SHAPIRO

LONDON

LONDON—Sparks are flying in Lloyd's of London over syndicate analyst Chatset Ltd.'s prediction that currently open syndicate accounts will cost members 5.3 billion pounds ($8.2 billion).

Chatset analyst Charles Sturge last week unveiled a new guide to syndicate runoffs, which outlines 102 syndicates with an aggregate of 162 open years. The total capacity of these open years is 2.7 billion pounds ($4.18 billion); 1.9 billion pounds ($2.94 billion) is from 63 syndicates that left their 1989 year open.

All but 18 of the 102 syndicates with open years have ceased trading.

U.S. casualty-related losses, especially asbestos and pollution claims, constitute 75% of the $8.2 billion cost forecast, Mr. Sturge said.

If a reserve for the ultimate loss were established on a discounted basis today, Lloyd's members would need to find an additional 2 billion pounds ($3.09 billion) to increase reserves to 3.5 billion pounds ($5.41 billion) from the current 1.5 billion pounds ($2.32 billion), projected Mr. Sturge.

So far, the open years have cost members an average of 434 million pounds ($671.1 million) over the last four years, he said, which wipes out any chance of a profit.

Mr. Sturge calculated this ultimate loss by using a mathematical formula that doubles the net outstanding liabilities of each syndicate with long-tail business; uses loadings to project incurred-but-not-reported pollution, asbestos and U.S. casualty losses; and gives credit for investment income of 10 times what was earned in 1991.

"Of course, underwriters will hotly deny this methodology and maintain that they are carrying adequate reserves," Mr. Sturge said in the Chatset guide. "But one only has to look at syndicates that have been in runoff for some time to see what happens in practice.

"That there is serious underreserving for syndicates with books of U.S. casualty business is not in question, nor is it confined to Lloyd's. . .The question is 'What could be the amount that names are going to have to find in the future to pay their open year debts?' "

Underwriters, however, are outraged by Chatset's predictions and guide.

"To make statement of the eventual cost of runoff without any factual basis is clearly irresponsible and grossly misleading," said a statement from Lloyd's underwriters John Wetherell, Richard Youell and David Foster, a member of Lloyd's pollution committee.

"No reference appears to have

Continued on next page

Gooda names reject large remuneration for leaders

By GAVIN SOUTER

LONDON—Leaders of a group of Lloyd's of London members seeking to recover huge losses stemming from defunct syndicates managed by Gooda Walker Ltd. are rethinking proposals for their own remuneration.

The members—who plan to sue dozens of members agencies—have forced their own leaders to scrap plans that would have generated more than 300,000 pounds ($463,920 at current exchange rates) in fees for the leaders if 100% of the members' losses were recovered.

In addition, the group has retained Ulrich von Eicken, retired U.K. managing director of Munich Reinsurance Co., to act as an expert witness if the claim goes to court. Mr. von Eicken was a plaintiffs' expert witness in the trial that pitted Lloyd's members against underwriter Richard Outhwaite (*BI*, Nov. 4, 1991).

Members of the Gooda Walker Action Group, who met last week at their annual general meeting, considered several aspects of their fight to recover their losses.

The GWAG is seeking to recover the 273 million pounds ($422.2 million) that Lloyd's members have lost on the disastrous Gooda Walker syndicates.

So far, Gooda Walker members have had to meet cash calls totaling 682.2 million pounds ($1.05 billion) for losses stemming mainly from London market excess-of-loss reinsurance business written between 1983 and 1990.

The most controversial part of the meeting centered on the proposed remuneration of committee members.

Under the proposed remunera-

Continued on page 49

ACE explores market for shareholder stock

By ROGER SCOTTON

BERMUDA

HAMILTON, Bermuda—ACE Ltd. is considering making its debut on either public or private international capital markets next year.

The company, which late last month unveiled 1992 results detailing its second consecutive underwriting loss (*BI*, Nov. 30), is asking its 192 corporate shareholders to indicate whether and to what extent they would be interested in selling their stock. Many ACE shareholders are Fortune 100 corporations.

However, Chairman and Chief Executive Walter Scott made clear that an initial public offering is only one of several options now under consideration. Bermuda's other major liability insurer, EXEL Ltd., used an IPO last year (*BI*, May 27, 1991).

Mr. Scott was careful to stress that capital-raising initiatives are being reviewed as a means of raising funds for ACE's shareholders, not for the insurer, which has capital and surplus of $1.1 billion.

In the past, ACE's dividends and share redemptions had returned almost $397 million to its shareholders, and these measures had "kept the pressure off" the company to give its stockholders a market for their shares.

However, Mr. Scott said, "Over the past two years, we've done none of these, concentrating instead on building up our capital rather than returning it to shareholders. As a result, we've had requests from some of the stockholders who are looking for liquidity.

We're now in the process of contacting all shareholders to determine their wishes," he added.

Mentor payout plan

Mentor Insurance Ltd. creditors met last month to review the workings of a proposed "scheme of ar-

Continued on page 48

UNI Storebrand refinancing rejected

By MARIA KIELMAS

OSLO, Norway—UNI Storebrand A/S creditors and shareholders have vehemently rejected a proposed refinancing plan for the Norwegian insurer, significantly worsening the outlook for Scandinavian insurers.

The rejection of the plan follows increasing skepticism in the stock markets about the outcome of a proposed refinancing plan for Denmark's Baltica Holding A/S and the ability of Sweden's Skandia Group to meet short-term debt obligations.

The government-appointed administration committee for UNI Storebrand is now trying to craft an alternative restructuring plan for the company, which was bankrupted in an attempt to take over Skandia (*BI*, Aug. 31).

The plan, which the administration committee outlined Nov. 25, stipulated that those UNI Storebrand creditors owed more than 5 billion Norwegian krone ($777 million) would be able to convert this debt partly into equity in UNI Storebrand New A/S, a recently formed holding company, and partly into convertible bonds. The bonds could be converted later into shares and ordinary long-term bonds.

Creditors owed less than 5 billion Norwegian krone would be able to convert debt into long-term publicly traded bonds.

In addition, UNI Storebrand's nominal share value was to be written down to 1 Norwegian krone (15.5 cents) per share from 20 Norwegian krone ($3.11) per share with a subscription price for a new share issue set at 2 Norwegian krone (31 cents) per share. This new issue was expected to raise about 1 billion Norwegian krone ($155 million).

Stock market analysts derided UNI Storebrand's expectations that the capital markets would subscribe to a capital increase after its failed attempt earlier this year to take over Skandia (*BI*, May 11).

Westdeutsche Landesbank, one of

Continued on page 50

Oil spill liability

Continued from previous page
ability caps for oil pollution compensation.

In 1984, an IMO meeting tried to increase the liability limits to 59.7 million SDRs under the CLC and an overall limit of 135 million SDRs under the Fund convention.

But before the amendments were ratified by the necessary number of countries, it became clear that the United States would not approve them. To bypass this difficulty, the meeting last month eased the ratification requirements for the agreement.

Now the CLC limit can be raised 12 months after it is accepted by 10 nations, including four with not less than 1 million units of gross tanker tonnage. The 1984 agreement needed six of the nations to have more than 1 million units of gross tanker tonnage.

The Fund protocol will now be enforced after being accepted by eight nations that have imported 450 million tons of "contributing" oil a year. Contributing oil is oil that is imported for use in the receiving country. The 1984 figure was 600 million tons.

"It is expected that this will make entry into force easier because it will not necessitate acceptance by all the major oil importing countries," an IMO spokesman said.

Ratification could still take three to four years, though, because it requires governmental approval, he said.

Despite the increased liability that shipowners will be subject to, P&I clubs have broadly welcomed the agreement.

"International conventions bring a degree of certainty, and these are conventions that have worked in the past," said Luke Readman, a partner at Thomas Miller & Co., which manages the United Kingdom Mutual Steam Ship Assurance Assn (Bermuda) Ltd.

The higher limits imposed by the new agreements might encourage more countries to sign the conventions, he said.

Low liability limits tend to encourage companies to try to bypass them through litigation, said Kenneth Norman, senior associate at the West of England Ship Owners Insurance Services Ltd.

Higher limits will also push rates up, Mr. Norman said. "It can only have an adverse impact in terms of premiums as the clubs will have to pay more to meet the higher claims."

Meanwhile, the International Group of P&I Clubs has warned shipowners that the clubs do not offer all of the coverage that might be necessary for shipowners operating in U.S. waters because of the stringent requirements of the 1990 oil spill law.

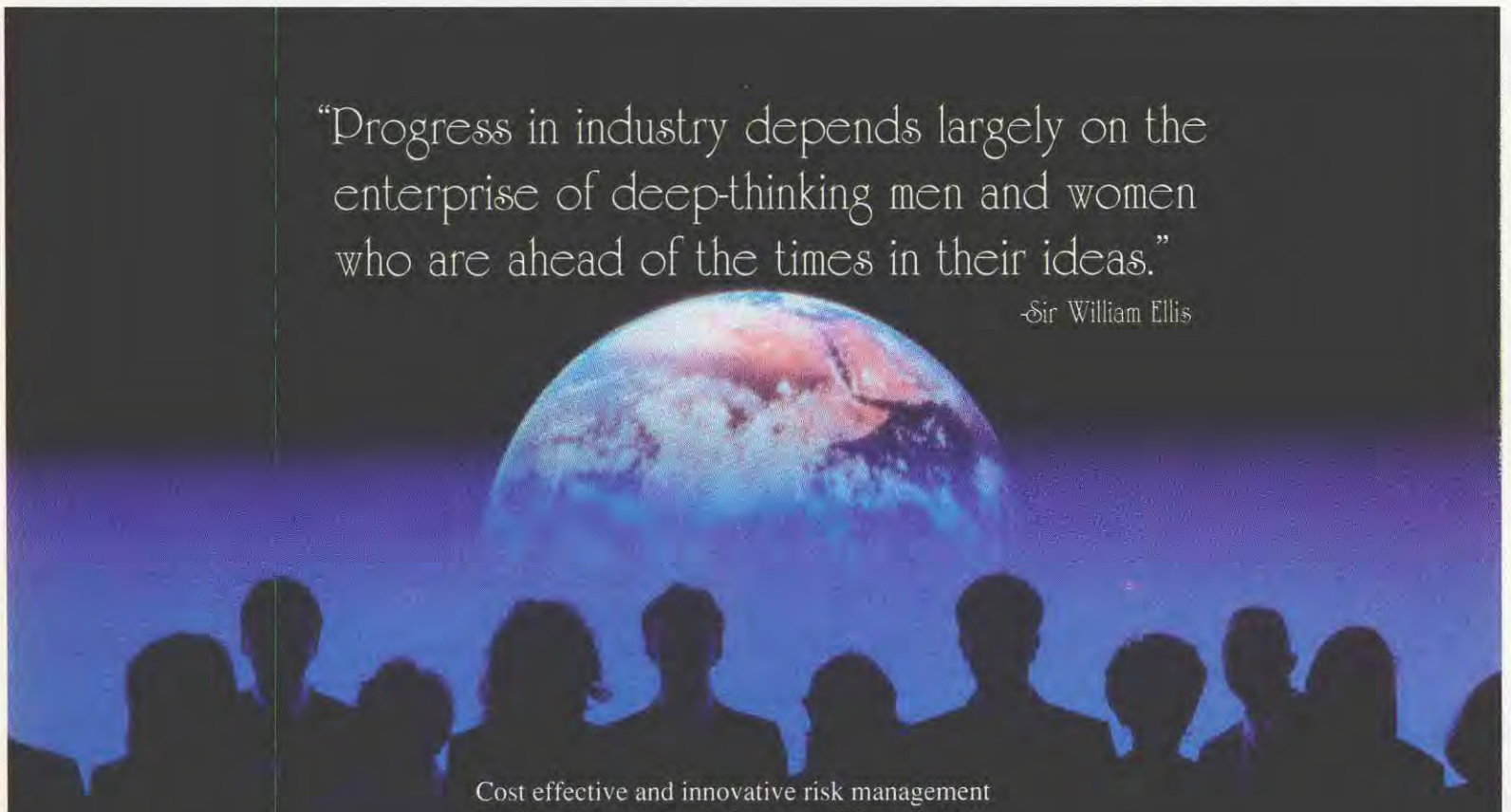
In a joint memorandum sent out to all members, the clubs say that the ship response plans proposed by the U.S. Coast Guard under the law impose liabilities on the members that the clubs' standard P&I coverage does not cover.

