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update

Claims-made policy to get limited approval in Michigan

LANSING, Mich.—The Michigan Insurance Bureau is close to approving limited use of the Insurance Services Office claims-made commercial general liability form.

Under guidelines prepared by the bureau, the form could be used for professional liability, medical malpractice, municipal liability, product liability for distributors and manufacturers, liquor liabil-

Continued on next page

'Look to the past,' comp reformers told

By CAROL CAIN

The start of many state legislative sessions is only a calendar page away, and in more than a dozen states that signals the beginning of renewed debate on how to redesign their workers compensation systems.

But work comp scholars and experts are cautioning legislative "reformers" against excessive remodeling of a system that celebrates its 75th anniversary in the United States this year.

They advise these modern-day legislative architects to study the beginnings of both U.S. and European workers compensation systems before putting their chisels to existing state laws.

"The people calling for reforms today are not calling for anything new," observes Sam Sorich, assistant vp of the National Assn. of Independent Insurers in Des Plaines, Ill. He suggested reformers should "get back to basics."

In at least three states—New York, California and Kentucky—study reports already are on the table, awaiting legislative response.

The New York report suggests reforming its workers compensation system by better coordinating the elements of the system, including indemnity and medical benefits, rehabilitation efforts, prevention programs and administration (*BI*, Aug. 4).

In California, reform legislation that failed to win approval before lawmakers adjourned in September is expected to be reintroduced next year. That legislation—which was the result of months of study and negotiation by employers, employees, insurers, physicians, attorneys and legislators—called for an increase in maximum weekly benefits, the repeal of the current permanent disability rating schedule and the integration of vocational rehabilitation with permanent disability benefits (*BI*, Sept. 15).

And a study on permanent partial disability benefit recipients in

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University, alumnus envision chair to honor workers comp scholar
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First risk retention group licensed under new law

By JERRY GEISEL

WASHINGTON—The first risk retention group established under the newly expanded federal Risk Retention Act will begin writing professional liability policies for certified public accountants next month.

C-PAC-O, short for CPA Risk Retention Group Corp., licensed Dec. 2 in Delaware, will provide up to $1 million in coverage for a potential market of 25,000 small and medium-sized accounting firms.

The licensing of C-PAC-O, a stock company owned by policyholders, was announced last week with fanfare at a press conference in Washington by Delaware Insurance Commissioner David N. Levinson and C-PAC-O backers and organizers. They said its formation is only the first of what is likely to be a wave of risk retention groups.

"The licensing of this CPA risk retention group establishes the starting point in our efforts to make Delaware the major national center for risk retention groups," Mr. Levinson said.

C-PAC-O was licensed under Delaware's captive insurance company law, which can ease the licensing of a risk retention group. C-PAC-O also is the first company to be licensed under Delaware's 1984 captive law.

Delaware regulators say they are engaged in serious discussions with about a dozen organizations interested in setting up risk retention groups.

And in Vermont, which has a highly attractive captive law, Chief Insurance Examiner Ed Meehan says three—and possibly four—risk retention groups could be licensed by the end of the year. Applications for 10 more risk retention groups are expected soon, he said.

"My phone keeps ringing off the hook," Mr. Meehan says, noting that the number of Vermont captives, including single-parent companies, conventional association captives and risk retention groups, could double in a year to 120.

"There never has been anything like it," Mr. Meehan said, adding that Vermont's current roster of 60 captives compares with just 33 captives at the beginning of the 1986.

Other risk retention groups will be formed soon.

For example, the University Risk Management and Insurance Assn. is forming a Tennessee-based risk retention group, University College Mutual Insurance Co., that will offer up to $5 million in educators legal liability insurance to colleges and universities (see story, page 2).

New York-based Alexander & Alexander Services Inc. is organizing a risk retention group—Environmental Protection Insurance Co.—to provide environmental impairment liability coverage to enable small and medium-size companies to meet federal and state financial responsibility requirements (see story, page 22).

The group probably will be chartered in Illinois, said A&A Vp Harry Shuford.

A&A also is working with two trade associations for computer and health care companies that are interested in setting up risk retention groups, Mr. Shuford said.

A large Bermuda captive providing liability coverage for dozens of chemical manufacturers is considering coming onshore as a Delaware risk retention group, *Business Insurance* has learned.

In addition, broker Johnson & Higgins announced last month that it is organizing a risk retention group —to be domiciled in Vermont—to provide EIL coverage to policyholder-investors (*BI*, Nov. 17).

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Reinsurers expect results to improve through 1987

By JUDY GREENWALD

U.S. reinsurers, whose underwriting results continued to improve during the third quarter, are optimistic their good fortunes will continue through the remainder of 1986 and through 1987.

The 70 reinsurers surveyed by the Reinsurance Assn. of America posted a 104.9% aggregate combined ratio during the first nine months of 1986, compared with a 119.3% combined ratio for the comparable period a year ago and 106.3% at the end of the first half of 1986.

Fifteen of the 70 companies reported combined ratios of less than 100% during the nine-month period.

However, Bard E. Bunaes, chairman and president of New York-based Constitution Reinsurance Corp., said, "That's probably not an entirely true picture, because there are a large number of companies that have gone out of the reinsurance business and are not included" in this survey but were included in last year's study.

The Top 20 reinsurers, based on net written premium volume, reported virtually identical results to the whole group, posting a 104.8% aggregate combined ratio, compared with a 118.6% combined ratio for the first nine months of 1985 and 105.9% at the end of the first half of this year.

Five members of the Top 20 reported combined ratios of less than 100% during the first nine months of 1986.

Reinsurers noted their results have been bolstered so far this year partly because of mild weather conditions, which reduced the amount of catastrophe-related losses. That factor was also cited by primary property/casualty insurers in explaining their improved results (*BI*, Dec. 1).

Mr. Bunaes, who noted he was surprised by the rapid improvement in the reinsurance industry's underwriting results, said, "The absence of large, natural

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Lowest combined ratios

Reinsurer	Nine months 1986	1985
Home Re	97.9%	111.0%
St. Paul Re	98.1	121.7
American Re	98.5	118.9
USF&G Corp.	99.0	108.0
Munich Re	99.4	110.1

Highest combined ratios

N.Y. Insurance Exchange	129.0%	149.8%
Skandia America Group	114.0	129.3
Transatlantic Re	109.9	128.1
North American/Swiss Re	109.1	117.7
Buffalo Re	108.9	123.2
Constitution State Mgt.	108.9	118.9

Chart: Amy Palmer

update

Michigan to set CGL guidelines

Continued from previous page
ity for restaurants and bars and environmental liability for ground and water pollution. The guidelines also allow the form to be used for policies that provide at least $1 million in aggregate limits.

So far, 42 states have approved the form. Among those that have not are New York, Massachusetts and Texas.

Bailey to head new MBIA

WHITE PLAINS, N.Y.—William O. Bailey will leave his position as president of Aetna Life & Casualty Co. to assume the position of chairman and chief executive officer of the newly reorganized Municipal Bond Insurance Assn., a financial guarantee insurer.

Mr. Bailey will become Aetna's vice chairman and divide his time between the two companies. Aetna Chairman James T. Lynn will assume the position of president, and the two will serve jointly in the company's newly created Office of the Chairman.

MBIA, an association of multiline insurers, is reorganizing to become a monoline insurer, Municipal Bond Investors Assurance Corp., which will be capitalized at about $420 million.

Investors in the new corporation will be Aetna, Fireman's Fund Insurance Cos., CIGNA Corp. and Continental Insurance Cos., which have been MBIA participants. Travelers Indemnity Co., which had participated in MBIA, will not be an investor.

PBGC allowed to terminate plan

NEW HAVEN, Conn.—The Pension Benefit Guaranty Corp. has the right to force the termination of an underfunded pension plan of a company in bankruptcy proceedings, a federal judge ruled.

Judge Jose Cabranes' ruling gives the PBGC the right to terminate a pension plan sponsored by Century Brass Products Inc. covering about 3,000 former and current United Auto Workers union members. Waterbury, Conn.-based Century Brass filed a petition for reorganization under the Bankruptcy Code last year.

The decision sets a retroactive termination date of Dec. 2, 1985, when the PBGC filed suit to terminate the plan (*BI*, Dec. 30, 1985). A UAW local had opposed the forced termination.

The Century Brass plan has an unfunded liability of about $32 million, according to the PBGC.

NAIC sets risk retention rules

ORLANDO, Fla.—A model state law for regulating risk retention groups and risk purchasing groups will be presented to state insurance regulators for adoption this week during the annual winter meeting of the National Assn. of Insurance Commissioners.

The expanded federal Risk Retention Act grants state regulators certain authority over risk retention groups. State laws need to be amended to incorporate that authority.

The NAIC also will consider a recommendation from a working group of regulators that the NAIC reject the Insurance Services Office's proposal to include defense costs within the limits of ISO's commercial general liability forms.

The working group will recommend that ISO adopt an "outside" limit on defense costs, restricted to commercial lines where defense costs are clearly demonstrated to be a significant problem.

The Risk & Insurance Management Society, which is represented on an advisory committee to the working group, is expected to "strongly advocate" that any outside limit on defense costs at least equal the aggregate limit of the policy and that the policyholder have the right to control all aspects of litigation once the outside defense limit is exhausted.

5 sentenced in Kenilworth case

CHICAGO—Jack V. Goepfert was sentenced last week to three years in prison on mail fraud charged stemming from his role in the 1982 collapse of Kenilworth Insurance Co. (*BI*, May 12).

Four others involved in the premium diversion and commission kickback schemes also were sentenced for fraud:

- Chester Mitchell, former Kenilworth president, sentenced to six months in a work-release program and 3,000 hours of community service. He pleaded guilty to mail fraud.
- Robert Patterson, a Chicago agent who produced business for Kenilworth, sentenced to 18 months in jail, $8,000 in fines, 1,000 hours of community service and ordered to divest any interest in the insurance business. He was convicted of mail fraud.
- Joseph Cosentino Sr., another Chicago agent, sentenced to a nine-month jail term and 3,000 hours of community service. He was convicted of mail fraud and pleaded guilty to three counts of failing to file income tax returns.
- Willard W. Hayne, former owner of Essex Insurance Brokers Inc. in San Diego, which produced business for Kenilworth, ordered to make restitution of $7,300 and sentenced to 200 hours of community service. He pleaded guilty to wire fraud and transporting a check obtained for fraudulent means over state lines.

All five men also were given five years' probation and barred from work in the insurance industry for the same period.

Briefly noted

The 1,275-member National Assn. of Mutual Insurance Cos. is forming a captive stock insurer, **NAMIC Insurance Co. Inc.** in Indianapolis, to write directors and officers liability, company professional liability and agents errors and omissions coverage. . . .**Union Carbide Corp.** and the Indian government agreed Union Carbide will maintain assets worth $3 billion in the United States to satisfy potential judgments for victims of a 1984 gas leak in Bhopal, India. As a result, an Indian court lifted a temporary restraining order forbidding Union Carbide from selling any assets, paying dividends or buying back debt (*BI*, Nov. 24).

Two new facilities to write educators liability policies

By JUDY GREENWALD

NEW YORK—The continuing liability insurance crunch and the passage of the expanded Risk Retention Act are prompting the formation of two new insurers for educational institutions.

School, College, and University Underwriters Ltd., a Bermuda insurer now being organized by Marsh & McLennan Inc. and Morgan Guaranty Trust Co., expects to offer up to $5 million in primary or excess educators legal liability insurance, which covers individuals as well as the institutions like directors and officers liability insurance covers corporate directors and officers.

SCUUL, a stock insurer, also expects ultimately to offer excess liability coverage of up to $25 million excess of $1 million to tax-exempt and non-profit educational institutions, according to its organizers.

In addition, the University Risk Management & Insurance Assn. has incorporated a Tennessee- based company, University College Mutual Insurance Co., to offer up to $5 million in limits for educators legal liability, says John H. Walker, director of the Office of Risk Management and Insurance at the University of Alabama at Birmingham, who has been named president of the insurer.

University College Mutual expects to be licensed as a risk retention group by January.

Both insurers expect to begin writing policies early next year.

During the next six to eight weeks, SCUUL Ltd., SCUUL's Cayman Islands-based holding company, will seek to attract sponsors willing to contribute $1 million or $2 million each from among the 3,000 non-profit or tax-exempt educational institutions nationwide, said Philip J. Brown Jr., M&M executive vp.

A group of about 30 institutions and educational-related institutions that are members of the Washington-based National Association of College & University Business Officers already have committed to contributing $40 million to SCUUL by year-end, Mr. Brown said.

They include Cornell University, Dartmouth College and the Massachusetts Institute of Technology, according to NACUBO.

Minimum retentions under the educational legal liability coverage will be $5,000 for individuals and $25,000 for institutions. In addition to university trustees, the coverage can be extended to administrators, faculty and employees, said Mary Jane Calais, director of management programs and federal affairs at NACUBO.

Most commercial educational legal liability coverage is limited to trustees and often excludes coverage for events such as athletic contests, which is included in SCUUL's coverage, she noted.

On the basis of the $40 million committed so far, SCUUL could offer the full $5 million of educators legal liability insurance, but only $5 million excess of $1 million for the excess coverage, which excludes educators legal liability, Mr. Brown said.

SCUUL is not offering coverage to non-sponsors at this point.

The educators legal liability coverage will be written on a claims-made form but excess liability coverage will be written on both an occurrence form and on the "discovery" form also used by A.C.E. Insurance Co.

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Court strikes defense cover for Galaxy

By AVRA WING

RICHMOND, Va.—A U.S. Court of Appeals says that a liability insurer had no duty to defend a chemical solvent recycling company against a government suit that sought to recover costs of cleaning up hazardous substances from a dump site.

In a decision written by Judge Robert F. Chapman, the 4th Circuit ruled last month that Canadian Universal Insurance Co. had no duty to defend Galaxy Chemical Inc. against the government action under the conditions of a 1969 manufacturers and contractors liability policy it wrote for Galaxy, because:

- The alleged damages at a Maryland dump site did not occur until the pollution was discovered. This would have been no sooner than 1981, when Maryland and U.S. Environmental Protection Agency officials began investigating the site—11 years after the policy period in question.
- The EPA and Maryland were seeking recovery for cleanup costs at the site, not for property damages.
- In a settlement of a previous suit, Galaxy and its directors, Paul Mraz

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Guaranty funds mull Mission liquidation

By STEVE TARAVELLA

SAN FRANCISCO—California Insurance Department officials continue to pursue reorganization of Mission Insurance Co. but also are quietly discussing liquidation plans in case reorganization proves impossible.

The department conferred in San Francisco Nov. 20 with representatives of several state property/casualty guaranty funds to discuss various measures that might be taken if and when the insurer were liquidated.

Mission was placed in conservation by the California Insurance Department in October 1985 (*BI*, Nov. 11, 1985).

Last month's meeting, which was not publicly announced, was called by Karl Rubinstein, a Dallas attorney recently retained by the California department to handle MIC's insolvency (*BI*, Dec. 1).

Mr. Rubinstein, appointed special deputy commissioner about six weeks ago, emphasized that the meeting was called to address contingency planning only and that observers of Mission's prolonged financial problems should not assume liquidation is imminent just because the meeting took place.

The meeting came about two months after Mission Insurance Group Inc., Mission's parent, issued a 1½-page statement that said Mission's reorganization "may not be feasible" because of rising losses and an inability to recover reinsurance proceeds (*BI*, Oct. 6).