The guidelines for the response plans say the plans should incorporate detailed information on the owner's shoreside response if oil spills anywhere the ship visits.

Central to this part of the plan is the identification of a "qualified individual," resident in the United States to implement the plan, the clubs say.

"It should be noted that the clubs are not able to give specific additional cover for the liabilities of a qualified individual acting in this capacity either directly or by way of an indemnity from the member," the clubs say.

Also, the clubs say they do not cover members against failure to prepare an adequate plan. BI



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LONDON

Continued from previous page
been made to the original policies involved. Instead, the figures used in the Chatset publication can only be based on rash and uninformed guesswork."

Mr. Youell particularly objects to Chatset's prediction of further deterioration of 300% to 400% of capacity on his syndicate 932, which is managed by Janson Green Ltd.

"I have no idea how Chatset arrived at their prediction for the runoff of syndicate 932," stated Mr. Youell. "They have not sought any information from us, and on our own continuing analysis—probably the most informed in the market—we believe their conclusions are meaningless and misleading and wholly contrary to our views."

"I'm worried about the names' reaction to this," said Mr. Wetherell. "It must be disconcerting to read information that could be alarming."

But Chatset's Mr. Sturge is standing firm in his calculations despite the protest. "I expected underwriters would squawk," he said. "The truth is that there's a big black hole. And I make no apology. Lloyd's can't go on socking it to names."

Airline liability cap

A senior aviation lawyer in London has written to 30 airlines worldwide suggesting that they follow the lead of 10 Japanese airlines and offer unlimited liability per passenger on international flights.

The Japanese airlines—led by Japan Air Lines—became the first to drop passenger liability limits on international flights as set by the Warsaw Convention (*BI*, Nov. 23). The limits under Article 22(1) in the convention vary, but flights to and from the

Continued on next page

INTERNATIONAL

Continued from previous page
United States, for example, limit airlines' liability to $75,000 per passenger.

For airlines in those countries that accepted the Montreal Protocol to amend the Warsaw Convention, including Japan, liability limits are equal to 100,000 special drawing rights ($140,000).

The Japanese airlines recognize the rest of the terms and conditions in the Warsaw Convention. One provision has been interpreted by the U.S. Supreme Court to mean that plaintiffs can only claim compensatory damages and not punitive damages.

Peter Martin, a senior partner in London law firm Frere Cholmeley, said: "In pursuit of my own campaign—which I'm waging almost single-handedly now—I have written to 30 different airlines drawing their attention to what the Japanese have done, and inviting them to do the same. I think it is so important we shouldn't wait until the next accident."

The letters included ones sent to United Airlines, American Airlines and Delta Air Lines, he said.

Mr. Martin said that he believes that U.S. airlines have everything to gain from offering unlimited liability on international flights. The U.S. airlines already carry unlimited liability on domestic flights.

London aviation underwriters have expressed concern about the move toward unlimited liability on international flights, because they usually pay for all compensation awarded after an air disaster.

One underwriter wondered whether awards would increase to the level of the $20 million settlement recently made between underwriters and the relatives of a senior executive who died on the United flight to Sioux City, Iowa, a few years ago (*BI*, Sept. 21).

"He's absolutely right. There are some big risks in this," acknowledged Mr. Martin.

But, he added, "If you can avoid the need for litigation in international carriage cases—and you can't have punitive damages under Warsaw in the United States—then the possibility of negotiating a sensible settlement successfully, instead of having it forced on you by litigation two or three years down the road, must be commercially sensible.

"The underwriter must get the premium for the increased exposure. He's not obviously (taking the additional risk) for nothing," said Mr. Martin. But the insurance cost to the airline "is substantially less per passenger than the cost of the kind of freebies you get on any transatlantic flight. It's probably less than the cost of the washcloth and razor in the overnight pack you get—certainly less than the daily cost of the video or a hot breakfast. It's so tiny a cost that when you look at airline advertising—which is all about service—you'll see the cost of additional services is substantially less than the per passenger cost of giving unlimited liability."

Scan Re stops claims

Scan Re Insurance Co. Ltd., a Scandinavian-owned London market reinsurer, has stopped paying claims.

The move comes eight months after the company ceased accepting new business.

In a brief statement, Managing Director Len Alliston said: "In the light of recent developments, the directors consider that it would be prudent to suspend the payment of claims, pending further consideration of the company's financial position."

A further announcement would be made before the end of the year, he said.

Scan Re is owned equally by Lansforsakringsbolagens A.B. in Stockholm and Gjensidige Norsk Skadeforsikring in Oslo.

The reinsurer has a paid-up capital of 15 million pounds ($23.2 million).

In 1991, the company posted an underwriting loss of 8.3 million pounds ($15.5 million at the year-end exchange rate). BI

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UNI Storebrand

Continued from page 45

the company's largest creditors with 1 billion Norwegian krone of outstanding debt, rejected the plan, UNI Storebrand said. Vesta Group, Skandia's Norwegian subsidiary, also rejected the deal.

Creditors filed an injunction in an Oslo court to stop UNI Storebrand from continuing with the plan. UNI Storebrand had said it would implement the plan if creditors did not respond by Nov. 30.

UNI Storebrand shareholders' reaction was even more fierce. They charged that the restructuring plan was tantamount to expropriation.

Martin Imbach, CEO of Zurich-based Swiss Insurance Systems, a financial services company that is a large UNI Storebrand shareholder, said he was very happy that the refinancing plan failed. He contends that even the Norwegian government was pleased with the rejection because it realized the implications of a "de facto nationalization."

The proposal by UNI Storebrand's administrative committee raises serious questions about the security of foreign investments in Norway, Mr. Imbach said. But, he added, "Norway is an immature country financially."

One insurance executive said that the Norwegian government mistakenly views that shareholders' stakes in UNI Storebrand are almost worthless, so it should make no difference if the government takes them over.

Creditors, shareholders and analysts suggest that UNI Storebrand should sell its operating subsidiaries. Sweden's Skandia is known to be interested in UNI Storebrand's life insurance unit, but analysts believe selling a life insurance company to a foreign buyer would be politically impossible in Norway.

Meanwhile, speculation has been increasing in the European stock markets that Denmark's Baltica Holding could be headed for even greater financial difficulties.

"Creditors are looking at the refinancing plan very critically," said Jonathan Lawlor, an analyst at London-based Kleinwort Benson Securities, referring to a plan announced in October (*BI*, Nov. 9).

Under the plan, Baltica Holding agreed to sell 32.35% of its shares in subsidiary Baltica Forsikring to creditor Den Danske Bank. Baltica Holding now owns 50.74% of Baltica Forsikring shares. Also, Baltica's Banking subsidiary, Baltica Bank, would concentrate on activities that support the insurance group.

"Even if the operating companies (of Baltica Holding) pulled through, shareholders' interest is low on the list of priorities. The bankers' interests come first," Mr. Lawlor said.

He said that if the company were to go into government administration, then the Danish government would likely be forced to discriminate between the interest of individual policyholders, whose protection would be a political issue, and corporate policyholders, which may be expected to carry the risk.

Baltica's situation has been further complicated by the long-running talks between France's Union des Assurances de Paris and Cie. de Suez over control of Germany's Colonia Versicherung. The talks collapsed last week (see story, page 45). UAP had sought to swap its 34% stake in Suez's Group Victoire for Victoire's stake in Colonia.

Although the talks collapsed, the relationship between the French and Danish insurers means that difficulties in Baltica could have a significant effect in France.

Victoire holds 23% of Baltica Holding and UAP holds an indirect stake of about 8% in Baltica through its 34% stake in Victoire.

If Baltica eventually collapses, the linkage of Victoire, Suez, UAP and Colonia could be severed, said Angus Runciman, insurance analyst at London-based BNP Securities.

A Baltica spokesman said he understands the speculation due to the turbulent Scandinavian financial markets. But, he said, Baltica has solved its short-term refinancing difficulties.

Sweden's Skandia also faces stock market speculation that the insurer could face difficulties meeting its short-term debt obligation.

"They are rolling over a lot of short-term debt and seem to be living from hand to mouth," said one London-based insurance analyst. "It's a very sensitive issue and all based on confidence. It's all very well to have a lot of (real estate) assets, but Skandia can't sell them."

However, analysts believe Skandia will overcome any problems it may have now and it eventually will be virtually the only Scandinavian insurer of any standing.

Despite analysts' concerns, Skandia's stock price in the past month has doubled to more than 90 Swedish krona ($13.26) from 45 Swedish krona ($6.63).

Skandia Vp Johan Bergenstjerna rejected speculation that Skandia has problems meeting its short-term debts. He said Skandia maintains good relations with the banking community in Sweden and abroad.

No one in Sweden currently can raise money by issuing commercial paper because such financing now requires a state guarantee, he said.

An effective 15% devaluation of the Swedish krona has boosted Skandia's investment portfolio, he noted. Also, Skandia has a clear policy to try to eliminate currency risks by matching assets and liabilities in the same currencies.

Skandia's 51% stake in the London-based credit insurer Panfinancial Insurance Co. Ltd. is also on the block. "We have declared that credit insurance is not part of our core business," Mr. Bergenstjerna said.