Mission and its five subsidiaries, which also are under conservation in California, reported last week a net loss of $53.5 million for the third quarter. That is even greater than the $48 million net loss reported for the second quarter and brings Mission's net loss for the nine-month period ending Sept. 30 to more than $101 million.

California regulators remain committed to making Mission's rescue plan work, Mr. Rubinstein said last week, but he added it

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inside

Reinsurance intermediaries face increasing liability in disputes involving reinsurer insolvencies, New York attorney Harold Tract told the International Reinsurance Law conference held in London last month. Coverage of the conference begins on **PAGE 14**

The solution to the backlog of coverage submissions now piling up with commercial property/casualty insurers could be increased use of personal computers in the underwriting process, contends a Perspective article by W. Eric Meyer, a risk management consultant with The Wyatt Co. in Washington. **PAGE 31**

The European Court of Justice in Luxembourg rules that corporate insurance buyers in European Community nations can purchase coverage from insurers in any EC nation, nullifying regulations in West Germany, France, Denmark and Ireland that block the cross-border purchase of insurance. **PAGE 51.**

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Health care cost controls are booming

By JERRY GEISEL

WASHINGTON—Employers are drawing more weapons from their cost-containment arsenals as they battle rising health care costs, according to a new survey.

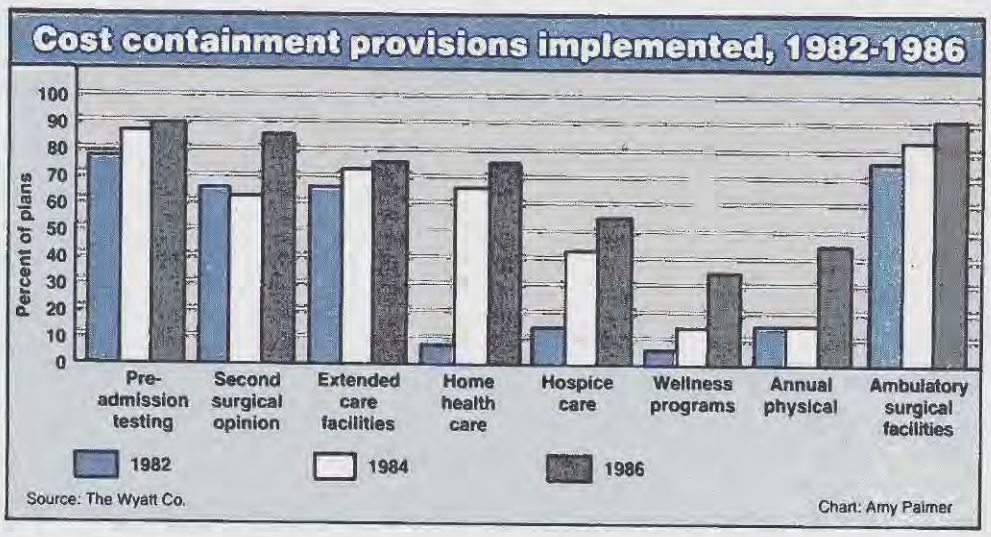
Among 263 employers surveyed over the last four years by The Wyatt Co., some 44% said they now have implemented at least seven health care cost-containment techniques. In 1982, less than 1% of this same employer group had implemented that many techniques.

The growth of some cost-saving techniques has been explosive. For example, in 1982, just 7% of the employers said they offered home health care coverage—a cost-effective alternative to coverage limited to high-cost hospitalization.

But by 1984, 67% of the employers were providing home health care coverage, and in 1986 that percentage rose again to 75%.

In addition, coverage for hospice care—offered by 15% of the employers in 1982—was provided by 41% of the employers in 1984 and 55% of the employers this year.

At the same time, wellness programs spurted in popularity: This year, 36% of the employers offered wellness programs, up from 14% in 1984 and 5% in 1982. Wellness programs can help employees reduce weight, stop smoking and lower high blood pressure, among other things.



John A. Menefee, an economic consultant in Wyatt's Research and Information Center in Washington, says growing employer sophistication about the most effective cost-containment techniques explains the dramatic growth in home health care, hospice and wellness programs.

"While hospice and home health care programs are relatively inexpensive and easy to implement, the programs are extremely important and cost-effective," Mr. Menefee noted.

"When you consider that employees' hospital bills during the last six months of their lives may be more than health care costs incurred during their entire working careers, you begin to realize how cost-effective home health care and hospice programs can be," Mr. Menefee said.

At the same time, wellness programs have mushroomed because employers can see the benefits: a healthier workforce, which can be much more productive, he said.

Other health care cost-containment techniques, already popular four years ago, have become even more widespread.

For example, 90% of the employers said they now require preadmission testing, up a bit from 87% in 1984 and 78% in 1982.

In addition, second surgical opinion programs are offered by 85% of the employers, up from 61% in 1984 and 66% in 1982, while 45% of the employers this year offered annual physicals, up from 15% in both 1984 and 1982.

Some 91% of the employers this year said they provided coverage for ambulatory surgery, up from 84% in 1984 and 76% in 1982.

The steps employers are taking to combat rising health care costs is the subject of The Wyatt Co.'s new survey, one of the most definitive of its kind.

The survey, the seventh in a series of biannual reports on group benefit plans, details benefit practices and costs for salaried employees among 1,418 employers, repre-

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B.R.I. sues former employee to block solicitation of clients

By DOUGLAS McLEOD

NEW YORK—B.R.I. Coverage Corp. is suing one of its former employees in an effort to block the employee from competing for the insurance business of B.R.I. clients.

Robert Cottone, who resigned as a B.R.I. assistant vp in September, has so far "lured away" nine B.R.I. clients representing at least $356,000 in premiums, court papers say.

Mr. Cottone is now an employee of National Insurance Associates Inc. of New Brunswick, N.J. NIA—which reported 1985 gross revenues of $7.6 million—also is named as a defendant in B.R.I.'s lawsuit.

The suit, filed Nov. 13 in U.S. District Court for the Southern District of New York, seeks a permanent injunction barring Mr. Cottone and NIA from soliciting business from B.R.I. clients.

B.R.I., the 20th-largest U.S. insurance brokerage with $20.1 million in 1985 gross revenues, argues that the injunction would enforce a non-competitive agreement that Mr. Cottone signed while working at B.R.I.

The suit also seeks monetary damages for business lost to NIA; $2 million in compensatory and punitive damages from NIA for alleged tortious interference with B.R.I.'s business relationships; and $2 million in compensatory and punitive damages from Mr. Cottone for alleged breach of fiduciary duty related to the non-competitive agreement.

B.R.I. last month also filed a motion for a preliminary injunction to prevent Mr. Cottone and NIA from soliciting B.R.I. accounts pending a trial.

A Nov. 25 court hearing on the motion was halted, however, when Mr. Cottone's lawyer pointed out a reporter's presence in the courtroom. B.R.I.'s lawyer then objected that testimony at the hearing would involve B.R.I. trade secrets.

The parties later met privately and disposed of the preliminary injunction motion by stipulation.

This agreement was sealed by U.S. District Judge Robert J. Ward, and neither Judge Ward nor lawyers involved in the case would comment on the agreement or say whether a preliminary injunction is in effect.

Mr. Cottone joined B.R.I. in 1979 as a life insurance salesman and later switched to brokering property/casualty coverages for construction and other industries, court papers say.

He announced his resignation on Sept. 29, 1986, to B.R.I. President Donald P. Ferrarini and Senior Vp Howard Miller.

Mr. Cottone had become "increasingly disenchanted" with B.R.I. during 1986 for several reasons, according to a memorandum filed by his lawyer.

One reason was B.R.I.'s "admission of liability in a civil litigation that its senior officers had steadfastly characterized as meritless. . .and as a 'personal hatchet job' against B.R.I.," according to the memorandum.

Although the memorandum does not identify this litigation, B.R.I. last year agreed to pay $450,000 to settle a New York Insurance Department lawsuit charging B.R.I. and more than a dozen other defendants with conspiring to defraud the now-defunct Resources Insurance Co.

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U.K. brokers to follow new terms of trade

By STACY SHAPIRO

LONDON—Virtually the entire London non-marine insurance and reinsurance market, including Lloyd's of London, will introduce new internal systems Jan. 1 designed to speed up the payment of claims and premiums.

On Jan. 1, non-marine underwriters belonging to Lloyd's of London's Non-Marine Underwriters Assn. and non-Lloyd's non-marine underwriters belonging to the Policy Signing & Accounting Center and the Reinsurance Offices Assn. will introduce new terms of trade that will force brokers to pay premiums to London insurance and reinsurance underwriters more quickly.

Sources say underwriters may be willing to write more risks if they receive their premium payments more promptly.

Currently, brokers say they take an average of five months to pay premiums to underwriters. Under the terms of trade, which will be reviewed in six months, brokers will be required to pay the premiums under a set timetable, based on the country where the business originates.

Also beginning Jan. 1:

- Lloyd's non-marine underwriters are introducing an improved claims payment program that is designed to shorten the length of time it takes to pay long-tail claims. And, underwriters are expected to agree that, for claim payments to be made, brokers need to get the agreement only of the lead underwriters, rather than all the underwriters on the risk, as is the case now.

Generally, property claims already are paid promptly, with the approval of the lead underwriters.

- The PSAC, which represents 120 non-marine underwriters outside Lloyd's, is going to study claims settlement procedures similar to those being adopted by the Lloyd's underwriters. The PSAC

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Injured athletes lose ground in N.Y. ruling

Photo: AP/Wide World

Jockey Ron Turcotte heads Secretariat toward the winner's circle after capturing the Triple Crown at Belmont Park in June 1973.

By MICHAEL BRADFORD

ALBANY, N.Y.—A recent New York Court of Appeals decision may make it more difficult for athletes injured during competition to win damages, attorneys say.

The New York Court of Appeals late last month upheld a lower court's denial of a $100 million damage suit filed by former jockey Ronald J. Turcotte, who was paralyzed as the result of a fall during a race in 1978.

Mr. Turcotte, best known for riding Secretariat to the Triple Crown in 1973, remains a paraplegic as a result of his injuries received in the fall, which occurred during a race at Belmont Park in Elmont, N.Y. Belmont is owned and operated by the New York Racing Assn.

The former jockey sued NYRA, another jockey in the race and the owner of that jockey's horse, charging that the accident was caused by the condition of the racetrack and by careless riding by the other jockey, Jeffrey Fell.

Mr. Turcotte charged the NYRA was negligent because it failed to water the portion of the racetrack near the starting gate and over-watered the rest of the track. The result of the improper watering, the plaintiff charged, was a track with "cupping" conditions that caused the track surface to stick to the underside of the horses' hooves.

However, according to the unanimous opinion of New York's highest court, Mr. Turcotte testified that " 'cupping' conditions are common at racetracks and that he had experienced them before at Belmont Park and also at many other tracks."

In fact, the former jockey had ridden in three prior races at Belmont on the day of his injury and was "well aware" of the track conditions before the injury-causing spill, according to the opinion.

Regarding the charges of improper riding by Mr. Fell, the court said Mr. Turcotte later "conceded that there is a fine line between what is lawful and unlawful in the movement of a horse on the track during a race and that when and where a horse can lawfully change its position is a matter of judgment."

Edward M. Cooperman, a Garden City, N.Y., attorney who represented Mr. Turcotte, said the court's ruling against the former jockey will "cripple terribly" the ability of a professional athlete to seek damages in New York for injuries sustained during a sporting event.

And, Mr. Cooperman says, the decision probably will

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Risk retention

Continued from page 1

Consultants also report enormous interest from employers, insurers and brokers in understanding and ultimately tapping the Risk Retention Act.

For example, close to 1,800 people registered for a series of briefings on the Risk Retention Act held in 13 cities over the last several weeks by Tillinghast/Towers, Perrin, Forster & Crosby.

"We would have considered 1,000 registrants a success," said Brady Young, a consultant in Tillinghast's Darien, Conn., office. He added that special sessions had to be added in New York and Chicago because of a flood of registrants.

"There is a new found maturity among buyers," explains Jon Harkavy, director of governmental affairs for the New York-based Risk & Insurance Management Society.

Businesses are willing to take on more risk through captive arrangements, including risk retention groups, to give themselves greater immunity from the boom and bust cycles of the conventional insurance market, Mr. Harkavy added.

The expanded Risk Retention Act, signed into law on Oct. 27 by President Reagan, gives businesses a new tool with which to assume more risk. The law allows businesses and professionals to band together in a risk retention group to self-fund all their liability risks except workers compensation.

A risk retention group that is chartered in one state is free to operate nationwide without having to obtain a license as an admitted insurer to operate in other states or use a licensed insurer as a front. A risk retention groups, which can be incorporated under captive laws, also will not have to obtain prior rate and policy form approval from each state in which it does business.

"You pay through the nose for a front," observed James Sullivan, president of Professional Services Corp. of Boise, Idaho, C-PAC-O's managing general agent, which specializes in CPA coverages.

While the amendments to the original 1981 Risk Retention Act increased reporting requirements for risk retention groups in states in which they are not domiciled, that additional burden is far outweighed by the ability of the groups to write all commercial casualty coverages, except workers compensation.

By contrast, the 1981 law only allowed risk retention groups to provide product liability and completed operations coverage.

Because the 1981 law was so narrow and because it was passed during the soft market, it isn't surprising that it didn't elicit much interest, experts say.

In fact, Delaware-chartered HOW Insurance Co., which provides product liability coverage to about 11,000 home builders, is believed to be the only major risk retention group formed in the United States under the 1981 act.

The 1986 expansion of the act, observers say, will allow a host of groups—accountants, physicians, municipalities and nurse-midwives, to name a few—to form risk retention groups. These types of buyers were prohibited from covering their general and professional liability exposures through risk retention groups by the narrow 1981 act. At the same time, there appears to be a marked change in attitude about risk retention groups among regulators, a factor that bodes well for the formation of risk retention groups.

In fact, the Delaware Insurance Department, led by former Commissioner David Elliott, harassed HOW Insurance Co., forcing the captive's organizers to go to court to force the department to certify HOW as a risk retention group.

Now, in an ironic twist, Delaware—in extending an invitation to quality risk retention groups—is championing its experience in regulating risk retention groups.

"We have been practicing risk retention regulation longer than any other state in the nation. . . .We are more qualified by virtue of experience than any other state to properly regulate risk retention groups," Mr. Levinson said.

The CPAs, though, were initially interested in establishing an offshore captive and in April had filed an application with the Barbados insurance regulators.

But the offshore option was dropped when Congress passed the Tax Reform Act of 1986, said Mr. Sullivan. A provision in the tax law eliminated incentives for forming offshore captives by making shareholders—starting in 1987—of many offshore group captives liable for current-year taxes on the captives' income from insuring U.S. risks (*BI*, Sept. 15).

The CPAs, who have seen the number of insurers writing accountants professional liability insurance—as well as available limits—drop sharply since 1984, then considered establishing a conventional insurer or a risk retention group. A risk retention group was chosen because of the ability to provide coverage nationwide immediately after the group was licensed in one state.

"The biggest advantage of a risk retention group is that we can immediately sell coverage in the 50 states by filing the proper documentation with each department," Mr. Sullivan said.

The CPAs opted for Delaware because of the state's pro-business climate, its accessibility and the attitude of Commissioner Levinson, who wants strong, sound risk retention groups, he said.

C-PAC-O, which will write professional liability coverage for members of state CPA societies, will offer claims-made policies with $100,000, $250,000, $500,000 and $1 million per claim and aggregate limits. Defense costs will be included within policy limits.

A variety of deductibles also will be offered.