Since 1991, Skandia's losses from credit insurance and reinsurance have been about 1 billion Swedish krona ($147 million), of which 450 million Swedish krona ($66.3 million) was due to the collapse of Swedish credit insurers Svenska Kredit and International Credit, he said (*BI*, Sept. 14). BI

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NOTICE IS HEREBY GIVEN that Christopher John Hughes and Malcolm John London, as Joint Provisional Liquidators of Fremont Insurance Company (UK) Limited (the "Company"), have obtained a Preliminary Injunction from the United States Bankruptcy Court for the Central District of California, directing that the creditors of the Company or holders of the Company's property are enjoined from: (1) commencing or continuing any actions against the Company or its property in the United States; (2) commencing or continuing any actions to create, perfect or enforce any lien, set-off or any other claim against the Company or its property; and (3) relinquishing any property of the Company in the United States to any person other than the Joint Provisional Liquidators. Copies of the Preliminary Injunction have been provided to all known creditors of the Company in the United States. Any creditor who has not received one should contact counsel for the Joint Provisional Liquidators at the following address:

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Vice-presidents, directors, managers, and other related department personnel of: insurance, risk, employee benefits, personnel, compensation, pension, safety, security, industrial relations, human resources and employee/labor relations	14,998
Sub-total	**28,089**
Associations	416
Government, Unions and Educational Institutions	1,148
Commercial Consumers	
Sub-total	**29,653**
Insurance Agents and Brokers	8,947
Insurance Companies	8,080
Accountants, Actuaries, Attorneys & Consultants	3,449
Adjusters, Appraisers, TPA's, Captive Managers & Health Care Providers	1,748
Others Allied to the Field	904
Single Copies	4
TOTAL	**52,785**

* Source Business/Occupational breakdown of qualified circulation, May 25, 1992 issue, as submitted to BPA for June 1992 BPA Publisher's Statement.

Largest U.S. reinsurers' nine-month 1992 results

Ranked by net reinsurance premiums written. All amounts in thousands of dollars.

Reinsurers	Net reinsurance premiums written 1992	Net reinsurance premiums written 1991	Policyholders surplus (reinsurers only)	Net income 1992	Losses & loss adjustment expenses	Loss ratio	Underwriting expenses	Expense ratio	Combined ratio 1992	Combined ratio 1991
1. General Re	$1,624,258	$1,581,556	$3,353,725	$393,426	$1,267,291	79.2%	$462,976	28.5%	107.7%	101.9%
2. Employers Re	1,111,841	925,717	1,578,443	216,691	808,914	76.7	288,264	25.9	102.6	103.7
3. American Re	733,038	653,581	820,463	95,664	459,882	67.1	254,806	34.8	101.9	100.1
4. North American/Swiss Re	519,861	571,837	689,073	21,696	485,599	83.8	191,744	36.9	120.7	106.8
5. Prudential Re	512,890	494,142	538,867	15,581	505,632	99.1	173,426	33.8	132.9	112.7
6. Berkshire Hathaway	473,934	311,733	N/A	N/A	491,842	141.0	20,546	5.9	146.9	132.2
7. Munich Re	470,584	415,924	667,043	(4,214)	410,295	91.3	155,658	33.1	124.4	109.8
8. Kemper Re	429,095	367,569	312,325	1,708	369,392	89.6	91,474	21.3	110.9	107.2
9. Transatlantic/Putnam	357,284	362,668	440,469	41,077	307,934	86.9	91,043	25.5	112.4	107.0
10. Skandia America Group	295,626	290,242	310,643	(9,095)	259,395	87.4	110,021	37.2	124.6	112.1
11. The St. Paul Cos.	277,509	280,085	N/A	N/A	404,344	143.9	85,407	30.8	174.7	131.1
12. Constitution Re	273,039	179,589	254,576	5,317	188,152	79.1	86,747	31.8	110.9	106.2
13. Transamerica Re	270,113	268,670	255,756	25,908	220,295	83.2	74,319	27.5	110.7	105.1
14. CIGNA Re	254,795	257,963	200,082	(18,882)	256,208	99.3	56,888	22.3	121.6	104.4
15. NAC Re	196,393	171,632	300,236	(357)	167,324	88.5	74,542	38.0	126.4	108.2
16. National Re	182,518	193,578	320,702	38,988	138,380	75.3	52,263	28.6	103.9	101.9
17. F&G Re	181,549	175,097	N/A	N/A	144,748	77.2	32,733	18.0	95.2	89.1
18. Winterthur Re	170,069	154,867	174,237	13,622	134,379	82.7	57,189	33.6	116.3	109.0
19. Scor Re/Unity	150,556	127,581	230,621	16,151	110,869	77.5	57,729	38.3	115.9	100.8
20. American Agricultural	113,660	92,644	120,356	(16,829)	122,361	129.2	13,942	12.3	141.4	109.3
Totals for Top 20	**8,598,612**	**7,876,675**	**10,567,617**	**836,452**	**7,253,236**	**87.5**	**2,431,717**	**28.3**	**115.8**	**106.9**
Total for all companies	**9,425,710**	**8,785,234**	**13,635,975**	**971,835**	**7,706,665**	**84.4**	**2,918,263**	**31.0**	**115.4**	**105.7**

Source: Reinsurance Assn. of America and *Business Insurance*

Reinsurer results

Continued from page 1

Meanwhile, the hardening catastrophe reinsurance market has led to a hardening of the general property reinsurance market as well, some reinsurance executives say. However, all agree that the tightening clearly has not yet spread to the casualty market.

In fact, some say that as reinsurers shy away from property risks, more capacity will be fed into casualty business, leading to even more intense competition for casualty accounts.

While analysts and reinsurers agree that more claims for Andrew will be reported by reinsurers, the storm already has done severe damage to U.S. reinsurers' nine-month results. The 59 reinsurers surveyed by the RAA reported a 115.4% combined ratio for the period, compared to 105.7% for the first nine months of 1991 (*BI*, Dec. 16, 1991). And, the nine-month combined ratio is a sharp increase from the 106.7% reported for the first half of 1992 (*BI*, Sept. 7).

Net premium volume for the reinsurers surveyed increased 7.3% to $9.43 billion in the first nine months of 1992 from $8.79 billion in the corresponding period last year.

The 20 largest U.S. reinsurers based on net written premiums reported a 115.8% combined ratio for the nine months, compared with 106.9% for the first nine months of 1991 and 107% in this year's first half. Nine-month net premium volume for the Top 20 reinsurers increased 9.2% to $8.6 billion in 1992 from $7.88 billion in 1991.

The RAA results were "not as bad as expected," though almost every reinsurer will report additional claims from Hurricane Andrew in the fourth quarter, said Bard E. Bunaes, chairman and chief executive officer of Constitution Reinsurance Corp. in New York. "We have seen an increase in our Andrew claims, certainly, in the fourth quarter."

"I think there's a lot of losses yet to be reported," agreed Alan Levin, senior vp at Standard & Poor's Corp. in New York.

"The Andrew losses have just continued to grow" on a daily basis, said Tom Case, chairman, president and CEO of Employers Reinsurance Corp. in Kansas City, Mo. Primary insurers are reopening closed files because of policyholders' inability to buy replacement building materials at the original estimates, he said.

"I think the fourth quarter results are going to show continued growth in the Andrew claims, and it may well go into next year also," Mr. Case said.

Another factor in the delayed reporting is that "sometimes it takes a while for those losses to work through the system," said Marvin Shulman, an analyst with Moody's Investors Service.

There is "no question" reinsurers will absorb more Andrew and Iniki losses than have been reported so far, said Jerome Karter, president and CEO of SCOR Reinsurance Co. in New York. "That's because of primary companies continuing to report increasing amounts of losses."

But reinsurers will assume a lower percentage of newly reported Andrew losses as primary insurers exhaust their catastrophe coverage, he said. "A lot of the covers have been eaten up."

While property catastrophe rates and capacity are tightening because of the storms, some say other market segments have been unaffected.

"It doesn't seem to carry through to the rest of the business. It's an isolated phenomenon," said Mr. Bunaes. "We're all hoping that it will carry through."

Increases have not been "anywhere near as dramatic" in either working-layer property programs or casualty treaties as in property catastrophe,said Mr. Case of Employers Re.

However, Mr. Case said he has heard talk of reinsurers moving back into casualty business because property has become so tough, which could eventually lead to a softer casualty market.

Mark Mosca, vp and manager of the treaty department at NAC Re Corp. in Stamford, Conn., said he believes the property reinsurance market in general—not only the catastrophe market—has hardened. "The hardening in the catastrophe market, coupled with Iniki and Andrew, have influenced and affected the property market."

But he shared Mr. Case's concern about a softer casualty market. As reinsurers re-evaluate their commitment to property business, there is "at least the chance" capacity diverted to casualty exposures will create more "willing capacity" for that business, Mr. Mosca said.

James E. Dwane, president of Prudential Reinsurance Corp. in Newark, N.J., commented it would be "foolhardy" to say that, because the property reinsurance market is hardening, it is a good opportunity to write ca-

Continued on next page

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Reinsurer results

Continued from previous page
sualty insurance business since it is hard to get a feel for ultimate casualty losses because of the long tail.

"That would be a mistake," he said. The casualty business "is going to have to stand on its own."

Mr. Dwane said that while the property reinsurance market is "turning as we speak," the casualty market will turn either with the January renewals, or shortly afterwards. "It's got to follow very closely with the property."

Ajit Jain, president of the reinsurance division of Berkshire Hathaway Inc. in Stamford, commented: "I think I certainly see the property (reinsurance) market starting to harden." However, "Casualty is really up in the air."

Paul Ingrey, president of Morristown, N.J.-based F&G Re, a unit of USF&G Corp., said while non-catastrophe property reinsurance rates are no longer falling, "I've been surprised they haven't been improving at a faster rate."

Hardening in the catastrophe market does not necessarily mean a turn in the overall property/casualty insurance market is near, reinsurance executives point out.

"We're hopeful the market will turn next year, but we do not think there are enough clear reasons for it to turn," said Constitution Re's Mr. Bunaes. "We're very concerned about that. The bloodletting hasn't been bad enough.

"There's nothing happening in the primary end. That's the problem," he commented.

NAC Re's Mr. Mosca said, "I don't think we have an overall market turn upon us, nor do I think it's imminent."

While property reinsurance conditions have tightened, they "are clearly solely driven by catastrophe results and fears of future catastrophes. They are not driven by property results excluding catastrophes, they are not driven by general pricing levels, they are not driven by an absence of non-catastrophe capacity, and I also do not see any evidence whatsoever of any kind of a general turn," said Mr. Mosca.

The catastrophes could eventually accelerate a general market turn simply because of the large amounts of cash they will absorb, "but I don't think it's here yet," Mr. Mosca said.

"I think generally we're bound to see some type of improvement" next year, which means no additional deterioration, or a slight upswing in prices, but no big swing, Mr. Case said. "I can't see it getting any worse."

One trend that is emerging is a flight to quality as ceding companies seek out larger, better capitalized reinsurers.

"I think what is starting to happen is a number of people are starting to get a little sensitive about long-term relationships, security and the size of the company," said Berkshire Hathaway's Mr. Jain.

In some cases, ceding companies are willing to pay higher premiums for the "right" reinsurer, Mr. Jain said.

"The issue of quality is certainly starting to come into focus," he added.

Stronger companies "should be able to charge a little higher price for that stability," said Mr. Case.