Mr. Sullivan, who says the coverage written by C-PAC-O will be broader than policies issued by commercial insurers, said C-PAC-O also eventually expects to offer up to $25 million in excess coverage.

For every $1,000 of premium paid, policyholders must contribute $500 toward surplus. Policyholders will receive shares in C-PAC-O in proportion to their surplus contribution, which is made only in the first policy year.

C-PAC-O was capitalized last week with a $500,000 letter of credit from Morgan Guaranty Trust Co. of New York.

If C-PAC-O is profitable, stockholder-policyholders may receive dividends. Profits also may be used to reduce rates.

Mr. Sullivan said C-PAC-O is being aimed at accounting firms with fewer than 50 CPAs. Such firms have been hit hard by the tight commercial market, he explained.

For example, from 1979 to 1984, a one-person CPA firm paid about $400 for a professional liability policy with $1 million limits. Now, the premium is about $2,250, he said.

In addition, many insurers stopped writing professional liability coverage for CPAs, leaving just a handful of major domestic markets, Mr. Sullivan said.

Corroon & Black Management Inc. of Nashville, Tenn., will manage C-PAC-O. The New York law firm of LeBeouf, Lamb, Leiby & MacRae will provide legal advice.

The estimated annual premium flow that C-PAC-O may produce was not available late last week. Mr. Sullivan said reinsurance for C-PAC-O currently is being arranged. ■

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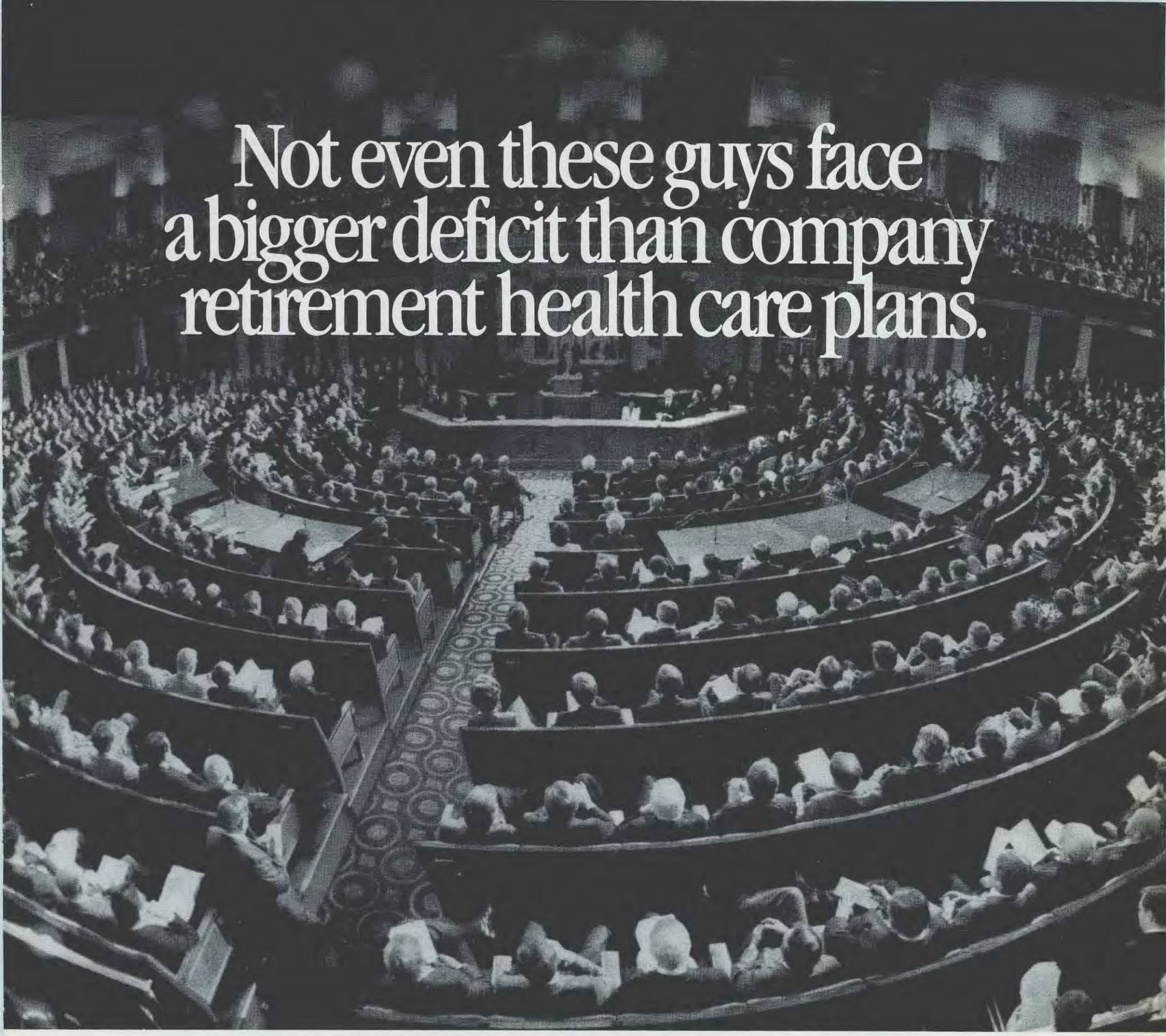

Everyone talks about the federal deficit. But there's another deficit that poses equally difficult problems for American business in the future.

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Terms of trade

Continued from page 3

may implement these procedures next year.

● Lloyd's, PSAC and ROA members and the Institute of London Underwriters will introduce a central "slip registration" for slips once the lead underwriter has signed.

In the London market, risks are underwritten by circulating a "slip" describing the risk. The lead underwriter, who often accepts the largest portion of the risk, initials the slip first. Then following underwriters agree to write portions of the risk.

All these system changes have been agreed to by the Lloyd's Insurance Brokers' Committee, which represents most insurance and reinsurance brokers in the London market that will be affected by the new systems.

It is believed to be the first time that nearly the entire London market—brokers and underwriters alike—have agreed to act together to improve the market's internal systems, observers say.

"This is part of a much bigger move to draw together the various factions of the London market," noted Kenneth Haddon, general manager of the NRG London Reinsurance Co. Ltd. and chairman of the PSAC. "Before, the market was fragmented. Now, it is standardizing procedures."

Reasoning that corporate policyholders that place business in the London market may not be directly affected by the new systems, several London brokers did not inform clients about the internal changes in the London market.

However, buyers may indeed benefit from the changes.

"It might affect the policyholder in that underwriters will be paid premiums more quickly, so they might be more interested in writing the business," noted Robin A.G. Jackson, chairman of the Lloyd's Non-Marine Underwriters Assn. and director of Merrett Holdings P.L.C.

And, claims may be paid more quickly, especially casualty insurance claims.

"For the policyholder, it should mean that, certainly in the longer term, there will be more efficient services from the London market as a whole," Mr. Haddon predicted. "It should mean that premiums will flow from the insured to the insurer to the reinsurers more quickly and for claims to be paid down the same pipeline more quickly," he said.

However, one Lloyd's broker said: "For the policyholder, it won't mean a row of beans. But, underwriters have said they will try to pay claims quicker because premiums will be paid quicker."

The move to improve the London non-marine market's internal systems began in April 1985, when members of the Lloyd's Non-Marine Underwriters Assn. decided that Lloyd's brokers had to part with policyholders' premiums much more quickly.

Brokers admit that it has taken an average of five months for underwriters to begin receiving premiums for non-marine risks, even though policyholders already have paid the premiums to the original brokers. The longer the brokers hold on to the premiums, the more investment income they earn.

Last summer, the underwriters group set out proposals, which essentially were followed by the PSAC, and the Lloyd's Insurance Brokers' Committee approved the proposals in August.

It was agreed that, beginning in January, Lloyd's current payment scheme would be replaced by the terms of trade and that the PSAC and ROA members also would follow the terms of trade.

The terms of trade will be introduced for six months and will be reviewed by underwriters and the Lloyd's Insurance Brokers Committee in July.

But, Mr. Jackson says the terms of trade are "in forever," although some changes in the timetables may be made.

Under the terms of trade, brokers are to pay premiums to underwriters according to a specified timetable based on the country from which the premiums come.

For example, for insurance business originating in the United States, brokers must pay underwriters premiums within 90 days of the end of the month of the policy's inception. For U.S. reinsurance business, brokers must pay premiums to underwriters within 60 to 150 days, depending on the type of reinsurance program.

Brokers may ask underwriters to include clauses in insurance and reinsurance policies that will cancel a policy if the premiums are not paid on time by the policyholder to the broker, according to the LIBC. Underwriters will make the final decision about whether to include these cancellation clauses.

However, there will be no financial penalty against the broker if the broker does not pay the premiums on time, according to a letter to members of the LIBC from Simon Arnold, chairman of the LIBC and Lloyd's broker Bain Dawes P.L.C.

"There is no penalty, and that is deliberate," Mr. Haddon said. "It is a pilot scheme, and it will be done in good faith."

However, Mr. Haddon agreed that the issues of penalties and cancellation clauses will be considered when the terms of trade are reviewed in six months.

In addition to the terms of trade, underwriters have agreed to speed up the payment of claims. Already this year, Lloyd's non-marine underwriters have introduced a weekly settlement of claims rather than a monthly settlement.

And, the PSAC next year also will begin settling claims and premiums weekly; it currently has a two-month payment period.

The PSAC also is looking into establishing a centralized claims bureau, which Lloyd's already has. The results of a study on this issue will be presented next spring.

In the meantime, Lloyd's, PSAC and ROA non-marine underwriters are expected to agree that brokers only have to show claims—particularly non-marine liability claims—to leading underwriters on the policy rather than to every underwriter on the policy.

The LIBC "has always maintained that the greatest delays result from the time taken to agree (on) claims, particularly on non-marine liability business," Mr. Arnold said in his letter.

Under the new system, brokers usually will have to obtain the agreement only of the first four underwriters on long-tail claims.

So far, the premiums and claims settlement agreements will apply only to the London's non-marine market. However, other changes will affect all the London markets —marine, non-marine and aviation.

Lloyd's, the PSAC, the ROA and the Institute of London Underwriters have agreed to introduce slip registration in January. This means that as soon as a leading underwriter decides to write a risk and has placed his initials on the slip, information about the slip will be centrally filed.

The slip can be amended or canceled if it is not completed.

And, in July, Lloyd's is introducing a flexible settlement system, so that claim and premium settlements do not have to be made at a certain time each month, but can be made throughout the month.

And, in the future, the London market hopes to introduce automation systems and networking of computers that will allow a further standardization of the London market, Mr. Haddon said. ■

PERFORMA

Galaxy ruling

Continued from page 2

and Sally Mraz, had signed a general release that freed Canadian from covering further claims.

The ruling overturns an August 1985 District Court decision that said Providence, R.I.-based Canadian Universal had a duty to defend Galaxy because alleged damages occurred when Elkton, Md.-based Galaxy buried 1,300 drums of the waste at the site in 1969 (*BI*, Sept. 9, 1985).

If the appellate court's decision stands, Canadian Universal will not have to cover $100,000 in Galaxy's defense costs incurred in defending the cleanup action.

Galaxy sought $100,000 for its defense of the cleanup suit, *United States vs. Bissell*. The company, which went out of business during the 1970s, and other defendants in the case reportedly have reached a $900,000 settlement with the government, but Galaxy attorney Robert Faron would not comment on the settlement.

The appellate court's ruling also would relieve Canadian Universal from reimbursing $200,000 of defense costs Galaxy incurred in a related case, according to Hartman J. Miller, Canadian Universal's attorney with the Baltimore firm of Rollins, Smalkin, Richards & Mackie.

Attorneys for Galaxy, with the Washington firm of Barnett & Alagia, have filed for a rehearing of the appellate court's decision.

Galaxy purchased manufacturers and contractors liability policies from Canadian Universal during calendar years 1966 through 1969. The policies also covered the directors and officers of the company, Paul Mraz and Sally Mraz.

The 1969 policy Galaxy purchased from Canadian Universal—the policy in question—had limits of $50,000, but defense costs were not included within the policy limits.

In August that year, Galaxy removed from its plant site barrels containing chemical wastes and buried them in a nearby clay-lined pit. The disposal arrangements had been made with the cooperation of state and county health department officials, according to court papers.

After the passage of the Comprehensive Environmental Response, Compensation and Liability Act of 1980, known as the Superfund Act, the EPA and Maryland investigated the dump site. In September 1982, the EPA informed Galaxy that the buried drums were hazardous and sought to have Galaxy clean up the site or pay for the cost of the cleanup.

After Galaxy refused to comply, the government removed the drums, disposed of the contaminated soil, treated contaminated water and took other cleanup actions.

The EPA and Maryland then filed suit in 1983 to recover the cleanup and removal costs.

Galaxy sought coverage under its 1969 policy with Canadian Universal, but the insurer refused to defend or indemnify the chemical company. The Mrazes then filed suit against Canadian Universal for a declaratory judgment that the insurer had a duty to defend and indemnify them.

In August 1985, U.S. District Court Judge Joseph H. Young ruled that the alleged damages occurred when the waste leaked, which constituted an occurrence under the Canadian Universal policy. Therefore, Canadian Universal had the duty to defend Galaxy in the Bissell case, Judge Young ruled.

But, in finding for Canadian Universal, the appellate court held that the alleged damages—the contamination of soil and water in the area, which injured individuals and damaged property near the site—had not occurred during the 1969 policy period.

The court noted that the policy in question defines occurrence as "an accident, including injurious exposure to conditions, which results, during the policy period, in bodily injury or property damage, neither expected nor intended from the standpoint of the insured."

Judge Chapman said that it is often difficult to determine the time of the occurrence of an accident in cases in which the scope of damage remains concealed or uncertain for a period of time.

"Therefore, we hold that in hazardous waste burial cases such as this one, the occurrence is judged by the time at which the leakage and damage are first discovered," Judge Chapman wrote.

"Nothing in the complaint indicates that the release (of hazardous substances) was discovered any earlier than 1981, over 11 years after Canadian went off the risk," the judge wrote.

The court further found that the EPA and Maryland had not sought recovery for damage to natural resources under Superfund. While the complaint alleges property damage occurred, it does not allege the plaintiffs sustained any property damage, the court reasoned.

"The allegations of property damage set forth the basis for the government's response costs. . .the United States and Maryland have claimed only the response costs for the. . .site."

The court concluded that response costs are not themselves property damage.

Judge Chapman also noted that a 1973 settlement in another case against Galaxy—brought because of fumes generated by its plant—contained a clause by which Galaxy released Canadian from every claim that Galaxy might claim to have against the insurer "by reason of any other manner, matter, cause or thing whatsoever."

The court found that the subject of the current suit "is certainly within the scope" of the broad language of the clause, and thus is covered by the release. ■

Guide to FASB 87 to be issued soon

WASHINGTON—A guide to help actuaries apply new pension accounting standards contained in the Financial Accounting Standards Board's Statement 87 is expected to be issued later this month or in January.

The guide will be released by the Interim Actuarial Standards Board, which was established a year ago by the American Academy of Actuaries in Washington, D.C. to develop actuarial standards.

The actuaries' guide will be issued after FASB releases its interpretive guide on the new standards, said Thomas D. Levy, head of the IASB's pension committee and senior vp at Martin E. Segal Co. in Washington, D.C.

The actuaries' guide, which FASB endorses, is an effort to translate FASB's accounting orientation into actuarial concepts, according to Diana Scott, project manager at FASB who handles pensions and other post-employment benefits.

The IASB, which originally planned to issue a more formal standard for actuaries, decided it was more appropriate for the academy to issue the informal guide as an educational publication, Mr. Levy said.

FASB 87, which was issued last December, requires major changes in the accounting of pension funds for most company plans after Dec. 15. However, implementation of the new standard has been delayed for two years for a few categories of employers, including the foreign operations of U.S. multinationals and employers with fewer than 100 employees in each pension plan, Ms. Scott said. ■

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opinions

Workers comp needs help

LEGAL SCHOLAR Arthur Larson is correct in his declaration that the U.S. workers compensation system is no longer a stepchild of the legal justice system.

At 75 years old, it's all grown up.

But after weathering numerous court interpretations and hundreds of statutory amendments—many of which are discussed in Professor Larson's 10-volume treatise on workers compensation—this no-fault, state-administered system is beginning to show signs of its age. Few are suggesting that the system be scuttled. Instead, those who work in the system perennially gather to update and improve work comp laws and regulations.

But they need help in trying to come up with better methods to award injured workers adequate benefits in a timely manner, devise cost-effective programs to get workers back on their jobs, reduce litigation and identify occupational diseases.

What's needed is more education in the workers compensation field, raising everyone's level of expertise, and better communication. Such an opportunity is presented with the creation of a teaching chair, as proposed by work comp troubleshooter John H. Lewis and his alma mater, Duke University Law School in Durham, N.C., where Arthur Larson is a professor of law (see story, page 41).

The chair would be created in honor of Professor Larson—an honor we and those in the workers compensation field consider well-deserved by a man who has almost single-handedly pulled together in his treatise a thoughtful, knowledgeable and valuable analysis of U.S. work comp laws.

Such analysis needs to be undertaken by more students, attorneys and others. Even Professor Larson says: "We need well-educated people to devote their lives. . .to look after the system and maintain its standards."

But such an effort needs both dedication and financial commitment from those who will benefit—employers, unions, attorneys, physicians and insurers.

Mr. Lewis is on a nationwide campaign, soliciting a total of $1 million for the chair. He believes it would not be difficult for corporate risk managers and insurers to come up with $500 or $1,000 per year over the next 10 years for the project.

We agree. Insurance brokerages, consultants, third-party administrators, which all are involved day-to-day in the workers compensation system, also should contribute. In this "information society," such an expert resource is critically needed.

We believe so strongly in the need for this chair that *Business Insurance* is pledging a one-time contribution of $1,000 to the chair.

We encourage everyone to contribute to the chair in proportion to their resources. Contributions can be sent to Duke University School of Law, Towerview & Science Drives, Durham, N.C. 27705.

letters

Use annual statements to check reinsurer's security

To the editor: Robert A. Finlayson's two articles on reinsurers' financial results and evaluation of various informational services (*BI*, Nov. 10) are timely and well prepared.

However, the articles appeared to give nominal direction to "small" companies and brokers on how to possibly obtain a degree of comfort relative to companies they do business with. Having been in a situation where little information and resources were made available to perform adequate security evaluation, I found at least one method which borders more on common sense than statistical formulas: Review the company's ceded reinsurance per Schedule F of the annual statement filed with state insurance departments.

In comparing the named reinsurers with available listings of insolvent/financially troubled companies, you may be surprised how fast the possible "additional" Schedule F penalty will add up.

This type of analysis becomes more intriguing when those named reinsurers are also listed in the unauthorized reinsurance part of Schedule F and have provided offsetting "security," such as letters of credit or funds withheld, resulting in no adjustment to the published surplus.

Likewise, a similar review performed on the assumed reinsurance part of Schedule F may result in likely surplus adjustments due to company management's unwillingness to accept the fact that its collateralized assets in dealing with insolvent/financially troubled companies are need downward adjustments.

To fully address the issue of Schedule F evaluation would take more than the space allowed for letter commentary, but the point I am trying to convey is that one need not be a financial wizard to initiate a basic reinsurer security analysis. A little logic and common sense can be very helpful.

Henry Dykowsky
President
Henry Dykowsky & Associates Inc.
New City, N.Y.

Tax law really hits offshore captives

To the editor: Bob Hedges' letter to the editor in the Nov. 17 edition entitled "Forming Mutual One Way to Circumvent Tax Law" is in error.

The 1986 Tax Reform Act reads, under (c) Special Rule for Certain Captive Insurance Companies:

"(4) TREATMENT OF MUTUAL INSURANCE COMPANIES—In the case of a mutual insurance company—

"(A) this subsection shall apply,

"(B) policyholders of such company shall be treated as shareholders. . ."

I wish it were not so, but this rule is going to be cruelly financially painful for some of our very small shareholder foreign captives.

E. Richard Crebs
President
Commercial Insurance Alternatives Inc.
St. Helena, Calif.

28 states enacted medical malpractice reforms

To the editor: In your Nov. 17 issue, you carried a story on medical malpractice tort reform. In that article you reported a survey presented to the Society of Risk Management Consultants that suggested "During 1986, 12 states passed tort reform measures specifically addressing medical malpractice issues." Actually, the number of states enacting medical liability tort reform was more than double the number quoted in your story.

"Medical Liability Monitor" newsletter, a nationally circulated publication dealing exclusively with medical professional liability, does an annual survey of all tort reform measures related to the medical malpractice field. In our 1986 survey we found that at least 28 states had enacted some 58 specific bills that directly relate to medical professional liability and that ultimately could improve the outlook for health care in the future. A copy of that summary is available upon request for those readers who might be interested.

Carol Brierly Golin
Publisher
Medical Liability Monitor
Winnetka, Ill.

■ *Editor's note: To obtain Medical Liability Monitor's summary, contact Malpractice Lifeline Inc., 990 Green Bay Road, Suite 3, Winnetka, Ill. 60093; 312-446-3100.*

Will industry's new capacity really be needed?

To the editor: Addressing the annual meeting of the National Assn. of Independent Insurers, insurance executives made their case for maintaining current rates in the coming years (*BI*, Nov. 17). In the same issue, nine major companies report earnings increases of 19.7% to 176.5%. A 10th company reports a $263 million turnaround for the first nine months of 1986.

Insurance companies should have the opportunity to operate profitably and to develop adequate capacity and reserves. While they do that, they also should stay in touch with the needs of their clients.

What the industry people are not discussing publicly is a growing trend of large corporate clients to assume a greater share of their own risks. Some of these are undoubtedly high quality accounts. Is it possible the industry will build up large capacity, with their present pricing, only to find they have no place to use it?

William apHugh
Insurance Manager
The Chronicle Publishing Co.
San Francisco

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Ship insured for $8 million may be total loss

By CAROLYN ALDRED and STACY SHAPIRO

london

LONDON—An $8 million vessel carrying iron ore worth 2.7 million pounds ($4.05 million) may be a total loss, according to the ship's hull insurers.

Dutch salvage teams trying to rescue the Kowloon Bridge, which broke in two in heavy seas off the coast of Ireland last month, abandoned their efforts last week, said Renaldi Rossi, director of Societa Italiana Assicurazione Trasporti.

Genoa-based SIAT leads a consortium of European insurers that wrote 60% of the $8 million in hull coverage for the Kowloon Bridge, according to Mr. Rossi. The remaining coverage is placed in the U.S. market, he said.

A. Altermann of Bremen, West Germany, is acting as broker for the Hong Kong-registered vessel's owners. The claim is being handled by the Assn. of Bremen Marine Underwriters, although an association spokesman said none of its member underwriters participated in the Kowloon Bridge's hull coverage.

Mr. Rossi said salvage attempts had proven unsuccessful because of the severity of the damage to the vessel and weather and sea conditions.

However, salvage crews were continuing last week in attempts to recover some 1,100 metric tons of oil from the vessel's fuel tanks under a contract with Kowloon Bridge's liability insurer, London Steamship Mutual Insurance Assn. Ltd., a London-based P&I club.

John Hawkes, director of A. Bilbrough & Co. Ltd., managers for London Steamship Mutual, said the P&I club was responsible for claims arising from any pollution caused by the vessel's grounding and the costs of wreck removal under a "standard P&I dry cargo legal liability policy."

The Irish government had served an oil removal notice on the ship's owners, he said. But, a spokesman for Zodiac Maritime Agencies, the owners' London based agency, said last week that only a "very small quantity of oil" had leaked from the ship and that it had drifted away from the Irish coast.

According to Tony Coles, assistant chartering manager with British Steel, owner of the cargo aboard the ship, the Kowloon Bridge was carrying 160,000 tons of iron ore from Canada to Hunstanton, on the East Coast of Britain.

Coverage for the cargo was placed through Lloyd's of London broker Willis, Faber & Dumas Ltd.

A spokesman from Willis Faber said the 2.7 million pounds of cargo coverage had been placed in the London market, led by Lloyd's underwriters. Willis Faber also acted as brokers for SIAT in placing reinsurance for the hull coverage, he confirmed.

E&O coverage

Lloyd's of London brokers, worried about the increasing cost of errors and omissions coverage, are planning to exchange in-house information to reduce E&O claims.

E&O coverage rates for brokers have doubled over the past several years because of a large increase in both frequency and severity of claims, brokers say.

Now, more than a dozen major Lloyd's brokers are working together to help hold the line on rate increases, according to David Hough, secretary of the Lloyd's Insurance Brokers Committee.

The brokers are hoping to exchange loss-control information and develop a code of practice. The committee also will look at improving brokers' internal audit procedures, training and disciplinary measures, Mr. Hough said.

The sensitive nature of the information to be exchanged will require the full cooperation of the participating brokers, he added.

Meanwhile, more than 30 small change loss-control information and medium-sized Lloyd's broker-change loss-control informations are considering forming a mutual insurer to write their E&O coverage, Mr. Hough noted.

A spokesman for Tindall, Riley & Co., which is investigating the feasibility of such an insurer, said responses from interested brokers currently are being studied. In addition, these small brokers are considering an exchange of information with the LIBC, he said.

"If a mutual is found to be viable, it will be several months before we are in a position to get it off the ground," the spokesman said. He added that it was too early to comment on details of the proposed insurer.

Skandia decision

Two British insurers must pay up to 60% of the legal costs for a group of banks that won a landmark court decision in October against the insurers, a London High Court judge determined last week.

However, High Court Justice John Steyn will wait until after Christmas to decide how much the two British insurers must pay the banks in damages, attorneys say.

In October, Justice Steyn ruled that Skandia (U.K.) Insurance Co. Ltd. and Westgate Insurance Co. Ltd.—formerly Hodge Mercantile & General Insurance Co. Ltd.—were liable for up to $33 million in damages because an underwriter,

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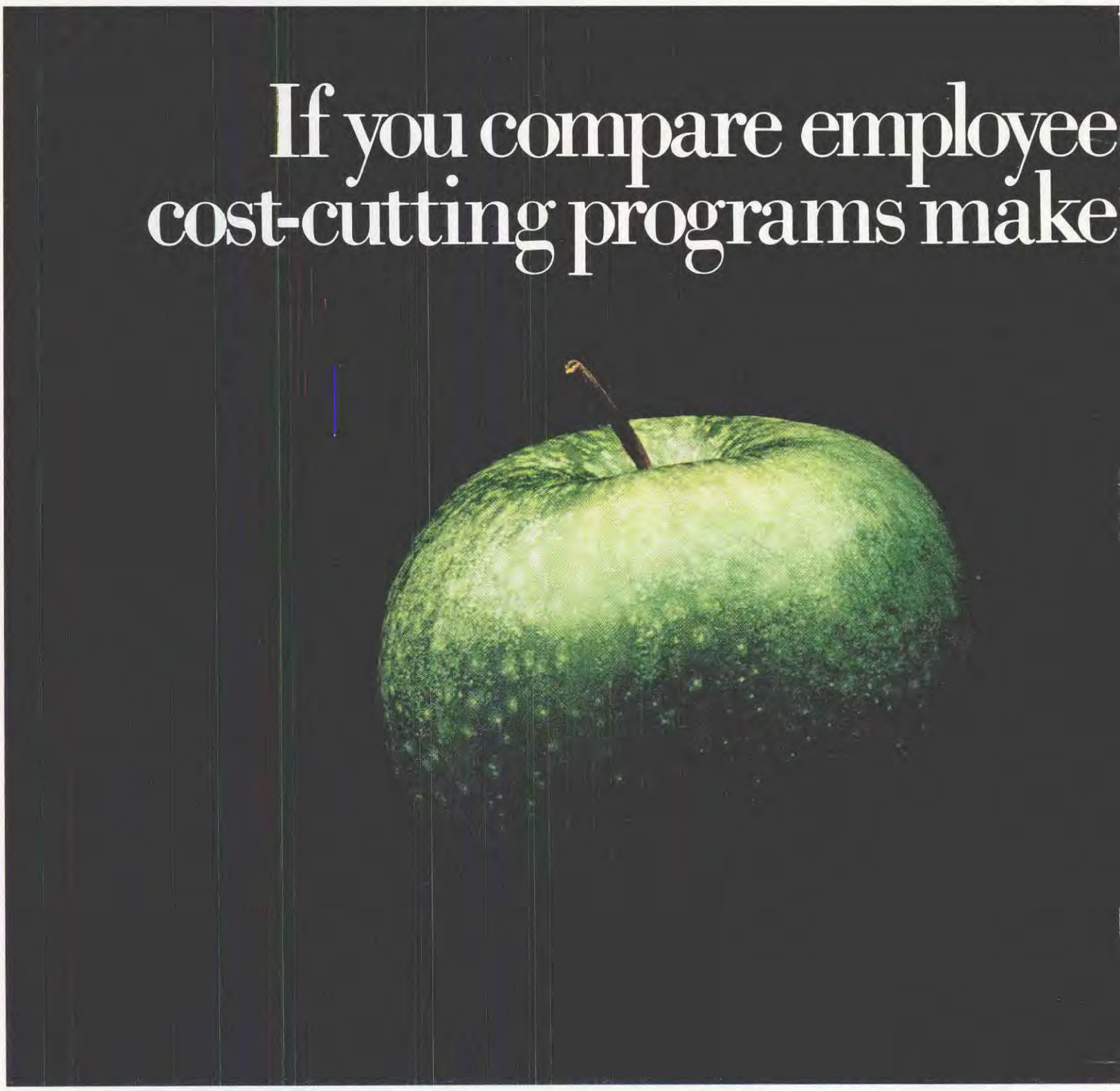

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Continued from previous page
who worked at different times for both insurers, failed to tell the banks that the cover notes for credit insurance policies were inaccurately prepared by a broker (*BI*, Oct. 13).

The credit insurance policies at issue in the case were written to guarantee loans worth up to 53.8 million Swiss francs ($32.8 million) on which the borrower later defaulted.

Justice Steyn ruled that Hodge, which was sold by Standard Chartered Bank and is now called Westgate, may be liable for the bank's losses on one loan insured by Hodge worth 10.8 million Swiss francs ($6.6 million), while Skandia U.K. is liable for the losses on the rest of the loans, which total 43 million Swiss francs ($26.2 million).

Neither insurer has insurance to cover the potential judgments.

The decision marks the first time a British court ruled that insurers are liable for damages for failing to give information to a policyholder that was relevant to an insurance contract.

On Dec. 2, Justice Steyn ruled the two insurers were responsible for paying 60% of the banks' legal costs, except for Chemical Bank of New York; the insurers were told to pay 40% of that bank's legal costs.

The banks together spent about 2 million pounds ($2.84 million) on legal costs in the case, estimated an attorney for the banks.

But, damages have not been determined "because the case is so complicated," said an attorney involved in the case.

In the meantime, Skandia has served notice with the British Court of Appeals that it intends to appeal Justice Steyn's opinion.