S&P's Mr. Levin concurred. "We definitely see a very clear trend toward the larger, more capitalized, more secure reinsurers." BI

UNITED STATES BANKRUPTCY COURT
SOUTHERN DISTRICT OF NEW YORK

In re

Petition of Christopher John Hughes and Ian Douglas Barker Bond, as Joint Provisional Liquidators of Kingscroft Insurance Company, Ltd.,	In Petition Under Section 304 Case Nos. 92-B-41974 (PBA) through 92-B-41977 (PBA) Jointly Administered
Debtor in Foreign Proceedings	

PRELIMINARY INJUNCTION ORDER

This matter has come before the Court on Petitioners' request for a Preliminary Injunction Order pursuant to Bankruptcy Rule 7065 and Federal Rule of Civil Procedure 65(b). The Court has considered and reviewed the Petitions filed in these cases, the Affidavit of Ronald DeKoven, one of the attorneys for the Petitioners, duly sworn to the 7th day of April, 1992, the Declaration of Gabriel Moss, duly sworn to the 8th day of April, 1992, the Declaration of Christopher John Hughes, one of the Petitioners herein, duly sworn to the 8th day of April, 1992, and the Memorandum of Law in support of the application, and the responses filed thereto, and having held hearings and heard arguments by counsel on April 10, 1992, May 12, 1992, August 19, 1992, and November 17, 1992, and based on the foregoing the Court finds and concludes as follows:

1. Petitioners have demonstrated a substantial likelihood of success or have raised serious questions on the merits of the contentions that Kingscroft Insurance Company Ltd. ("Kingscroft"), El Paso Insurance Company Ltd. ("El Paso"), Lime Street Insurance Company Ltd. ("Lime Street") and Mutual Reinsurance Company Ltd. ("Mutual") (collectively, "KELM") are companies subject to foreign proceedings, that Petitioners are the foreign representatives of the debtors, that the commencement or continuation of any judicial, administrative or regulatory action or proceeding against KELM, or any of their property in the United States, should be enjoined* pursuant to 11 U.S.C. § 304(b) to permit the orderly resolution of claims in the pending proceedings brought under foreign law, and that the relief requested will not cause hardships to parties which are not outweighed by the benefits;

2. Unless an injunction is issued, it appears to this Court that one or more parties in interest will relinquish or dispose of property of KELM in the United States, or will commence or continue the prosecution of judicial, administrative or regulatory actions against KELM and/or seek to retain assets of KELM, thereby interfering with, and causing harm to, the Petitioners' efforts to administer the estates of KELM pursuant to the foreign proceedings, and that as a result the Petitioners will suffer immediate and irreparable injury for which they will have no adequate remedy at law;

3. The interest of the public will be served by restraining such disposition of KELM property and the commencement or continuation of such judicial, administrative or regulatory actions or proceedings;

NOW, THEREFORE, IT IS HEREBY ORDERED as follows:

ORDERED, that all persons (except as provided in the Orders of Conservation) are hereby preliminarily enjoined and restrained from:

(1) relinquishing or disposing of any property of KELM in the United States, or the proceeds of such property, to third parties;

(2) commencing or continuing any judicial, administrative or regulatory action or proceeding against Kingscroft, El Paso, Lime Street and/or Mutual or any of their property in the United States;

(3) enforcing any judicial, administrative or regulatory judgment, assessment or order and commencing or continuing any act or any judicial, administrative or regulatory proceeding to create, perfect or enforce any lien, set-off or other claim against Kingscroft, El Paso, Lime Street and/or Mutual or any of their property in the United States;

ORDERED, that nothing in this order shall in any respect prevent the continuance or commencement of proceedings against or involving other London Market insurers or any other insurance company defendant;

ORDERED, that pursuant to Bankruptcy Rule 7065, the security provisions of Fed. R. Civ. P. 65(c) be, and the same hereby are, waived; and it is further

ORDERED, that this Preliminary Injunction Order shall be served (A) by hand delivery, facsimile or United States mail, first class postage prepaid, on or before November 27, 1992 upon the parties in interest appearing in these cases and in *In re Petition of Christopher John Hughes, Ian Douglas Barker Bond and Gareth Howard Hughes as Joint Provisional Liquidators of Walbrook Insurance Company Ltd.,* Case No. 92-B-44623 (PBA) (Bankr. S.D.N.Y.), at the time of such service; and (B) by publication of a summary of this Preliminary Injunction Order in Business Insurance Magazine on or before December 7, 1992; that service pursuant to this paragraph shall be deemed good and sufficient service and adequate notice; and it is further

ORDERED, that the time to answer or move with respect to the Petition is extended sine die, but that parties wishing to move for modification of or relief from this Order or otherwise may do in accordance with the schedule set forth by the Court herein and in any subsequent Scheduling Order entered by the Court in this case;

ORDERED, that this injunction shall remain in effect pending further order of the court, after a hearing scheduled to be held in Room 617 of the Alexander Hamilton House, One Bowling Green, New York, New York on February 23, 1993 at 2:30 p.m.; and it is further

ORDERED, that all papers submitted for the purpose of controverting the petition or opposing a continuation of the relief provided for in this Preliminary Injunction Order shall be filed with the Court with a copy to the Chambers and delivered personally or by overnight mail or so as to be received by Shearman & Sterling, 599 Lexington Avenue, New York, New York 10022 (Attention: Ronald DeKoven), Attorneys for Petitioners, on or before February 13, 1993.

Dated: New York, New York
November 17, 1992

/S/PRUDENCE BEATTY ABRAM

U.S.B.J.

*Petitioners' request for relief, and the terms of this Order, are subject to the provisions of the Orders of Conservation obtained by the New York Superintendent of Insurance in the New York Supreme Court for New York County (the "Orders of Conservation").

Poe & Brown

Continued from page 2
wholesale brokerage division specializing in national programs, which represent $20 million in Poe revenues, are "a strength we don't have."

Poe, with 1991 gross revenues of $48.5 million, is the 17th-largest U.S. brokerage (*BI*, June 29, 1992). Brown & Brown ranks 24th, with $33.9 million in gross revenues.

The combined annual revenues of what will be known as Poe & Brown Inc. will exceed $83 million, putting it just below Hilb, Rogal & Hamilton Co., ranked No. 13, with $115.2 million in 1991 gross revenues.

The merger will also guarantee Poe & Brown's pre-eminence in the Florida market. Brown & Brown, a well-established name in Florida operating as a privately held, family business since 1939, maintains 17 offices in the state.

Poe & Associates has 19 offices in Florida, as well as branches in Arizona, California, Georgia, New Jersey, North Carolina and Texas.

The two brokerages both maintain offices in Fort Lauderdale, Fort Myers, Jacksonville, Orlando, Palm Beach and Saratoga, which likely will be combined, Mr. Brown said. By putting these Florida offices together, Poe & Brown will become "twice as large as our closest competitor" in Florida in terms of premium volume placed, he said.

Mr. Poe said layoffs were not likely.

Mr. Brown will act as president and chief executive officer of Poe & Brown, and Mr. Poe will be chairman. Poe & Associates President V.C. Jordan will become vice chairman, while other officers of both corporations will retain their current titles.

Poe & Associates has been on a fast acquisition track. It has acquired about 10 agencies over the past two years, Mr. Poe said. After the merger, Poe & Brown will continue this trend, with emphasis on growth in Florida and in the eight other states with Poe & Associates branch offices, he added.

Michael Morrissey, an analyst with Firemark Inc. in Parsippany, N.J., says that the brokerage's emphasis on acquisitions—and the merger with Brown & Brown—is the work of Executive Vp Bernard M. Mizel.

Mr. Mizel, who joined Poe & Associates in May, was formerly president and CEO of American Business Insurance Inc., the world's 19th-largest broker. Mr. Mizel helped build ABI through acquisitions, and he may be attempting to repeat this strategy, said Mr. Morrissey.

"This is definitely a Barney Mizel deal," he said of the Brown & Brown merger. "He's a man with a mission to do deals."

Poe & Brown will be able to compete with the world's largest brokers in Florida, Mr. Morrissey said.

"We think Poe is a very good regional firm that would grow into a national firm with this merger," he added. "They know the (Florida) business better than the national firms do."

Poe & Associates plans to submit the merger plan to the Securities and Exchange Commission for approval by early January. The transaction should be completed by April, Mr. Brown said.

Poe & Associates shares rose $1 to $16.50 in over-the-counter trading when the merger was announced last Monday. BI

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Punitive awards

Continued from page 1

not clarify things," said Paul Brown, director of governmental affairs for the Risk & Insurance Management Society Inc. "Courts are still obviously out of control."

Many courts since Haslip have failed to follow the 4-to-1 ratio of punitive-to-compensatory damages that the Supreme Court called "close to the line," contends Mr. Horvitz. "They pay lip service to Haslip and then proceed to ignore it."

The West Virginia case is a good example because the $10 million punitive award was 526 times higher than the $19,000 compensatory award, Mr. Horvitz pointed out.

ATRA's Mr. Connor agreed: "It illustrates the extent of the problem with punitive damages. It's an extreme case."

Furthermore, *TXO vs. Alliance* "is not a case that involves particularly outrageous behavior, so it presents the issue rather starkly," Mr. Connor added.

In the West Virginia case, a jury found that TXO knowingly filed a frivolous lawsuit against another company, Alliance Resources, as leverage to increase its oil-and-gas rights on a tract of land in McDowell County. Alliance had filed a counterclaim in the suit, alleging slander of title.

The jury found for Alliance on the counterclaim. Although it found Alliance had suffered no actual damages, it awarded $19,000 for attorneys' fees and punitive damages of $10 million.

The State Supreme Court upheld the punitive award last May.

Other awards since Haslip also appear to flout the Supreme Court guidelines. For example:

- A Cook County, Ill., jury awarded $124.6 million in punitive damages and $3 million in compensatory damages to a man whose left eye was irreparably damaged after a doctor accidentally injected it with a drug manufactured by Upjohn Co. (*BI*, Oct. 28, 1991). The drug company is appealing the award.
- A Corpus Christi, Texas, jury awarded $30 million in punitive damages and $3.8 million in compensatory damages to the parents of a Texas girl born with defects allegedly caused by her mother's use of the anti-nausea drug Bendectin while she was pregnant (*BI*, Oct. 14, 1991). The manufacturer, Marion Merrell Dow Inc., is appealing the award.
- The Georgia Supreme Court ruled that punitive damages need not be reasonably related to actual injuries or the defendant's wealth after it was ordered to reconsider a case in light of Haslip.

In that case, the state high court affirmed a $1.3 million punitive award and a $5,001 compensatory award to the estate of a burn victim who died in a helicopter crash while he was being airlifted to a hospital (*BI*, Nov. 18, 1991).

Bruce A. Beckman, the attorney who represented Pacific Mutual Life Insurance Co. in the Haslip case, said he was "a little surprised it was a West Virginia case that went up since the Supreme Court there reformed its punitive damage criteria based on the Haslip decision."