Sources say that appeal will not be heard for at least 18 months, and they expect the case eventually will reach the House of Lords, Britain's highest court.

Aviation broker

Lloyd's of London broker Harrison Horncastle Insurance Brokers Ltd. is expanding its aviation insurance brokerage business with the acquisition of fellow Lloyd's broker Hargreaves, Reiss & Quinn Ltd.

Hargreaves—whose parent company, Edinburgh-based Caledonian Produce (Holdings) Ltd., has been placed in receivership—deals mainly in aviation insurance business and is one of the few specialist airline brokers outside the major Lloyd's of London brokerage houses.

Most of Hargreaves' business will be integrated into Harrison's international division, which specializes in North American reinsurance and aviation business.

Although Harrison refused to disclose the purchase price, Chairman Kristian Siem said that the company hoped to double its existing brokerage revenues of 6 million pounds ($8.52 million) with further acquisitions and growth in the next few years.

Hargreaves registered a small profit last year on brokerage revenues of 950,000 pounds ($1.35 million). It derives 65%-70% of its business from aviation accounts.

Robin Ford, who was the former chief executive of Hargreaves, has been appointed managing director of Harrison's international division.

IATA captive

London brokers C.T. Bowring & Co. (Insurance) Ltd., Willis Faber & Dumas Ltd. and Stewart Wrightson International Group Ltd. will place reinsurance for Airline Mutual Insurance Ltd., the mutual insurer now being formed by the International Air Transport Assn. (*BI*, Nov. 17).

Tony Kelly, director of industry monetary affairs for IATA, said the three London brokers have been appointed to place reinsurance for the insurer, although it is not clear yet how much of the reinsurance will be placed in the London market or overseas.

Mr. Kelly said the new mutual hopes to begin writing business on Jan. 1.

"We have received eight to 10 commitments from airlines who will be joining the mutual next year and expect at least three to sign up in January.

"I believe at least 20 airlines will have joined the scheme by the end of next year," Mr. Kelly commented.

Under the initial terms proposed by IATA, the new insurer will underwrite 5% of the total hull and liability limits of each airline joining the mutual and receive 5% of the total premium paid by the airline.

"We will also ask airlines joining to contribute a further 25% of the 5% premium paid to provide the mutual's underwriting reserves," Mr. Kelly noted.

AMI is hoping to write $160 million in premium volume during 1987, Mr. Kelly said. "We already have $50 million worth of premium committed by airlines," he added.

Continued on next page

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Jersey captives

New captive insurance companies could spring to life in the dormant captive domicile of Jersey in the Channel Islands, a captive manager says.

Although no captives have been formed on the island since Jersey's government introduced the Insurance Business (Jersey) Law of 1983, which imposed tough regulations on captive formations, captive manager Samuel Montagu & Co. (Jersey) Ltd. is currently pushing for new captive formations.

The company recently published a detailed report called "Offshore Insurance in Jersey" to inform people about Jersey's status as a captive domicile, said Royan D. Ellis, managing director of Samuel Montagu (Jersey).

To obtain a copy of the report, contact Mr. Ellis at Samuel Montagu & Co. (Jersey) Ltd., P.O. Box 335, Queen's House, 13-15 Don Road, St. Helier, Jersey, C.I.; telephone: 011-441-534-7904.

New Lloyd's agency

A new Lloyd's of London underwriting agency, formed by the merger of four existing agencies, is now open for business.

Wendover Underwriting Agency was formed last month when three underwriting agencies—Crump & Johnson Underwriting Agencies Ltd., Butcher & Hall Ltd. and Crump & Cackett Agencies Ltd.—joined forces with members' agency Hine & Butcher Ltd.

The new agency has been registered by the Council of Lloyd's as a managing and members' agency and will take over the management of marine syndicate 744, aviation syndicate 957, non-marine syndicate 1001 and livestock syndicate 627.

"We appreciated that the companies were not individually strong enough to become viable units within the new regulations at Lloyd's. We have already been operating together for the last 18 months with an unofficial board so this merger will not involve any change in management," said Robin Crump, chairman of Wendover. Wendover, which he says will write a "substantial amount of business in North America," will have a premium capacity of 71 million pounds ($101 million).

Export coverage

The British government's Export Credits Guarantee Department is examining new insurance programs for British exporters in an effort to boost the ECGD's declining share of the export insurance market in the United Kingdom.

The department recently had to borrow 355 million pounds ($504.1 million) from the government because of heavy claims attributed to bad debts from Third World countries, an ECGD spokesman said. The department now owes the government 756.2 million pounds ($1.07 billion), he added.

In 1985, the ECGD paid out 697 million pounds ($989.7 million) in claims, more than twice the combined total of 175 million pounds ($248.5 million) in premium volume and 211 million pounds ($306 million) in investment income, the spokesman said. The 1985 premium volume was a 6.7% increase over the 1984 volume.

The ECGD and export finance bankers are now looking at three different new plans to increase the department's market share:

- Insuring bank letters of credit. Such coverage would allow loans to exporting companies to continue when lending banks have reached their internal lending limit the spokesman said.

Details on how the ECGD and banks would share the risk have not been worked out, the spokesman said.

- Commitment coverage. Such coverage would allow companies in regions and lines of business from which the ECGD is withdrawing to continue to be covered for trade with existing customers.
- Excess export coverage for large corporations that self-insure against export losses.

The spokesman denied that the main reason behind the ECGD's decline in market share was the growth of the private export insurance market.

"The fall reflects the change in our customers' trade rather than the growth of the private section," the spokesman said. "More and more British exporters are turning to North America and Europe rather than the Third World. In those markets, people feel there isn't a need for export cover."

Less than half of the ECGD's current policies cover exports to North America and other Western European nations, but the spokesman said the ECGD is looking to expand its presence in this sector of the market.

Broker acquisition

London broker Richards, Longstaff (Insurance) Ltd. is continuing to expand its Lloyd's of London brokerage business with the acquisition of the direct insurance business of Lloyd's broker Tower Hill Insurance Brokers Ltd.

Tower Hill Managing Director Colin Fellows and 20 staff members joined Richards, Longstaff last week as Richards, Longstaff acquired business previously placed through Tower Hill that generated 500,000 pounds ($710,000) in brokerage revenues, said Jeremy Coulter, director of marketing and new development at Richards, Longstaff.

Mr. Fellows and his team specialize in international marine and non-marine brokerage and in providing access to the Lloyd's market for non-Lloyd's British brokers, Mr. Coulter said. Last week's acquisition follows Richards, Longstaff's recent acquisition of a team of reinsurance brokers from C.T. Bowring & Co. to form a new reinsurance unit.

Crawley Warren

Lloyd's of London broker Crawley Warren & Co. Ltd. is hoping to broaden its focus rather than concentrate on specialty brokerage areas, like aerospace risks, for which it is best known.

"During the forthcoming year, we shall be considering other specific types of insurance and the commencement of trading in other areas of the world," said Chairman Bernard Warren in outlining the brokerage's plans in its latest annual report.

All four of Crawley Warren's trading units—which represent accident and health, aerospace, property/casualty and reinsurance brokerage—deal mainly with U.S. business. However, the company is looking to expand into other nations, a spokesman said.

In particular, Crawley Warren plans to expand its property/casualty operation in Europe, he said, noting that the Far East and Middle East also are regarded as potential areas of expansion.

Crawley Warren's pretax profits declined 1.1% to 1.95 million pounds ($2.77 million) in the year ending June 30 from 2.19 million pounds ($3.1 million) in the previous fiscal year. Revenues increased 8.7% to 11.19 million pounds ($15.8 million) in fiscal 1986 from 10.29 million pounds ($14.6 million) the previous year. ■

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Reinsurance law conference

Liability risk looms for intermediaries: Expert

By CAROLYN ALDRED

LONDON—Reinsurance intermediaries, which so far have avoided most of the legal battles over insolvent reinsurers, face an increasing liability risk, a prominent reinsurance attorney says.

Courts soon will examine reinsurance intermediaries' responsibilities for business placed with reinsurers that later become insolvent, predicts Harold Tract, a partner with the New York law firm of Kroll Tract Pomerantz & Cameron.

"Some ceding companies now are looking to reinsurance intermediaries for answers as to why business was placed with a reinsurance company that is now insolvent," Mr. Tract said at the International Reinsurance Law conference held Nov. 24-25 in London.

"While there currently is little precedent for holding a reinsurance intermediary liable. . .the courts may well be faced shortly with an examination of this subject," he explained.

Reinsurance intermediaries are considered insurance brokers under most U.S. laws, even though an intermediary sometimes performs more extensive functions than a broker, Mr. Tract observed. An intermediary, for example, may act as an underwriting agent for reinsurers, he said.

On the one hand, this fairly lenient treatment of intermediaries may be justified, he said, since a reinsurance intermediary deals with sophisticated ceding companies that in some cases have "expertise, experience and access to information equal to, if not superior to, that of an intermediary."

An intermediary acts as a middleman between two clients in the insurance and reinsurance field who understand one another, Mr. Tract stated. "Hence there is justification for imposing a lesser duty of care on intermediaries," he said.

But, Mr. Tract added that there is an argument for imposing a stricter duty of care on intermediaries.

"Reinsurers tend to be less regulated, (more) internationally oriented and involved in transactions of greater monetary value and risk than regular insurance companies," he said.

"Hence, an argument can be made for imposing a stricter duty of care on reinsurance intermediaries than on insurance brokers," Mr. Tract said.

So far, however, only one state in the United States has imposed stronger regulations on intermediaries, he noted. In 1976, New York became the first—and so far the only—state to require the licensing of reinsurance intermediaries, he said.

Four years ago, the New York Insurance Department issued a set of rules, known as Regulation 98, establishing procedures that must be followed by intermediaries doing business in the state.

Under Regulation 98, intermediaries are required to inquire into the financial condition of any unauthorized reinsurer and inform the ceding company of the results of that inquiry, he said.

Although this regulation might seem to expose intermediaries to new and substantial liability to ceding insurers in the event that a reinsurer becomes insolvent, the regulation is more a "reminder of pre-existing legal duties than a dramatic revision of those duties," according to Mr. Tract.

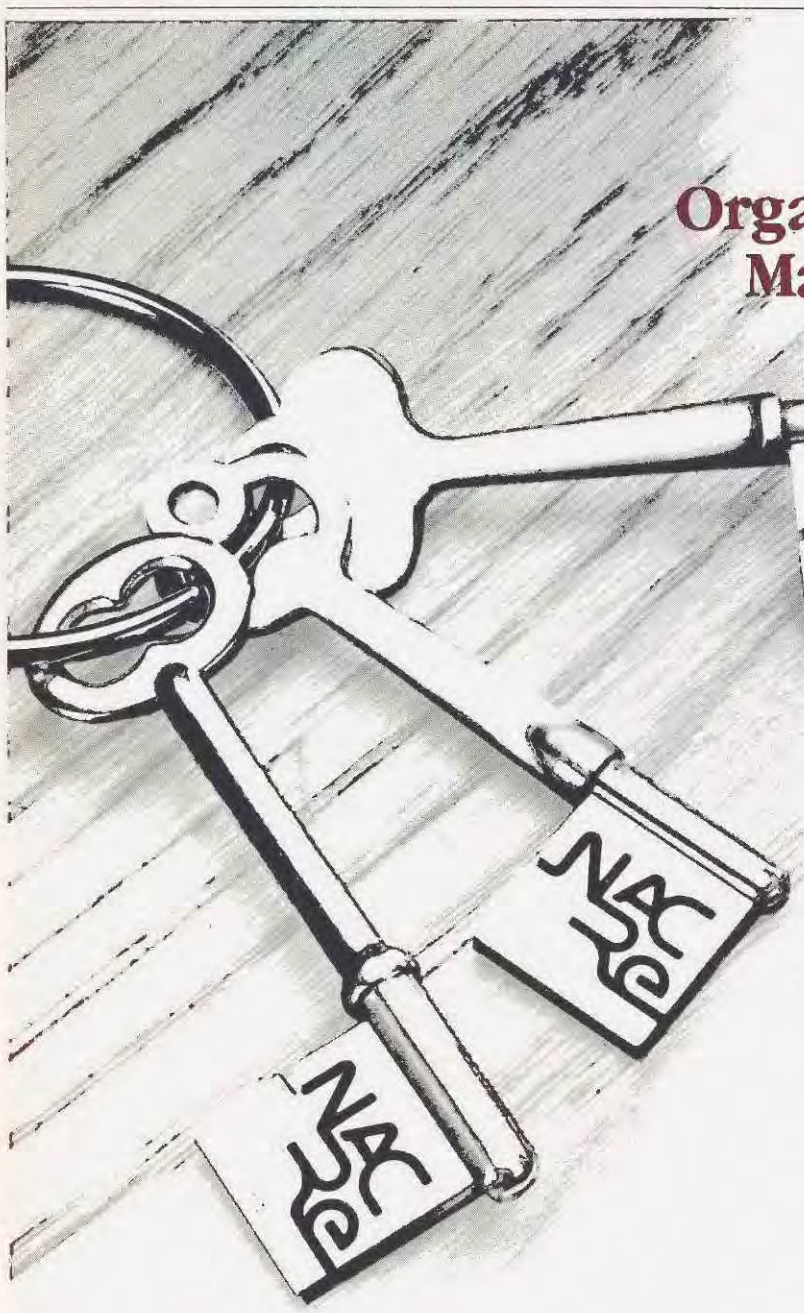
"The regulation's articulation of a minimum duty of care may inadvertently lower the ceiling on the maximum duty of care. . . .Common law duties may actually be broader than what Regulation 98 imposes," he added.

So far, the increased duty of inquiry regarding the financial condition of an unlicensed reinsurer has gone largely untested in the courts, but this appears likely to change, according to Mr. Tract.

"As courts further examine the question of the liability of reinsurance intermediaries, they may begin to move away from the analysis of liability in the context of the liability of direct brokers," he said.

Instead, the courts may focus more on the reinsurance marketplace as a specialized area of the insurance industry, and a set of guidelines applicable only to intermediaries may develop, Mr. Tract continued.

"With the number of reinsurers becoming insolvent increasing, the courts may be faced with the task of analyzing further the duty of care owed by the reinsurance intermediary," he concluded. ■



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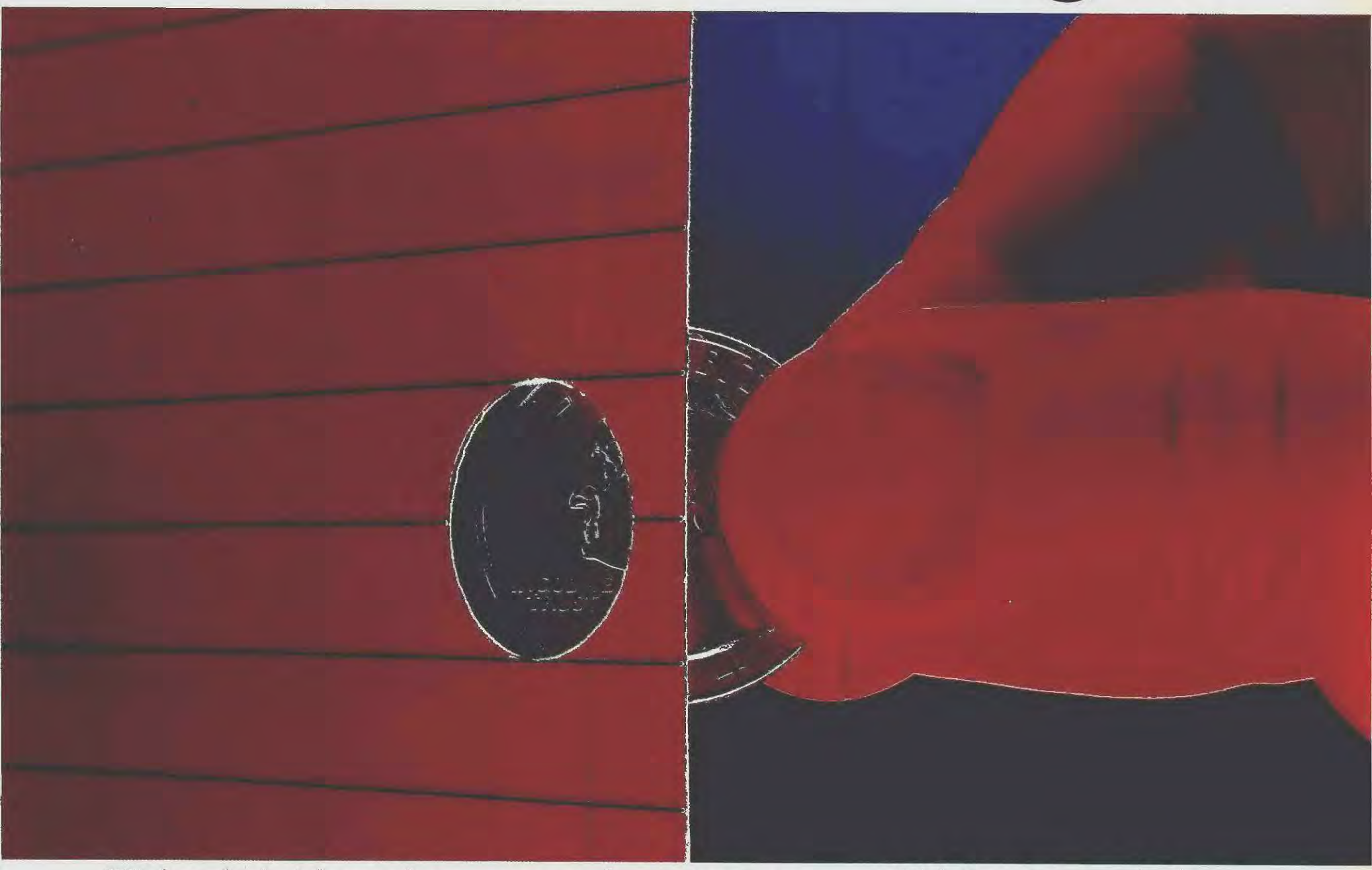

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Pay attention to arbitration clauses: Reinsurer

By CAROLYN ALDRED

LONDON—European reinsurers want to resolve international reinsurance disputes in their own countries instead of depending on the interpretation of reinsurance contracts in courts in the United States, a European reinsurance executive says.

To accomplish this, European reinsurers should pay more attention to arbitration clauses in reinsurance contracts, which frequently determine the country in which a reinsurance dispute should be heard, said Otmar Schmidlin, a senior vp with Swiss Reinsurance Co.

"Up to now, we have hardly paid attention to the arbitration clauses which have adorned reinsurance contracts from time immemorial," Mr. Schmidlin told delegates to the International Reinsurance Law conference, held late last month in London.

"These clauses have become important and deserve further study," he said.

"Arbitration clauses determine the forum by reference to the domicile of the defendant company," Mr Schmidlin noted.

In addition, as a result of mass litigation in the United States, European reinsurers would like to see civil laws enacted in their respective countries governing reinsurance disputes, he said.

Currently, the settlement of reinsurance disputes is based on common law, which is the accumulation of years of interpretations by the courts.

Considering the fact that common law was first developed in Europe during the Roman Empire, "it is indeed surprising that today the continental reinsurers appear to recoil from the prospect of being subject to any common law interpretation," Mr. Schmidlin observed.

"This reluctance is, however not the result of different legal principles in interpreting reinsurance contracts but is exclusively directed toward the U.S. courts," Mr. Schmidlin noted.

Mr. Schmidlin said that the European reinsurance community is taking steps to restrict the U.S. courts' involvement in disputes involving international reinsurance contracts, but he would not elaborate on what these steps were.

However, he said, there is "a lack of faith in the U.S. court system. . . .It is the result of reckless interpretation and one-sided appraisals of factual situations. Maximizing coverage in favor of what is perceived to be the weaker party to the contract is a popular and effective guideline, but it is playing havoc to the true intentions of the parties.

"This becomes particularly evident in the long-latent injury situations, which are the root cause of the present coverage crisis."

If European reinsurers are successful in using the civil laws of their own countries in interpreting reinsurance contracts, that could have a "quite considerable" effect on the final payment on some of the long-term liability losses being faced by the the industry, Mr. Schmidlin predicted.

He explained that European courts, unlike U.S. courts, should realize that reinsurers set limits in their reinsurance contracts and expect those limits to be followed. However, U.S. courts have stacked coverage limits and allowed ceding companies more coverage than was actually intended by the reinsurer.

"If we hear statements that the ultimate billion-dollar losses arising out of asbestos, DES, pollution, etc., will ultimately be borne by the reinsurers, one should add a word of caution," Mr. Schmidlin said.

"The potential liabilities arising out of mass litigation. . .will put enormous pressure on the contractual relationships between the parties." ■

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Underwriters' accounting upsets brokers

By CAROLYN ALDRED

LONDON—If insurance companies worldwide prepared their financial statements in the same manner as U.S. underwriters, would solvent insurers continue to outnumber the insolvent?

This is a concern of brokers, raised at the London conference on International Reinsurance Law by David Springbett, chairman of Lloyd's of London broker PWS Group.

"It might seem a very chilling prospect. (But) today there are billions of uncollected and disputed claims being treated as assets in insurer financial statements," according to Mr. Springbett.

Practices in the industry often appear to be topsy-turvy, he charged.

"It is very strange that large corporations very often insure with smaller companies, who in turn reinsure with even smaller companies," he said.

And, although the financial well-being of insurance companies in the United States is comparatively easy to assess from financial statements, the financial analysis of companies in the rest of the world remains a nightmare, according to Mr Springbett.

The solvency of state-owned insurers in the Third World remains a mystery, Mr. Springbett explained, adding that accounting standards and degrees of corporate financial disclosure differ throughout the world.

"The yellow peril—or (U.S. insurers') annual reports—goes further than anything in any other part of the world, but how do we assess the quality of any carrier's reinsurance elsewhere?" he pondered.

And, he added that brokers also must be aware of the possibility of blocked claims payments, a recurrent situation, particularly with the Third World state-owned insurers.

Mr. Springbett explained the broker's dilemma in assessing security in international reinsurance market by comparing annual reports to a selection of Valentine's Day cards.

A glossy annual report is like a glossy Valentine's Day card, Mr. Springbett said: both don't say very much.

But, a signed Valentine's Day card, just like a signed annual report, is backed by someone you know and trust, Mr. Springbett commented. ■

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ADAS to appeal U.K. reinsurance decision

BY CAROLYN ALDRED

LONDON—One of three contradictory British court decisions concerning the enforcement of policies issued by unauthorized insurers and reinsurers in the United Kingdom is being appealed to the House of Lords, the highest court in Britain.

ADAS, the Romanian state insurance company, plans to appeal to the House of Lords a Court of Appeal decision handed down in late October that overturned a lower court judgment against Phoenix General Insurance Co. of Greece, ADAS's lawyer confirmed last week.

The appellate decision permits Phoenix to claim recoveries from ADAS on 1978-79 aviation contingency reinsurance contracts.

"We are currently drafting the documents for an appeal. I would expect the appeal will be heard in the House of Lords sometime next summer," said Fergus Bateson, a partner in the law firm of Messrs. Thomas Cooper & Stibbard, representing ADAS.

In addition, observers say the recent enactment of the Financial Services Act in the United Kingdom may settle once and for all the dispute over the three conflicting cases involving unauthorized underwriters, which were discussed at the International Reinsurance Law conference held in London on Nov. 24-25.

The case involving Phoenix and ADAS was first heard last year in the Queen's Bench High Court. Justice J.P. Hobhouse ruled that contracts made by unauthorized insurers such as Phoenix are not void in themselves but are enforceable only by innocent policyholders seeking claims payment.

This meant that the unauthorized insurer —in this case Phoenix—could not collect unpaid premiums or recover from its reinsurer —ADAS (*BI*, Oct. 28, 1985).

The other defendant in the case was Halvanon Insurance Co. Ltd., which is not actively appealing the decision, although it will be affected by the result of ADAS's appeal.

Phoenix had been authorized to write aviation contingency insurance until new rules were put into effect by the Department of Trade and Industry on Jan. 1, 1978, following amendments to the 1974 British Insurance Companies Act.

However, Justice Hobhouse's decision was overturned by Lord Justice Kerr of the Court of Appeal in late October, Gordon Cornish, legal officer for Victory Reinsurance Co. Ltd., told the conference attendees.

Mr. Cornish said that Lord Justice Kerr ruled that transitional provisions in the 1978 British insurance requirements allowed any insurer that had been lawfully writing business in any class immediately before the regulations came into force to continue to do so.

Therefore, the contracts with Phoenix were legal and ADAS was required to pay the reinsurance claims, the judge ruled.

Lord Justice Kerr also took the opportunity to express an opinion on the legal position of such contracts in the light of two other conflicting court decisions made in the Bedford and Stewart cases, Mr. Cornish said.

In *Bedford Insurance Co. Ltd vs. Instituto de Ressegurcs do Brasil* in October 1983, Justice Roger Parker ruled that all insurance contracts made by an insurer conducting business in Great Britain without authorization are illegal and void (*BI*, April 30, 1984).

While the Bedford decision prohibited the payment of claims to policyholders that had purchased coverage from unauthorized insurers or reinsurers through London underwriting agencies, it allowed the unauthorized insurers and reinsurers to keep the premiums paid to them.

'We are currently drafting the documents for an appeal. I would expect the appeal will be heard in the House of Lords sometime next summer,' says Mr. Bateson.

The Bedford decision was not well-received in the London market according to Mr. Cornish.

"Perhaps the most far-reaching consequence of that decision was that even an insured or reinsured who was totally innocent had no right of action against the unauthorized insurers with regard either to payment of claim or, even, recovery of his premium," he said.

Then, in April 1984 Justice Andrew Leggatt ruled in *Stewart vs. Oriental Fire & Marine Insurance Co.* that contracts of unauthorized insurers and reinsurers are not void and that those insurers must pay claims to their policyholders. Justice Leggatt left open the question of whether an unauthorized insurer or reinsurer could, in turn, enforce the contracts it has with other parties (*BI*, Aug. 26, 1984).

In the Phoenix Court of Appeal judgment, Lord Justice Kerr basically rejects the Stewart judgment and supports the Bedford decision with some reservations, according to Mr. Cornish.

According to Mr. Cornish, Justice Kerr ruled that if Phoenix General contracted without authorization from the Department of Trade and Industry, which it had before the change in the law, the contracts would have been void and unenforceable. Although his decision followed the Bedford decision, he said that he hoped "reputable insurers" would hesitate before using the Bedford defense.

"Lord Justice Kerr added that if his conclusion were correct and applied to all cases of unauthorized insurance business, then that would be a most unfortunate state of affairs for the insurance market, as all judges who had grappled with the problem had recognized," according to Mr. Cornish.

However, these conflicting decisions that have confused the London market may be superseded by a clause in the Financial Services Act, which became law last month, sources say.

Included in the act, which is designed to self-regulate the British investment industry, is a section that attempts to resolve the confusion brought about by the Bedford and Stewart judgment (*BI*, July 7).

The act says that if a contract of insurance is entered into by an unauthorized insurance company, that contract shall be unenforceable.

However, it also includes an "innocence escape hatch," according to Mr. Cornish.

This allows a court to deem a contract enforceable if it is satisfied the insurer did not realize that it was acting without authorization, Mr. Cornish explained.

The act also states that an unauthorized insurer can collect claims from its reinsurers if the court rules that the original insurance contract is enforceable.

"This appears, therefore, to overrule the line taken in Bedford, which was explicitly supported. . .in the Phoenix General appeal," Mr. Cornish said.

Mike Jones, manager of legislation for the Assn. of British Insurers, hopes the new provision under the Financial Services Act will help clear up the position of British courts regarding unauthorized insurers and reinsurers.

"The Bedford, Stewart and Phoenix cases had given rise to a certain amount of confusion in the markets and the judgments had been difficult to follow," he said in an interview after the conference.

"We now have a degree of clarification with Section 132" of the Financial Services Act, he added.

However, Mr. Cornish warns that even the new provision in the Financial Services Act eventually will have to be tested in the British courts. ■

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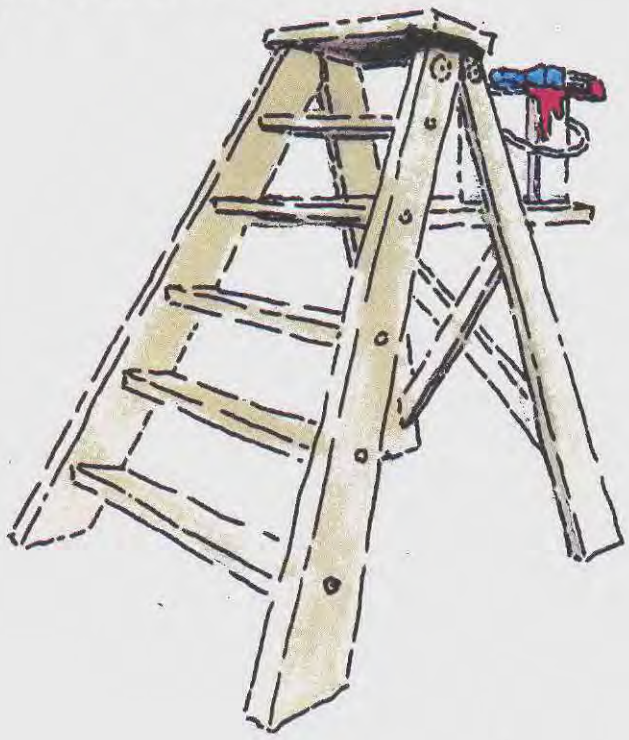

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EC directive may increase claims

LONDON—British insurers may be hit with more product liability claims if Britain adopts the European Community's directive on product liability as outlined in the new Consumer Protection Bill, reinsurers say.

However, most of the delegates to last month's International Reinsurance Law conference added that although the number of claims might increase substantially because of the EC directive, the level of damages awarded in product liability action probably would not rise dramatically.

The Consumer Protection Bill, which was introduced in Parliament last month, would introduce strict liability for product manufacturers and importers.

Under strict liability, an injured party does not have to prove that a manufacturer was negligent to recover damages.

Under current British law, a consumer must prove a manufacturer is negligent to collect damages.

In addition, under the legislation there would be no limit on the amount that could be awarded a plaintiff in a product liability case (*BI*, Dec. 1).

'The main reason behind the staggering difference in awards handed out here compared to the States lies within the legal system itself,' says Mr. Butler.

The bill also allows defendants to use the state-of-the art defense. Under this defense, the defendant would not be held liable if it can show that "the state of scientific and technical knowledge at the time was not such" that a product's manufacturer "might be expected to discover the defect."

John Butler, legal officer at the Mercantile & General Reinsurance Company P.L.C., said that the legal systems in England and Scotland would ensure that product liability awards in the United Kingdom do not increase dramatically, despite the new, stricter product liability standard.

"The main reason behind the staggering difference in awards handed out here compared to the States lies within the legal system itself," according to Mr. Butler.