But on second thought, he said, that may be precisely why the court decided to review this particular case.

"In TXO, they applied those standards and came up with a bad result," said Mr. Beckman, who is with Adams, Duque & Hazeltine in Los Angeles.

In December 1991, the West Virginia Supreme Court set standards for determining the reasonableness of punitive damage awards in *Garnes vs. Fleming Landfill*.

In that decision, the court said that punitive damages should bear a "reasonable relationship" to compensatory damages and established procedural guidelines for juries and appellate courts to follow when determining punitive awards.

The Garnes decision stemmed from a case in which a jury awarded $105,000 in punitive damages but no compensatory damages to Julian and Sharon Garnes, who sued John T. Fleming in Kanawha County Circuit Court alleging that Mr. Fleming's operation of a solid waste disposal facility constituted a nuisance.

Another reason the high court may have decided to look at TXO is the fact that the jurors considered the financial statement of its parent company when making the punitive award, even though a management connection had not been established between the two companies, Mr. Beckman suggested. TXO is a subsidiary of USX Corp.

"There was no alter ego established," he said.

RIMS' Mr. Brown suggested the court may have decided to review *TXO vs. Alliance* "because of the way the opinion was written."

In its decision upholding the punitive damage award in TXO, the West Virginia Supreme Court wrote that "an award of this magnitude is necessary to discourage TXO from continuing its pattern and practice of fraud, trickery and deceit."

The opinion, written by Justice Richard Neeley, also said that "when the defendant is not just stupid but really mean, punitive damages must be greater in order to deter future evil acts."

"In cases where the defendant has intentionally committed mean-spirited and harmful acts (especially when the provable compensatory damages are small, but the potential of harm is great), even punitive damages 500 times greater than compensatory damages are not per se unconstitutional."

And, "in the really mean cases, the cynosure in determining the reasonableness of the jury's verdict under Haslip and Garnes is the amount of punitive damages required to cause the defendant to mend its evil ways and to discourage others similarly situated from engaging in like reprehensible conduct," Judge Neeley wrote.

In its appeal, accepted Nov. 30 by the U.S. Supreme Court, TXO attorney Carter G. Phillips said the West Virginia high court had failed to give the case "meaningful and adequate review" as prescribed by Garnes. Mr. Phillips is a partner at Sidley & Austin in Washington.

Jaye Letson, an associate who is working with Mr. Phillips on the case, said the fact that the punitive award in *TXO vs. Alliance* was so much larger than the compensatory award—coupled with the state court's failure to apply the Garnes guidelines—demonstrated to the Supreme Court that its decision in Haslip "wasn't working."

Filing briefs in support of TXO were the American Petroleum Institute, the National Assn. of Manufacturers and the West Virginia Chamber of Commerce.

The court has not yet set a hearing date for its review of TXO, but some attorneys think it may not be heard until its next term, which begins in October 1993. If that is the case, a decision is not expected until early 1994. Briefing is scheduled to be finished by the end of March.

●

TXO Production Corp. vs. Alliance Resources Corp., McDowell County Circuit Court, Civil Action No. 85-C-550.

HIAA proposal

Continued from page 1

Medicare and Medicaid pay the same rates as other buyers of health care services (see related story).

The proposal was immediately welcomed by President-elect Bill Clinton's transition team. Its chief spokesman, George Stephanopoulos, called the proposal a "real breakthrough," adding that universal coverage and cost control are principles that Mr. Clinton supports.

But, unlike a Clinton proposal, the HIAA plan would not set targets or limit national health care spending.

Officials of the trade group said their plan will help to achieve universal coverage and control costs.

"It is also fair to say that it heralds a new era for hospitals, doctors and insurers," said Chairman Ian Rolland.

"This reform proposal marks a fundamental shift by insurers and indicates our deep commitment to meaningful health care reform that ensures coverage for all Americans while preserving the tradition of high-quality care," added Mr. Rolland, who also is chairman and chief executive officer of Lincoln National Life Insurance Co.

Indeed, the proposal does signal a radical break from the HIAA's earlier strident opposition to taxes on health benefits.

In the mid-1980s, the HIAA was a key member of a coalition of insurance companies, employers and labor unions that strongly lobbied against Reagan administration proposals that would have included as taxable income employer-paid health insurance premiums above certain levels.

For example, the HIAA and the American Council of Life Insurance in 1985 gave companies "Employee Action Kits." Included were graphics that could be reprinted in company newsletters. A graphic illustrating the hand of Uncle Sam forcing money out of a wallet briefly explained pending proposals and encouraged employees to write to their representatives (*BI*, May 13, 1985).

But the HIAA board now views the taxes "as a way to constrain prices" while providing a new source of revenue to help fund coverage for the poor, explained G. David Hurd, who is the group's chairman-elect as well as president and CEO of Principal Financial Group in Des Moines, Iowa.

Some health care economists contend that if employees are taxed on health coverage beyond a certain level, they will choose plans with more cost-sharing provisions and will become more careful health care consumers.

The HIAA board is not the first insurer group to endorse taxes on health benefits. As part of a comprehensive reform package, Blue Cross & Blue Shield Assn., the nation's largest private insurer, also proposed taxing the cost of health benefits that exceed a basic level as a way to help fund coverage for the uninsured (*BI*, June 1).

And in Congress, backers of "managed competition," an approach backed in principle by the president-elect, favor ending the corporate tax deduction for health benefits above a certain level.

With the HIAA board's switch, the once solid wall of opposition to taxing health benefits is beginning to crumble.

"It is another crack in the dike that once had been fairly solid against benefit taxation," observed Sylvester Schieber, director of The Wyatt Co.'s Research and Information Center in Washington.

"It is hard to see reforming the health care system and expanding coverage without raising revenues. And, it is hard to see how revenues could be raised without taxing benefits. It is a huge pot of money," said Frank McArdle, a consultant with Hewitt Associates in Washington.

In fact, the Congressional Budget Office has estimated that adding all employer-paid health care benefits to employees' taxable income would generate $39.8 billion in federal revenues this year and $96.3 billion annually by the year 2000.

Still, support for taxing health benefits is by no means unanimous.

Labor groups and employers say that capping the tax break on benefits could cause administrative complications. They compare such a cap to Section 89, the complex non-discrimination rules for health plans that Congress eventually repealed.

For instance, large corporations that offer flexible benefit plans would have to make thousands of calculations to determine whether, and by how much, the cost of benefits selected by employees with company-provided "flex dollars' or "flex credits" exceeded the cost of the essential package.

"Can you imagine the difficulty and nightmare that would result from this?" asked Claudia Bradbury, a policy associate in the AFL-CIO's employee benefits department in Washington.

"Certainly, there would be extensive testing of benefit plans" to determine the amount of taxes that would have to be paid, said Ken Feltman, executive director of the Employers Council on Flexible Compensation in Washington.

Others argue that defining the "essential" package would interfere with the rights of individual employers and employees.

For example, a company with a young female workforce might want to offer enriched prenatal care benefits. But, if such a benefit is not considered a core benefit, the cost of the benefit would be taxed, said Mark Ugoretz, president of the ERISA Industry Committee, a Washington-based benefits lobbying group representing large companies.

"That is one of the problems when you try to mandate a one-size-fits-all benefits package," said Henry Saveth, a principal with A. Foster Higgins & Co. Inc. in New York.

"What is a necessity to one person may be considered a luxury to another and vice versa," said Carson Beadle, a managing director with William M. Mercer Inc. in New York.

But, the Principal Financial Group's Mr. Hurd said the core benefit package still is only a concept rather than a "frozen" list of requirements.

While reserving judgment on the HIAA proposal, some employer benefit lobbying groups commended the HIAA board for trying to become more active in the debate over health care reform.

"What I think people should realize when they see a proposal like this from the HIAA is that more groups are taking the health reform wave seriously," said Ellen Goldstein, director of health care policy at the Assn. of Private Pension & Welfare Plans in Washington.

The HIAA has realized that it cannot defend traditional positions if it wants to have a say in shaping health care policy, she said.

Other groups will re-examine their positions on health care reform for the same reason, she predicted. "Almost every group that is serious about health reform and being involved in the process is going back to its membership and saying, 'We've got to take a look at these tough issues,' " she said. BI

Proposal goes beyond benefit tax

WASHINGTON—Aside from recommending an end to the tax break on health benefits above a certain level, the Health Insurance Assn. of America proposes a number of other reforms. They include:

- Universal coverage. All Americans would be covered by an "essential" health care plan, which the government would help delineate.

Employers would have to provide—though not initially pay for—such a plan. Individuals buying health insurance would be allowed to fully deduct the cost for the essential benefits package.

The HIAA also said, though, that if universal coverage is not achieved this way, employers might be forced to pay some portion of a basic health care plan.

- Cost shifting. Eventually, private insurers and government programs would pay the same or similar rates to doctors and hospitals. Medicare and Medicaid now typically pay lower rates, which drives providers to raise fees for privately insured patients.
- Underwriting reforms. Insurers, among other things, could no longer deny coverage to individuals based on prior medical histories or other factors.

—By Jerry Geisel

Washington state eyes single-payer, universal coverage

OLYMPIA, Wash.—Washington businesses would no longer provide basic health benefits to workers under a single-payer universal coverage plan proposed to Gov. Booth Gardner by the Washington Health Care Commission.

Under the proposal, which will be submitted to the Legislature in 1993, businesses would instead pay a health care payroll tax. An independent state commission would oversee the financing, purchasing and delivery of health services (*BI*, Aug. 17).

Within five years, all state residents would receive a comprehensive, basic "uniform benefits package" through competing certified health plans or through the public health system.

Individuals—except those with very low incomes—would pay at least 5% of the premium for the basic package and "a reasonable share" of medical costs. Employers would be taxed the equivalent of 50% to 90% of premium costs for the basic package for employees—including part-time and seasonal ones—and their dependents.

Employers would pay about 10% of payroll to finance coverage, projects the state Office of Financial Management. By 1999 when fully implemented, the program would require the state to spend an additional $745 million per year, which would be raised through new taxes. Overall, though, the program is expected to save $4.3 billion in medical costs statewide by the year 2000.

—By Louise Kertesz

Policyholders win cover in three Superfund suits

By MICHAEL BRADFORD

Policyholders have recently won a string of victories in Superfund coverage suits, including two where courts found coverage in comprehensive general liability policies even though no lawsuit had been filed against the policyholder.

The Supreme Court of New Hampshire, a Wisconsin appeals court, and a federal district court in Denver last month all sided with policyholders in cases that began with claims brought under the Comprehensive Environmental Response, Compensation and Liability Act of 1980.

"This is a good sign for policyholders," said Edward M. Joyce, an attorney with the New York firm Anderson, Kill, Olick & Oshinsky, which filed amicus briefs in the New Hampshire and Wisconsin cases.

Those two cases, he added, show that policyholders "don't have to be in the courthouse" to have "suits" lodged against them.

"You have a gun at your head under these CERCLA statutes and you have no choice," in defending yourself against claims brought by regulatory agencies. "These are things policyholders can't ignore and they expect to get a defense."