"Although the implementation of the bill will promote more concern about product liability leading to the insurance industry paying more in total liability claims, I don't believe the level of claims will increase that much," Mr. Butler observed.

Gordon Cornish, legal officer for Victory Reinsurance Co. Ltd. in London, agreed with Mr. Butler.

"The retention of the state-of-the-art defense and our judge and jury system will keep product liability awards (in Britain) to a level easily manageable by the insurance industry," Mr. Cornish said. ■

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Spiced tea tests positive, prompts suit

By MICHAEL BRADFORD

PARIS, Texas—The maker of a portable drug testing unit is facing a product liability lawsuit following a bizarre incident in which one of its units identified instant tea as hashish.

The suit was filed against Franklin Lakes, N.J.-based Becton Dickinson & Co. last month on behalf of a Paris Junior College student who was suspected by the county sheriff's department of receiving an illegal drug in the mail. The suit, filed in the state's 62nd District Court in Lamar County by Bill Flanary, an attorney in Paris, Texas, seeks an undetermined amount of damages from the company.

The saga began when 19-year-old Elizabeth Horn picked up a package at the college campus post office. The package, which her parents had mailed to her from Chicago, was battered and leaking a brown powder. Inside was an assortment of candy and other items, including a broken jar of Bigelow Constant Comment Instant spiced tea.

Mr. Flanary explained that when suspicious school personnel took a sample of the powder to the Lamar County Sheriff's office, officials there agreed to test it with a kit manufactured by Becton Dickinson. The unit tested the powder as hashish, he said.

Officers from the sheriff's department then were dispatched to search Ms. Horn's room at the college, where they took more samples of the brown powder from the trash can where the student had tossed the broken jar.

The next morning, when Mr. Flanary met with the officers and a county prosecutor, the tests were repeated. To check the equipment, officers tested a sample of marijuana, which the unit tested positive as an illegal drug, and a cigarette butt, which tested negative.

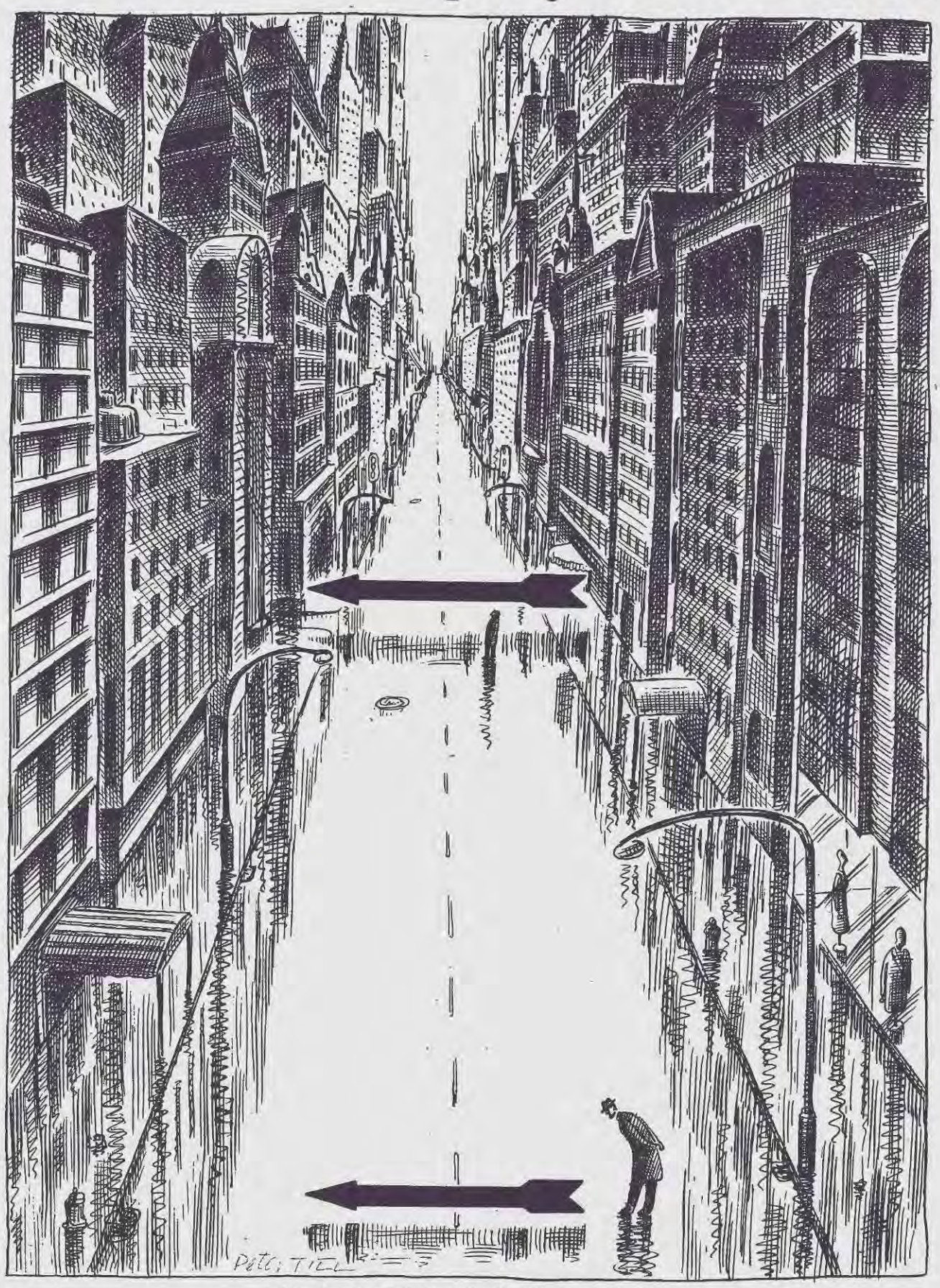
But again, the unit indicated that the brown powder was hashish, Mr. Flanary said. At that point, the attorney produced an envelope containing more brown powder and asked officers to repeat the test. Once more, the powder tested as hashish.

When officers asked him where he obtained that sample, Mr. Flanary showed them a jar of Constant Comment spiced tea he had bought that morning at a grocery store. The officers then realized a mistake had been made, Mr. Flanary said.

"We're charging that Becton Dickinson is liable for the product that they placed in the hands of the sheriff's department," Mr. Flanary said. The suit charges that Ms. Horn's name was tarnished and that she was subjected to embarrassment and taunting as a result of the incident, he added.

Mr. Flanary said last week that Becton Dickinson had not filed a response to the suit. Officials at the company could not be reached to comment on the case.

How far down the road should a reinsurance company be before it's considered secure?



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A&A to launch EIL risk retention group

Alexander & Alexander Services Inc. in New York will launch a risk retention group early next year to provide primary environmental impairment liability coverage to small and medium-sized companies.

Tentatively named Environmental Protection Insurance Co., the new EIL facility will provide participants with $5 million of primary coverage with a $10 million annual aggregate.

W. Lee Carter III, director of research and development for A&A, noted that all of the other proposed EIL facilities are seeking to offer very high limits and thus will require significant up-front financial commitments.

"Our focus is on companies that have the exposure and need the coverage, but aren't in the position

markets

to put up a million dollars or more in capital," he said. "By working on the primary coverage level, we will be able to rely more heavily on premiums rather than on capital for the funding source of the program."

A&A hopes 400 to 600 companies will join the facility. It will not comment on where the facility will be domiciled.

The capital contribution required to join the facility will vary depending on the size and type of company, but likely will be in the $100,000 range, Mr. Carter said.

As with other proposed EIL facilities, participants will have to undergo a risk assessment before they can obtain coverage. A&A has not yet selected the firm or firms that will be retained to perform these assessments.

A&A will hold regional conferences starting in early January to introduce EPIC to potential participants.

Shand Mcrahan & Co. Inc. will be the underwriting manager for the facility.

Hospital insurer

Premier Insurance Co. of America—the former National Excess Insurance Co.—will begin underwriting professional liability insurance for hospital medical staffs that belong to the Premier Hospitals Alliance Inc. of Westchester, Ill.

Premier Hospitals Alliance Holdings Inc., a division of the hospital service corporation, purchased National Excess Insurance from broker Corroon & Black Corp. for about $11 million earlier this year (*BI*, Aug. 25).

The company will begin writing both primary and excess professional liability insurance for physicians starting in January, said Bill Devoney, senior director of financial programs for the alliance.

The coverage will be written on a claims-made basis with limits of $1 million per claim and $3 million aggregate, he explained.

Next fall, the insurer will begin writing medical malpractice programs for hospitals in the alliance, he said. The insurer eventually will market coverage to non-alliance members, he added.

Currently, the alliance offers its members hospital malpractice coverage through a trust arrangement in which "hospitals have varying degrees of self-insurance and can then get coverage (above the self-insured retention) up to $5 million per occurrence and up to $8 million in aggregate," Mr. Devoney said.

The alliance also plans to write other coverages such as employee benefits for medical staff, residents and employees; general professional liability; directors and officers liability; and workers compensation, he said.

The purchase of Premier Insurance Co. was financed by member hospitals that planned to buy insurance from it, he said.

However, hospitals not affiliated with the alliance also will be able to purchase coverage from Premier if they make similar investments. Investment details have yet to be worked out.

For more information, contact Linda Klute, vp-finance at Premier Hospitals Alliance Inc., 1 Westbrook Corporate Center, Westchester, Ill. 60153; 312-531-8220.

Reinsurance broker

HJF International Ltd. is a new reinsurance brokerage in Bermuda specializing in insurance and reinsurance brokering in Bermuda.

Clarkson Puckle Group Ltd. in London is a majority shareholder in the new firm, whose three principals are Michael G. Folger, Michael T.W. Jenkins and Geoffrey A. Hunt, all formerly employed by Frank B. Hall (Bermuda) Ltd.

"Our intention is to provide insurance and reinsurance brokering services for placement of reinsurance business into the Bermuda market, and for accessing offshore facilities such as A.C.E. and X.L.," said Mr. Folger, referring to A.C.E. Insurance Co. Ltd. and X.L. Insurance Co. Ltd.

Both of these insurers accept business only from offshore brokers.

"There are a lot of smaller brokers in the states that don't have an offshore facility and perhaps do not want to deal with one of the alphabet houses," Mr. Folger commented.

HJF International also is placing reinsurance programs for captives and has applied to form a management company, HJF Management Ltd.

HJF International has access to the London market through Rostron Reinsurance Brokers Ltd., a new London-based reinsurance broker in which Clarkson Puckle also has invested.

Directors of HJF International include: Brian M. Waters, chairman and president, who also is managing director of Clarkson Puckle U.K. Ltd.; Mr. Hunt, Mr. Jenkins and Mr. Folger, as executive vps; David M. Berliand, deputy chairman of Clarkson Puckle; and Peter A.T. Davidson, financial director of Clarkson Puckle.

HJF International has offices at 7 Reid St., Suite 402, Hamilton, Bermuda; 809-292-8411.

Captive management

Continental Risk Services Ltd., the Bermuda-based captive management services unit of New York-based Continental Corp., has established a new subsidiary in Barbados.

Continental Risk Services (Barbados) Ltd. provides underwriting, reinsurance, claims and accounting management services for estab-

Continued on page 24

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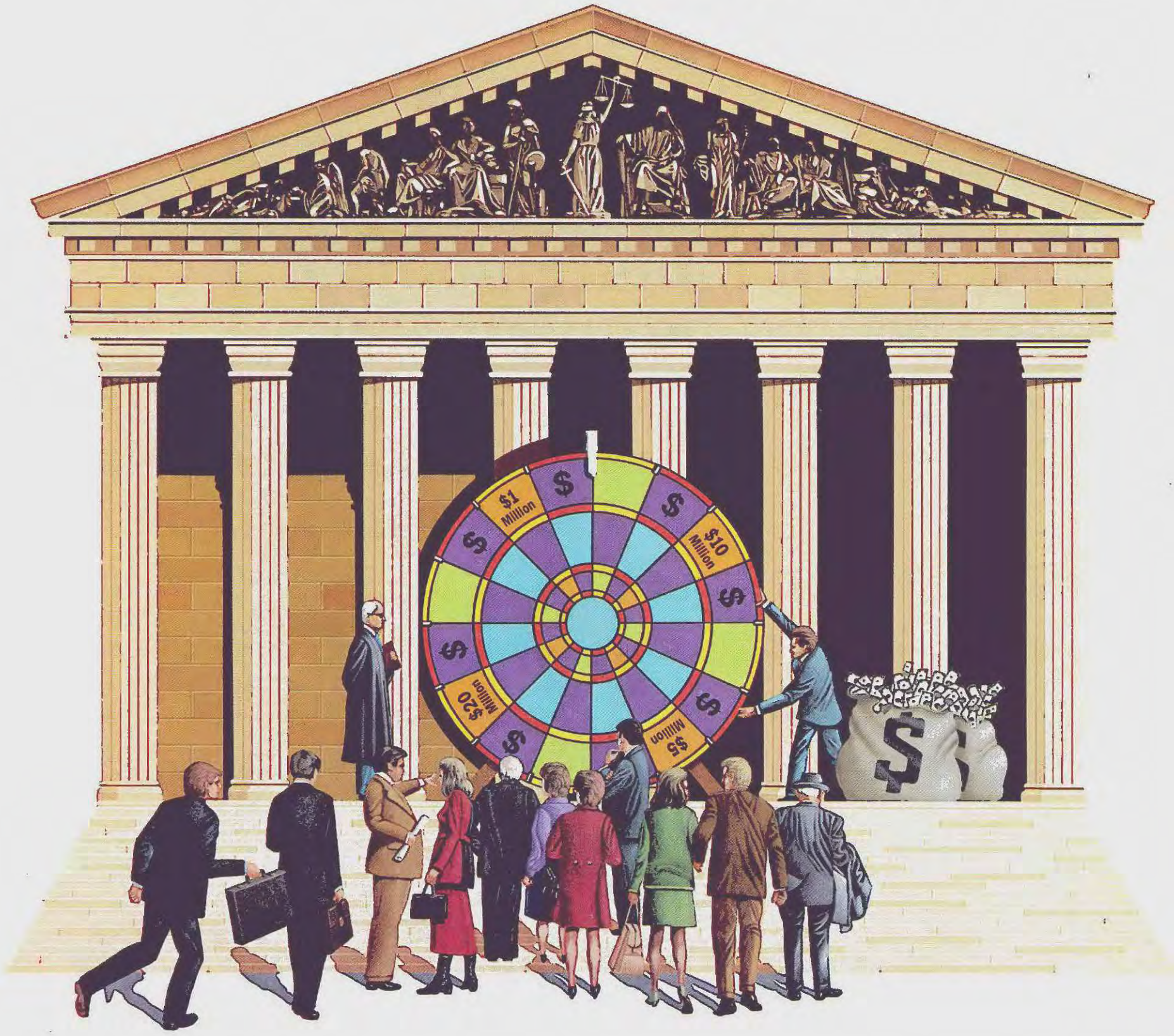

Courts and juries are now routinely awarding multi-million dollar settlements.

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Unfortunately, much of the money doesn't end up with the injured party. In a Rand Corporation survey of asbestosis cases, injured parties received less than 40% of the award.

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markets

Continued from page 22
lished captives or for companies interested in forming offshore captives.

The new company is directed by David B. Vaughan, president, and Lynne M. Fenton, vp. Ms. Fenton will be in charge of day-to-day operations in Barbados, reporting to Mr. Vaughan in Bermuda.