In a 3-2 ruling reversing a lower court decision and remanding the case back to the lower court, the Supreme Court of New Hampshire found that two insurers had a duty to defend the policyholder against administrative actions by a state agency.

The court also found that Coakley Landfill Inc. and Ronald C. Coakley were entitled to indemnification under CGL policies for costs they were charged by state and federal environmental agencies that investigated and cleaned up the landfill site. Liability coverage for the landfill was written by St. Paul Fire & Marine Insurance Co. and Maine Bonding & Casualty Co.—a Zurich Insurance Co. unit.

The landfill accepted municipal and industrial waste until it was forced to close in 1984, when state authorities discovered groundwater contamination.

New Hampshire's high court said, "It should make no difference in terms of insurance coverage whether the engineering firms hired to clean up the polluted groundwater received their money from the Coakleys or from the federal or state government."

Moreover, the court noted, "if we were to allow coverage only when the EPA performs the cleanup, we would encourage parties. . .to ignore EPA cleanup demands and court injunctions, at the added cost to the environment, the insurance companies, and the public."

The insurers argued they had no duty to defend because administrative actions are not "suits" as the term is used in their policies. New Hampshire courts had not previously ruled on this question.

Relying on a dictionary definition of suit as "an attempt to gain an end by legal process; prosecution of a right before any tribunal," the court found that the administrative actions did trigger the duty to defend.

It was not a complete victory for policyholders, though. The court did not allow coverage for costs related to "predominately preventive measures," like capping the landfill.

Although disappointed in the overall ruling, insurers were pleased with that portion of it. Preventive measures likely will cost a "significant sum," said Thomas W. Brunner of the Washington law firm Wiley, Rein & Fielding, which represented Maine Bonding.

In the Wisconsin case, a state appellate court similarly held that a government cleanup order triggered a duty to defend. That court also found that cleanup costs constitute damages and that the personal injury endorsement in a CGL policy provides coverage for groundwater contamination.

The case, which was remanded to the lower court, involved a landfill owned by Edgerton Sand & Gravel Inc. and leased by the city of Edgerton, Wis., from 1968 until 1984, when it was closed because of groundwater contamination.

In 1989, the EPA began its investigation of pollution at the site. Later that year and in 1990, Edgerton Sand & Gravel and the city notified their insurers, which denied that they had a duty to defend or indemnify.

General Casualty Co. of Wisconsin provided liability coverage to Edgerton Sand & Gravel from 1984 to 1986, and also to the city from 1982 to 1986. Aetna Casualty & Surety Co. wrote an umbrella policy for the gravel company from 1974 to 1977, but did not insure the city.

The decision, particularly because of its application of the personal injury endorsement, "will broaden coverage not only in Wisconsin but across the U.S.," said Buck Sweeney, the sole shareholder of the sand and gravel company and an attorney with Michael, Best & Friedrich in Madison, Wis.

The court said "access to, and use of, an undefiled underground water supply is a right of private occupancy" and the "invasion of that right is a personal injury."

William J. Mulligan, an attorney with Davis & Kuelthau in Milwaukee who represented the city, noted, "In a lot of cases there are less exclusionary terms for personal injury than for property damage."

The Wisconsin court held that the insurers' duty to defend was not triggered by letters from the EPA identifying the policyholders as potentially responsible parties in the pollution, but by a Wisconsin Department of Natural Resources letter that "unequivocally imposed upon ES&G and the city the responsibility to remediate and clean up the landfill or bear the expense thereof."

Mr. Sweeney pointed out that the court found that "whether it's from the DNR or the EPA, if it's coercive enough you've got a suit."

The court also ruled that damages include "the costs incurred by ES&G and the city in responding to the Superfund initiative."

Defending their denial of coverage, the insurers argued that the owned-property clause excluded coverage for damage to property owned or used by the insured.

But the court found that the owned-property exclusion did not apply. "This is not a case where the insured is incurring costs primarily to repair its own property," the court ruled. "The cleanup and remediation is intended to repair the environment."

The case is not a total loss for insurers because the court left open some issues to be decided in a trial, said Thomas Harrington of Cook & Franke, the Milwaukee firm that represented General Casualty.

The appeals court disagreed that there was a "continuous trigger" of coverage that calls for coverage from policies written over several years by both General Casualty and Aetna and said the trial court must reconsider that issue.

The case heard in U.S. District Court in Denver was settled before the court's ruling could be finalized.

Following the settlement, the defendant, Transportation Insurance Co. filed a motion to vacate the court's order while plaintiff Gahagen Iron & Metal Co. has filed an opposition to that motion.

Keeping the order intact is important because "it has a potential continuing benefit to Gahagen," said William Watson, an attorney with Holme, Roberts & Owen in Denver, which represents the company.

Leaving the order intact, he explained, would mean that should future claims arise, there is no question that the insurer has a responsibility to provide coverage.

Transportation's attorneys and its parent, CNA Insurance Cos., would not comment on the case.

U.S. District Judge Sherman Finesilver ruled in the case that Transportation had a duty to defend Gahagen in a CERCLA claim filed by Douglas County, Neb., in 1990.

The judge held that Gahagen is entitled to indemnity of $47,000 for "response costs" it paid to settle its CERCLA liability and for an undetermined amount of attorneys' fees and the cost of bringing an action against the insurer.

In the underlying suit, Douglas County charged that Gahagen's sale of recycled wet cell batteries to a reclamation company made it liable for property damage caused by lead contamination at the site.

Gahagen then notified Transportation, which wrote liability coverage for the company. Transportation denied coverage.

Judge Finesilver rejected Transportation's arguments that it had no duty to defend "because the environmental harm did not constitute an 'occurrence' " as defined by the policy and because "Gahagen was not sued for 'damages' but only response costs."

He wrote that "we believe 'response costs' are 'damages' under the CGL policies as that term would be defined" by the Colorado Supreme Court. He added that the pollution exclusion in CGL policies did not apply.

"There is no evidence that Gahagen intended or knew that the sale of batteries to a Nebraska company would result in environmental harm." So, "the pollution was 'sudden and accidental' from Gahagen's perspective and the exclusionary clause is inapplicable," Judge Finesilver said.

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Ronald C. Coakley and Coakley Landfill Inc. vs. Maine Bonding & Casualty Co. and St. Paul Fire & Marine Insurance Co., Supreme Court of New Hampshire; Case No. 90-401.

City of Edgerton and Edgerton Sand & Gravel Inc. vs. General Casualty Co. of Wisconsin, Wisconsin Insurance Security Fund and Aetna Casualty & Surety Co., Wisconsin Court of Appeals District IV; Case No. 91-1408.

Gahagen Iron & Metal Co. vs. Transportation Insurance Co., U.S. District Court for the District of Colorado; Case No. 91 F 1984.

Update

New Jersey health bill enacted

Continued from page 2

New Jersey Gov. Jim Florio signed the hospital reimbursement plan last week. The new funding mechanism (*BI*, Nov. 30) replaces the recently expired 19.1% hospital-bill surcharge, which a federal judge in May ruled was illegal (*BI*, June 1). The state is appealing to the 3rd U.S. Circuit Court of Appeals.

That ruling is the model for a suit filed in federal court in Brooklyn Nov. 25 by locals of the International Brotherhood of Electrical Workers and the United Food and Commercial Workers. The unions argue that a 5.5% average surcharge for uncompensated care and a law that requires all health care payers except Blue Cross/Blue Shield plans, Medicaid and Medicare to pay an additional 13% hospital-bill surcharge violates the Employee Retirement Income Security Act. The surcharges paid for over $1 billion in uncompensated care last year.

"Based on the New Jersey decision, we're very confident we'll eventually win this case," said the unions' attorney, Edward Groarke of Colleran, O'Hara & Mills in Garden City, N.Y. The state has until year end to respond to the suit.

Shiley to appeal venue ruling

SANTA ANA, Calif.—Shiley Inc. plans to appeal a California trial judge's ruling that domestic out-of-state recipients of defective heart valves can sue the Irvine, Calif.-based manufacturer and its parent, Pfizer Inc. of New York, for emotional distress in California courts.

The Nov. 25 ruling by Judge William F. Rylaarsdam was in response to an order by the 4th U.S. Circuit Court of Appeal to reconsider his earlier ruling in light of a California Supreme Court decision (*BI*, March 16). In June, the state's high court ruled that non-residents cannot file emotional distress suits against the defendants in California simply because the states or countries in which they reside prohibit damages for mental distress caused by fear the valves might fail.

Judge Rylaarsdam's latest ruling "is incorrect and inconsistent with previous California appellate decisions," said Pfizer, adding that it will appeal the decision to the California Court of Appeal.

But Pfizer was pleased with a portion of the ruling that claims filed by foreign residents with properly functioning Shiley Convexo/Concave valves should be tried in their home countries.

California is the only U.S. jurisdiction that recognizes a cause of action for physical and mental distress caused by fear the valves might fail. Pfizer settled an additional 330 heart valve claims late last month for an undisclosed amount (*BI*, Nov. 30).

Briefly noted

In the first subrogation suit filed by an insurer over losses stemming from the **Chicago underground flood** last April, ITT/Hartford Group Inc. is seeking more than $3.4 million in damages from the city and Great Lakes Dredge & Dock Co. (*BI*, April 20). Hartford paid claims ranging from less than $1,000 to $3.38 million to 20 policyholders. . . .Overturning lower court rulings, the Illinois Supreme Court ruled Friday that the pollution exclusion clause in CGL policies **does not bar coverage for pollution** that is unintentional but does not occur abruptly. . . .Sixty-eight Boston residents who claim they were sexually abused by a **Roman Catholic parish priest** in the 1960s settled last week with the Fall River, Mass., Diocese. It is unclear whether the settlement will affect a coverage dispute between the diocese and Continental Insurance Co. (*BI*, Sept. 7). . . .The California Insurance Department has not decided whether to appeal a Nov. 30 state appellate court decision that the holders of guaranteed investment contracts backing municipal bonds should receive the same payout as other policyholders under **Executive Life Insurance Co.'s reorganization plan** (*BI*, Nov. 25, 1991). . . .Donald Payne, chairman of wholesale and reinsurance broker Willis Faber & Dumas will become chief executive of retail brokerage affiliate **Willis Corroon** in 1993. Max Taylor will become chairman and CEO of Willis Faber & Dumas. . . .Connecticut Insurance Commissioner Robert Googins last week approved a 12.8% **workers comp rate increase** for voluntary coverage and a 13% increase for assigned risks. The NCCI had proposed a 13.7% increase for the voluntary market and a 15.3% increase for the assigned risk pool. . . .Standard & Poor's Corp. has reduced the financial strength rating of the **State Workmen's Insurance Fund of Pennsylvania** to Bq, or "vulnerable." The state-owned residual market had previously been rated BBq, or "may be adequate". . . .**Ron D. Barbaro**, 61, president of the Prudential Insurance Co. of America, will retire at the end of the year. No successor was announced. . . .William R. Stover, 70, will retire as chairman of **Old Republic International Corp.** of Chicago at year-end. A.C. Zucaro, who is president and CEO, will assume the additional title of chairman. . . .California Insurance Commissioner John Garamendi rejected **a 12.6% workers comp insurance rate increase** proposed by the Workers Compensation Insurance Rating Bureau. . . .**Chubb Corp.** and its Chubb Capital Corp. unit received a preliminary senior debt rating of Aa2 for a $250 million shelf registration from Moody's Investors Service Inc., and an Aa+ rating from S&P. Moody's last week also placed the debt rating of **UNUM Corp.** and the financial strength rating of its subsidiaries under review for a possible downgrade, citing UNUM's planned acquisition of Colonial Cos. Inc. . . .United Security Life Insurance Co. is asking a state court to **disqualify Texas Insurance Commissioner Georgia D. Flint**, saying she lacks the 10 years experience as required by law to hold the position. . . .Ten retirees are suing **Unisys Corp.**, claiming its plan to begin phasing out retiree medical coverage on Jan. 1 is illegal (*BI*, Nov. 9). The suit seeks class-action status, a declaratory judgment and unspecified damages. . . .**Hawaiian Insurance Group** will cease writing and renewing policies immediately, following a revision of its estimate of claims from Hurricane Iniki. HIG expects claims to exceed $300 million, up from an early estimate of $200 million (*BI*, Sept. 28).

Mission offset ruling

Continued from page 2

case.

"This is the one everyone was waiting for," he said.

The ruling "settles once and for all the validity of (offsets) in liquidations," said Ronald Gass, assistant general counsel of the American Insurance Assn. in Washington. The AIA filed a friend of the court brief with four other insurance trade groups in the case.

"We are disappointed, but if that's what the court has said, that's what we have to do," said Geoffrey Nicholls, California special deputy insurance commissioner and chief executive officer of the Mission Insurance Cos. Trust.

John W. Gates, executive director of the California Insurance Guaranty Assn., also expressed disappointment with the ruling.

CIGA, which supported the liquidator's arguments against offsets, has pegged its gross paid, unpaid and incurred-but-not-reported losses from the four Mission units in liquidation at about $630 million as of Sept. 30, according to Mr. Gates.

This figure is somewhat less than the $714 million loss and loss reserve total CIGA reported as of Sept. 30, 1989, largely because loss development has been less severe than anticipated, Mr. Gates said.

Mr. Nicholls estimated the overall insolvency of the Mission units—ordered liquidated in February 1987—at about $1.3 billion, also slightly less than earlier estimates of $1.5 billion.

The vast majority of the 144 Mission reinsurers sued by the liquidator for full payment of claims have reached settlements with the estate, lawyers involved in the case say.

Many of these reinsurers had offset claims in varying amounts, and as part of their settlements the reinsurers placed funds in escrow pending the outcome of the offset litigation.

Though the total amount of offset claims had earlier been estimated at up to $300 million, the actual figure will be between $100 million and $200 million, "and probably in the low end of that range," according to Mr. Nicholls.

Separately, Mission's liquidator filed a new complaint against 56 reinsurers not named in the original action, seeking about $14 million in claim payments. These reinsurers had been paying claims or discussing settlements but have since stopped, according to Melissa Kooistra, a lawyer with Rubinstein & Perry in Los Angeles, which represents the liquidator.

The suit was filed in Los Angeles County Superior Court Oct. 5.

Mission's liquidator won the first round of the offset litigation in 1990, when a Los Angeles Superior Court judge issued a ruling that would have severely restricted Pru Re's offset claims.

The California Court of Appeals overturned the decision, though, after taking the unusual procedural step of suspending the ruling and ordering the trial court to show cause why it should not be overturned.

In its Nov. 30 ruling, a majority of the state Supreme Court affirmed the appellate decision.

Pru Re reinsured various Mission units under 14 different reinsurance treaties, while two Mission units in turn reinsured Pru Re and one of its subsidiaries, Gibraltar Casualty Co., under a different set of contracts.

Among other things, the Supreme Court found that:

- Most of the obligations arising from the contracts are "mutual credits and debts" that may be offset under California law.

The liquidator raised several objections to the finding of mutuality, all of which failed. The liquidator argued, for example, that the credits and debts didn't meet the required standard of being "contemporaneous," because loss payments owed by the reinsurers arose after the liquidation, while premiums owed by Mission were due before the liquidation.

The liquidator also argued unsuccessfully that the insolvency clause in the reinsurance contracts—which requires payment of reinsurance claims "without diminution because of insolvency"—bars offsets; and that the mutuality of the parties was destroyed by the liquidation order itself, which substituted the insurance commissioner for Mission.

However, the Supreme Court majority also refused to allow Pru Re to offset balances it owes Mission against balances Mission owes Gibraltar. Gibraltar ceded business to Mission but did not assume reinsurance from the group and therefore does not have mutual credits and debts.

Karl Rubinstein of Rubinstein & Perry said the exclusion of such "group to group" offset claims accounted for the difference between the $300 million estimate of offset claims and the current $100 million to $200 million estimate.

- Under California statutes, reinsurers' right of offset does not depend on the ability of an insolvent insurer's estate to first pay claimants in higher priority creditor classes.

The liquidator had argued that this would create an unfair preference, allowing reinsurers to recover claims before Mission policyholders and other higher priority claimants.

- Public policy considerations do not favor rejecting reinsurers' right of offset.

Although allowing offsets reduces the Mission estate's recoveries, there is no evidence that this would "harm the public," the majority concluded.

Citing the Midland ruling, the court also observed that offsets function as "mutual security for performance," strengthening the insurance marketplace.

In a 46-page dissenting opinion, three judges maintained that allowing offsets "elevates the economic interests of reinsurers over the legislatively preferred and equitably superior rights of policyholders."

The majority opinion "results from a fundamental misunderstanding of the insurance insolvency statutes and contravenes clear (state) legislative intent," the dissent argues.

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Prudential Reinsurance Co. vs. The Superior Court of Los Angeles County, respondent; John Garamendi, real party in interest; S 014036.

Storm's insured toll is put at $425 million

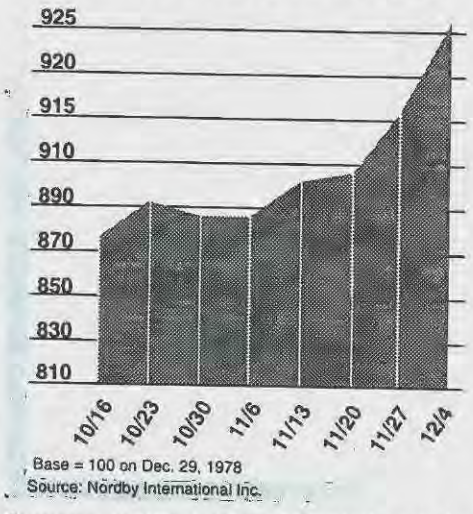
RAHWAY, N.J.—Severe weather—including killer tornadoes that raked much of the southern United States in late November—caused $425 million in insured property damage, estimates the Property Claim Services division of the American Insurance Services Group.

Hardest hit was Texas, with an estimated $125 million in insured property losses. Violent weather, including high winds, flooding and tornadoes, hit 11 states from Texas to North Carolina and north to Ohio Nov. 21-23. It was assigned Catastrophe No. 37.

Separately, wind and flooding caused an estimated $45 million in insured property damage to portions of Kentucky, New York, Ohio and Pennsylvania Nov. 12-13. The severe weather was assigned Catastrophe No. 36.

—By Mark Hofmann

BI Insurance Index



Base = 100 on Dec. 29, 1978
Source: Nordby International Inc.

Insurance industry stocks advanced again last week, as the *Business Insurance* Index climbed 10.5 points to 925.8 on Dec. 4 from 915.3 on Nov. 25. Advancing issues for the week were led by Seibels Bruce Group, up 22.2%; Travelers Corp., up 9.2%; and Kemper Corp., up 8.9%. Declining issues for the week followed FHP International, down 8.8%; Pacificare Health System, down 8.0%; and AVEMCO Corp., down 5.8%. The most active issue was Sears (Allstate), with 5.5 million shares traded. The *BI* Index was up 1.2%; the NYSE Composite was up 0.7%; the Standard & Poor's 500 was up 0.7%; and the Dow Jones 30 Industrials rose 0.7%.

British Issues

Dec. 3 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence	pence
Commi Union	595	N/M	31.5	5.3	625	595
Genl Accident	578	N/M	35.7	6.2	601	578
Gdn Royal Exch	174	N/M	10.0	5.7	185	174
Royal	273	N/M	7.0*	2.8	277	253
Sun Alliance	331	N/M	19.0	5.7	350	331
Brokers						
Bradstock	112	12.5	6.3	5.6	112	112
CE Heath	324	18.8	21.3	6.6	324	318
Hogg Group	150	14.1	10.9	7.3	150	150
JIB Group	145	11.1	10.0	6.9	145	145
Lloyd Thompson	234	18.9	7.5	3.2	234	234
Lowndes Lmbrt	313	12.2	16.8	5.4	316	313
PWS Holdings	40	4.6	5.3	13.3	40	40
Sedgwick Grp	147	11.7	8.0*	5.4	147	144
Steel Brrl Jones	198	9.7	17.7	8.9	201	198
Willis Corroon	178	11.3	17.6	9.9	180	178

Source: Philip Olsen, London * Estimated

BI Industry Stock Report

NOVEMBER 30, 1992 THROUGH DECEMBER 4, 1992

		Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
BROKERS												
Alexander & Alexander	NYS	26.75	1.90	30.49	27.38	18.00	1535	1.00	3.74	96	10.00	2.68
Gallagher Arthur J. & Co.	NYS	27.50	-0.45	22.91	29.00	20.00	372	0.64	2.33	18	6.35	4.33
Frank B. Hall	NYS	2.88	0.00	-32.35	5.50	2.63	0	0.00	0.00	-3	N/A	N/A
Hilb, Rogal & Hamilton	NYS	15.25	2.52	15.09	15.63	11.00	101	0.44	2.89	23	3.11	4.90
Marsh & McLennan	NYS	92.13	-0.14	13.21	94.50	71.25	564	2.68	2.91	22	14.40	6.40
Poe & Associates	OTC	16.00	3.23	33.33	16.75	11.25	63	0.40	2.50	20	2.64	6.06
BROKERS	AVERAGE		1.2	13.8					2.1	25		
CONGLOMERATES & HOLDING COMPANIES												
Berkley W.R. Corp.	OTC	43.75	0.00	43.44	47.75	27.25	1432	0.36	0.82	16	23.51	1.86
Berkshire Hathaway Inc.	NYS	10850.0	0.46	19.89	10850.0	259.38	19	0.00	0.00	43	6437.25	1.69
ITT (Hartford Group)	NYS	71.88	2.68	24.46	71.88	50.00	1451	1.84	2.56	17	68.23	1.05
Sears (Allstate)	NYS	44.13	3.22	16.50	48.00	32.50	5507	2.00	4.53	43	40.18	1.10
CONGLOMERATES	AVERAGE		1.6	26.1					2.0	30		
INSURERS/REINSURERS												
AEGON N.V.	NYS	40.75	0.31	16.43	42.75	33.00	20	2.68	6.58	7	34.06	1.20
Aetna Life & Casualty	NYS	47.75	7.91	8.52	47.75	36.50	1784	2.76	5.78	15	67.08	0.71
Allied Group Inc.	OTC	31.50	1.61	85.29	31.50	16.25	46	0.64	2.03	9	11.29	2.79
American General	NYS	52.50	-3.89	17.98	54.75	40.13	464	2.08	3.96	11	39.89	1.32
American Heritage Life Ins.	NYS	30.88	0.82	0.82	32.50	22.13	4	0.84	2.72	15	16.51	1.87
American Indemnity/Fin'l	OTC	5.75	0.00	21.05	9.25	4.63	0	0.08	1.39	3	14.43	0.40
American International	NYS	116.25	2.09	18.17	116.75	82.00	2066	0.56	0.48	16	54.21	2.14
Aon Corp.	NYS	50.88	0.00	28.39	51.63	37.38	453	1.68	3.30	13	27.17	1.87
Argonaut Group	OTC	28.50	0.00	20.00	30.00	21.75	23	0.84	2.95	8	21.70	1.31
AVEMCO Corp.	NYS	22.50	-5.75	-10.00	28.00	21.50	38	0.40	1.78	24	7.33	3.07
Baldwin & Lyons Inc.	OTC	36.50	7.35	41.75	36.50	25.00	1	0.48	1.32	9	30.85	1.18
Chandler Insurance	OTC	4.38	-5.41	34.62	7.63	3.19	4	0.00	0.00	20	8.63	0.51
Chubb Corp.	NYS	86.00	-2.96	11.69	89.75	62.38	1233	1.60	1.86	14	40.67	2.11
CIGNA Corp.	NYS	58.75	3.52	-3.89	61.75	47.13	780	3.04	5.17	11	81.73	0.72
CNA Financial Corp.	NYS	93.00	-1.59	-5.10	104.50	78.50	98	0.00	0.00	11	80.24	1.16
Continental Corp.	NYS	27.13	-2.25	-1.81	34.75	20.00	1054	1.00	3.69	20	38.32	0.71
EXEL Ltd.	NYS	44.63	-0.83	19.00	46.38	32.13	921	0.92	2.06	9	N/A	N/A
Fund American Corp.	NYS	73.25	-1.01	4.83	74.50	62.50	81	0.68	0.93	17	81.85	0.89
Fremont General Corp.	OTC	26.00	-1.89	6.67	27.25	17.00	169	1.00	3.85	6	25.62	1.01
Frontier Insurance Group	NYS	37.75	6.34	39.81	40.50	22.16	67	0.60	1.59	13	13.97	2.70
Gainsco Inc.	ASE	15.13	3.42	62.05	15.63	7.72	47	0.04	0.26	21	2.65	5.71
General RE Corp.	NYS	112.75	1.81	10.67	117.00	77.50	693	1.80	1.60	16	46.07	2.45
Guaranty National Corp.	NYS	17.75	-2.07	22.41	20.38	13.00	268	0.48	2.70	11	9.12	1.95
Hanover Insurance Co.	OTC	49.13	-0.25	37.41	49.63	33.00	154	0.44	0.90	8	40.44	1.21
Harleysville Group	OTC	26.50	1.92	24.71	28.25	17.75	72	0.64	2.42	11	16.77	1.58
Hartford Steam Boiler	NYS	56.13	2.75	-2.39	59.25	45.13	49	2.12	3.78	22	19.74	2.84
Kemper Corp.	NYS	29.00	8.92	-23.93	46.13	20.75	1273	0.92	3.17	21	37.66	0.77
Lawrence Insurance Group	ASE	8.75	-2.78	-21.35	11.13	7.00	8	0.48	5.49	20	4.66	1.88
Liberty Corp.	NYS	28.13	3.21	27.12	32.88	20.13	35	0.56	1.99	11	18.43	1.53
Lincoln National	NYS	72.75	3.01	32.88	72.75	49.38	397	3.04	4.18	11	58.92	1.23
Markel Corp.	OTC	29.25	2.63	32.95	29.25	18.00	70	0.00	0.00	7	15.44	1.89
Mutual Risk Mgmt. Ltd.	NYS	38.00	7.04	8.19	40.00	25.75	65	0.24	0.63	22	7.51	5.06
NAC Re Corp.	OTC	37.50	-3.23	19.05	42.00	21.75	689	0.16	0.43	33	13.60	2.76
National Re Corp.	NYS	27.50	-4.76	N/A	31.00	17.00	140	0.12	0.44	13	N/A	N/A
Navigators Group	OTC	34.00	-2.86	-17.07	48.25	28.50	30	0.00	0.00	24	15.69	2.17
Nobel Insurance LTD.	OTC	5.63	7.14	40.63	6.00	3.75	340	0.00	0.00	4	3.91	1.44
NWNL Companies	NYS	46.38	1.37	49.00	46.38	26.00	238	1.48	3.19	12	46.21	1.00
Ohio Casualty Corp.	OTC	61.13	-0.81	23.48	66.63	46.25	248	2.68	4.38	12	43.08	1.42
Old Republic Int'l	NYS	25.00	0.00	40.85	26.50	16.00	225	0.40	1.60	8	18.63	1.34
Orion Capital Corp.	NYS	37.63	0.33	18.97	41.00	29.00	38	1.00	2.66	6	28.62	1.31
Phoenix RE Corp.	OTC	13.75	4.76	30.95	13.75	8.75	238	0.20	1.45	-20	13.32	1.03
Provident Life	NYS	26.50	2.42	13.98	28.00	20.00	99	1.00	3.77	11	30.38	0.87
Re Capital Corp.	ASE	15.38	-2.38	6.96	16.38	12.25	8	0.24	1.56	27	16.88	0.91
Reliance Group Holdings	NYS	6.75	8.00	63.64	6.75	3.50	479	0.32	4.74	3	2.94	2.30
RLI Corp.	NYS	23.38	0.00	41.67	23.63	15.50	11	0.52	2.22	10	16.15	1.45
St. Paul Companies	NYS	75.00	1.18	2.92	80.75	66.50	946	2.72	3.63	11	59.79	1.25
SAFECO Corp.	OTC	56.75	1.34	16.41	57.00	41.88	565	1.64	2.89	14	35.37	1.60
SCOR U.S. Corp.	NYS	18.25	-1.35	18.70	19.50	13.13	28	0.28	1.53	18	14.39	1.27
Seibels Bruce Group	OTC	1.38	22.22	-75.00	6.50	0.38	198	0.36	26.18	0	6.22	0.22
Selective Ins. Group	OTC	22.00	5.39	31.34	23.50	16.00	81	1.12	5.09	9	20.22	1.09
Statesman Group Inc.	OTC	9.75	-1.27	69.57	10.25	5.00	589	0.00	0.00	5	6.71	1.45
Tokio Marine & Fire	OTC	46.13	0.27	-10.44	55.25	32.25	0	0.00	0.00	92	70.93	0.65
Torchmark Corp.	NYS	51.50	-0.24	33.48	54.50	34.41	702	1.04	2.02	15	14.87	3.46
Transamerica	NYS	47.75	2.41	19.75	47.75	35.63	352	2.00	4.19	22	35.86	1.33
Transatlantic Holdings	NYS	51.63	2.48	32.80	52.75	29.38	143	0.28	0.54	18	21.85	2.36
Travelers Corp.	NYS	25.13	9.24	16.18	25.13	17.13	3197	1.60	6.37	-14	43.85	0.57
Trenwick Group Inc.	OTC	39.50	1.94	38.60	42.00	25.00	126	0.80	2.03	16	23.87	1.65
United Fire & Casualty	OTC	42.00	5.00	40.00	42.50	29.16	0	1.00	2.38	18	28.47	1.48
Unitrin	OTC	39.25	1.95	9.79	39.50	31.00	199	1.20	3.06	12	36.51	1.08
UNUM Corp.	NYS	52.50	3.70	29.63	52.50	32.00	1059	0.64	1.22	15	21.83	2.40
US Facilities Corp.	OTC	9.25	8.82	-37.82	19.00	7.00	298	0.00	0.00	9	8.90	1.04
USF&G Corp.	NYS	13.38	-2.73	84.48	15.00	5.63	1093	0.20	1.50	-26	10.29	1.30
USLICO Corp.	NYS	17.13	0.74	-7.43	20.38	16.75	19	1.00	5.84	24	29.80	0.57
USLIFE Corp.	NYS	51.75	2.99	8.09	52.50	39.00	172	1.80	3.48	10	64.90	0.80
Washington National	NYS	22.63	-1.63	42.52	23.63	14.00	70	1.08	4.77	18	30.27	0.75
Zenith National Ins.	NYS	16.75	0.75	-0.74	19.50	13.75	79	1.00	5.97	12	14.81	1.13
INSURERS/REINSURERS	AVERAGE		1.6	19.1					3.3	15.3		
HEALTH MAINTENANCE ORGANIZATIONS												
FHP International	OTC	20.75	-8.79	45.61	23.00	10.38	1062	0.00	0.00	20	9.61	2.16
Pacificare Health Sys.	OTC	41.63	-8.01	110.76	46.75	15.25	475	0.00	0.00	23	3.90	10.67
Safeguard Health Enter.	OTC	9.25	0.00	-1.33	14.75	7.00	39	0.00	0.00	11	4.03	2.30
Sierra Health Services	ASE	40.00	-2.14	332.43	41.88	15.00	142	0.00	0.00	19	4.01	9.98
United Healthcare Corp.	NYS	56.88	3.41	52.68	56.88	31.81	906	0.01	0.02	37	4.68	12.15
United Medical Corp.	ASE	6.50	1.96	-7.14	8.75	6.38	0	0.20	3.08	59	10.30	0.63
U.S. Healthcare	OTC	46.00	-0.54	66.27	51.25	23.16	4998	0.52	1.13	27	3.60	12.78
HMOs	AVERAGE		-2.0	85.6					0.5	25		
ALL COMPANIES	AVERAGE		0.6	36.1					2.7	18		

System design: Nordby International Inc.

The snowshoe rabbit changes color with the season, adopting a white coat in winter and a brown coat in summer. This change, which is governed by the shortening length of day, enables the rabbit to blend into its background for protection.

The Ability To Adapt To The Environment Is Necessary For Survival In Nature. And In Benefits Management.

In nature, the ability to change and adapt is required for survival. In managing employee benefits programs, it's also becoming a necessity.

The Mutual of Omaha Companies recognize this need. Our experience in developing and offering PPO, EPO, HMO and point-of-service plans gives us the ability to work with companies to design benefit programs that can meet their changing needs. Our years of experience have taught us the best ways to prepare for change — and therefore, we're ready to help benefits managers meet it.

Nature is experienced at managing change. And so are we.

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