Continental Risk Services (Barbados) is located in the Pannell Kerr Foster Building, Bay Street, Bridgetown, Barbados, W.I.; 809-426-9551.

MOAC Australasia

A new marine insurer has been formed by the Marine Office of America Corp., a unit of Continental Corp., and Lombard Insurance Holdings Ltd., the holding company for the Australian operations of Hong Kong-based Lombard Insurance Group.

MOAC Australasia Ltd., headquartered in Melbourne, Australia, will offer liability insurance to the marine industry on an occurrence basis for hull, cargo and marine risks in the Pacific Basin region, said a spokesman for Continental in New York. MOAC Australasia also has a branch office in Sydney, Australia.

Marine Office of America Corp. has a 60% interest in the new insurer and Lombard Insurance Holdings, which is owned jointly by Continental and Jardine Matheson & Co. of Hong Kong.

He would not disclose the capitalization of the new insurer.

Benefit plan TPA

Benefit Plan Administrators Inc. is a new third-party administrator specializing in the design and administration of both self-funded and commercially insured employee benefit plans.

BPA, based in Boulder, Colo., is affiliated with Hofgard & Co., a full-service employee benefit consulting firm also based in Boulder, said William G. Hofgard, president of both companies.

The new TPA is a member of the National QicClaim Assn. of Independent Health Care Plan Administrators.

As a member of the association, BPA will process claims and provide management reports utilizing the QicClaim Health Care Data Management System marketed by Oak Brook, Ill.-based Resource Information Management Systems Inc., Mr. Hofgard explained (*BI*, May 26).

BPA also designs and administers flexible benefits plans, said Mr. Hofgard.

For more information, contact Mr. Hofgard at BPA, 1900 Folsom, Suite 100, Boulder, Colo. 80302; 303-442-1000.

New Houston PPO

HealthNet Plus is a new fully insured preferred provider health insurance plan available to employers in the Houston area.

The plan offers a network of about 700 physicians, eight hospitals and four outpatient surgery centers in the greater Houston area. Employees also have the freedom to choose providers outside the network, but will receive a reduced rate of coverage for expenses.

Medical costs under the plan are managed through utilization review, including pre-admission certification, second opinions for elective surgery and concurrent review.

HealthNet Plus is insured by Savers Life Co. of America in Overland Park, Kan. Claims administration, underwriting and billing for HealthNet Plus is handled by Kansas City, Mo.-based Administrative Concepts Inc.

For more information, contact Administrative Concepts, 9200 Ward Parkway, Suite 500, Kansas City, Mo. 64114; 816-361-3443.

Kaiser expansion

Kaiser Permanente Health Plan Inc. will expand to the Amherst, Mass., area by affiliating with Valley Health Plan in Amherst, announced Michael Dudley, vp and Northeast regional manager for Kaiser.

Valley Health Plan is a non-profit, federally qualified health maintenance organization operating four health centers in the Amherst area. Founded 10 years ago, Valley now has about 25,000 members.

Oakland, Calif.-based Kaiser Permanente has nearly 4.9 million members in 15 states and the District of Columbia. In the Northeast, it operates HMOs in the greater Hartford, Conn., area and Westchester County, N.Y., accounting for 55,000 members. Kaiser Permanente members from Connecticut and New York will be able to receive medical services at any of Valley's health centers.

Kaiser expanded to Connecticut by acquiring the former North Central Connecticut HMO in 1982, and to New York by affiliating with Westchester Community Health Plan in 1985.

New offices

Project Management, a new firm providing professional insurance services for underwriting reviews and audits, is located at P.O. Box 5434, Rockville, Md. 20853; 301-946-0676. The firm also has an office at P.O. Box 9715-120, Portland, Maine 04104; 207-774-3012.

Security Life of Denver has opened a new home office at Security Life Center, 1290 Broadway, Denver, Colo. 80203; 303-860-1290.

Hunter & Associates, benefit plan document and summary plan description writers, have relocated to 9842 Hibert St., Suite 152, San Diego, Calif. 92131; 619-578-7461.

Jardine Insurance Brokers Ltd. has opened a new office in London at P.O. Box 71, Thames House, 1-4 Queen Street Place, London EC4R 1JA; 01-236-4333.

KCC Capital Managers Inc. has opened a new corporate headquarters at 1 Greenwich Plaza, P.O. Box 2598, Greenwich, Conn. 06836-2598; 203-622-5500. Also headquartered in the new office are **Kramer Capital Partners; KCC Partners; Kramer Capital Consultants Inc.; KCP Holding Corp.; National American Insurance Co. of California and Kramer Capital Corp.**

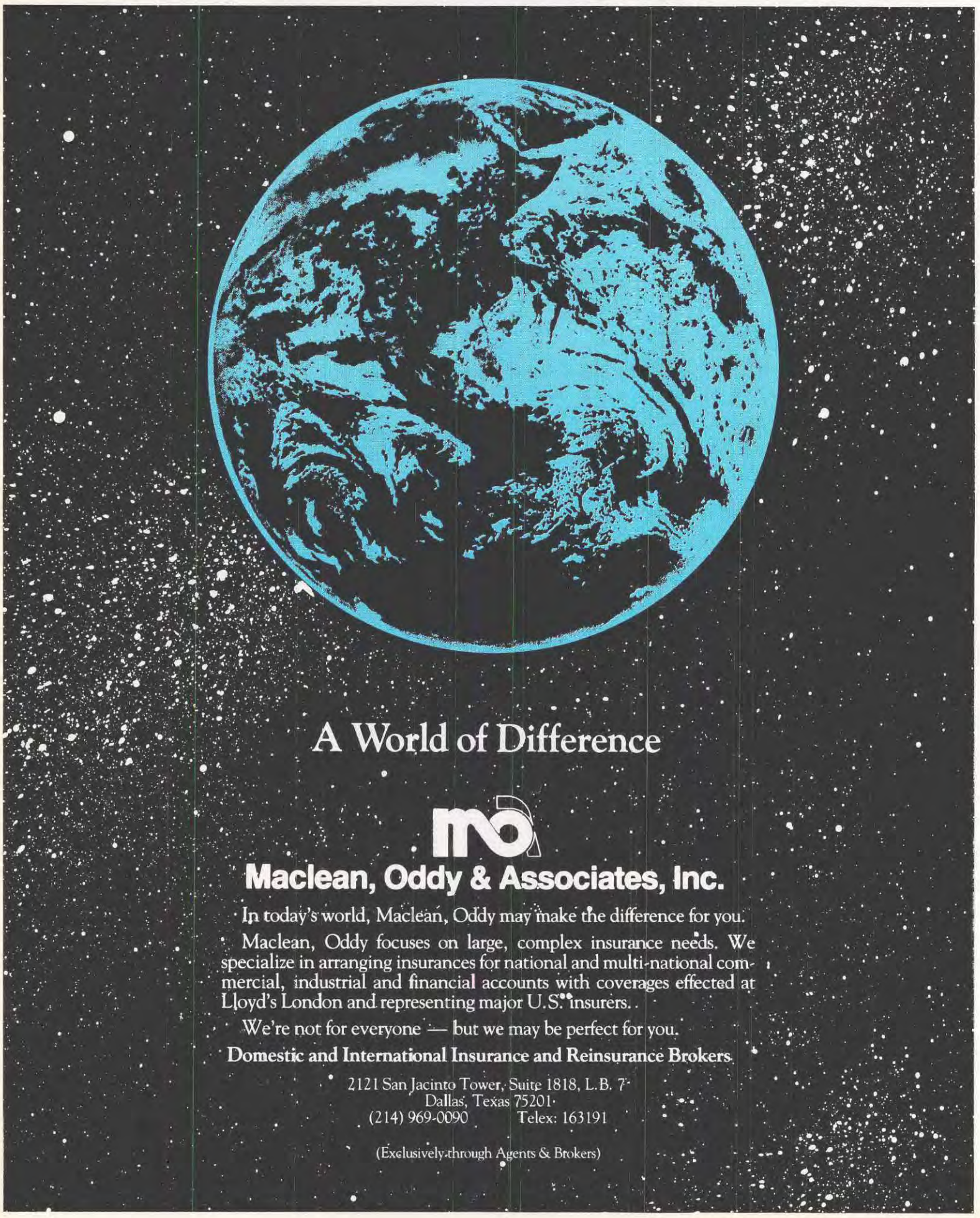
Mergers/acquisitions

Towers, Perrin, Forster & Crosby Inc. has acquired the general management and compensation consulting firm of **Hayes/Hill Inc.**, headquartered in Chicago with offices in Dallas and New York.

Name changes

Altamid Management Co., a Burlington, Vt.-based captive insurance company service firm, has changed its name to **Hanna Insurance Vermont Ltd.** It is located at 102 S. Winooski Ave., P.O. Box 730, Burlington, Vt. 05402-0730.

The South Florida Health Action Coalition, an alliance of employers concerned about health care costs, has changed its name to the **Florida Health Coalition**. The coalition has 30 employer members and represents about 1 million employees and dependents. ■



Chrysler offers universal life option

benefit beat

Chrysler Corp. is offering its salaried employees the opportunity to purchase additional life insurance under a new group universal life insurance plan effective Jan. 1.

Under the new plan, which is underwritten by Aetna Life & Casualty Co., employees can purchase as little as $5,000 in universal life coverage or as much as five times their annual salary, according to John Wilson, manager of benefit services, health care and group insurance for Chrysler in Detroit.

More than 27,000 salaried employees are eligible to participate in the new plan. The optional additional coverage is employee-paid through payroll deductions on a monthly basis.

Employees can vary the amounts of coverage they buy on an annual basis, he said.

Spouses of employees also can purchase coverage under the plan, from a minimum of $5,000 up to a maximum of $100,000. In addition, coverage for dependent children is available.

The universal life program includes a "cash account," to which employees can make aftertax contributions through payroll deductions and earn tax-deferred interest on the balance, he said. The account earns interest at a rate guaranteed by Aetna for a 12-month period.

Employees also can borrow any amount from the cash account from $200 up to 85% of the balance from Aetna and still earn interest on the balance. Or, employees can make withdrawals from a minimum of $200 up to the total amount in the cash account.

Aetna provides quarterly statements of coverage and cash account balances. The statements detail insurance amounts, credited interest, contributions, withdrawals and loans. The statements also project the value of the cash account at age 65 based on current interest rates and contributions.

"The group universal plan provides our employees with a lot of flexibility and the opportunity to get low-cost group term life insurance on themselves, their spouses and their dependents," Mr. Wilson said.

"All of the coverage and the cash account are fully portable," giving employees the opportunity to continue their coverage even if they retire or leave the company, he explained. "If they leave the company, they can make payments directly to Aetna up to age 100.

"Under the old optional plan, the coverage was not portable and employees could only buy insurance up to age 70," Mr. Wilson noted.

Chrysler currently offers employees an optional group term life insurance plan underwritten by The Prudential Insurance Co. of America.

This plan is "simply a straight optional insurance plan without a cash account."

Chrysler switched from Prudential to Aetna because "the group term rates were about 25% lower under Aetna's plan," Mr. Wilson said. Chrysler introduced the new plan to employees in October through letters and an enrollment brochure.

In addition, a toll-free telephone number also was made available for employees with specific questions about the insurance and cash account, Mr. Wilson said.

Payroll deductions begin this month, with coverage effective Jan. 1, he explained.

Along with the many advantages for employees, Chrysler also benefits from offering the new plan, he said.

"From an employee relations standpoint, we are pleased if our employees feel these benefits are providing them with flexibility and additional coverage.

"Financially, we get nothing from this. But, we have a better benefits program for employees, and we are able to attract and retain quality employees," he added.

In addition to the optional universal life benefit, Chrysler provides salaried employees with basic group term life insurance, Mr. Wilson noted. This coverage also is underwritten by Aetna.

Prescription drugs

Effective Jan. 1, more than 1 million federal employees, retirees and dependents will be covered under a new mail-order prescription drug feature that will be added to their current prescription program.

The new program, offered by Blue Cross & Blue Shield Assn., will offer substantial savings for employees requiring prescriptions on a regular basis, such as diabetics and heart disease victims, according to Richard Luehrs, executive director of the Blues' Federal Employee Program in Washington.

Under the program, employees or retirees enrolled in the government's "high-option" drug plan will pay only $3 for a 90-day supply of medication if they order by mail. Employees or retirees enrolled in the "standard option" plan will pay $5 for a 90-day supply.

The minimum supply that can be ordered through the mail program under either option is a 21-day supply, he explained.

"The mail-order program is quite advantageous for people who are on maintenance drugs," because they pay only the $3 or $5 copayment and no deductible, Mr. Luehrs explained.

Normally under the high-option plan, enrollees must meet a $200 annual deductible, plus 20% of all costs incurred if they do not use the mail-order plan. And, enrollees in the standard option normally pay a $250 deductible, plus 75% of all costs.

Enrollees in both plans also contribute about 40% of the premium costs.

Annual out-of-pocket costs for enrollees in the high-option plan who use the mail order program will be capped at $12. Annual caps for those enrolled in the standard option will be $20.

The mail-order program does not cover birth control pills, weight control pills, experimental drugs or drugs that can be purchased without a prescription, Mr. Luehrs said.

And, he explained, generic drugs will be used only if an enrollee's physician specifically prescribes them.

There is no lifetime or annual maximum under the high option plan. However, there is a $2 million lifetime maximum under the standard option plan, Mr. Luehrs said. ■

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Conference of Insurance Legislators

Reinsurance rates to remain high: Reeves

By STEVE TARAVELLA

NASHVILLE, Tenn.—Property/casualty insurance companies will continue to pay dearly for reinsurance for the foreseeable future, predicts a veteran U.S. insurance executive who also is a member of Lloyd's of London.

"The forecast is that the reinsurance companies are going to enjoy a seller's market clear through 1987 and, I estimate, substantially into 1988, and I don't see any help in sight," says Robert A. Reeves, president of Underwriters Safety & Claims of Tennessee Inc., an independent commercial brokerage in Nashville.

Mr. Reeves made this assessment as part of a panel on reinsurance and liability insurance presented to state legislators attending the recent 18th annual Conference of Insurance Legislators meeting.

Mr. Reeves, an industry veteran who helped develop OIL Insurance Ltd., the long-established captive for the petroleum industry, is a Lloyd's member and was, until a year ago, president of Hospital Corp. of America's insurance services division.

"If you want to solve the insurance industry capacity crisis, create a stable environment for a decent return on investment—that's your charge," Mr. Reeves advised the legislators.

Mr. Reeves was joined on the panel by Edmond F. Rondepierre, senior vp, general counsel and secretary at General Reinsurance Corp., and Warren D. Evans, Georgia's insurance commissioner and a former state legislator.

Mr. Reeves, who characterized reinsurers as "the gnomes of the insurance industry" and "the invisible bankers," proclaimed that reinsurers "wield more influence over the insurance industry than any other player."

"One small decision on their part can effect tens of billions of insurance policies that insurance consumers on the street must purchase," he said, citing the move to claims-made general liability policies as an example.

But Mr. Rondepierre countered that, in terms of assets and surplus, the group of companies specializing in assuming reinsurance is only about one-tenth as large as the pool of companies they reinsure. And this group of reinsurers doesn't have nearly the impact on primary insurance that most people assume, he said.

"Reinsurance cost does not directly affect the cost of primary insurance, if you look at primary insurance as a whole," Mr. Rondepierre asserted.

General Re does not perceive reinsurance "as having aggravated or precipitated the insurance crisis," he said.

Because of the way primary insurance rates are set, Mr. Rondepierre said, reinsurers can't have the pervasive influence over prices some observers believe they do.

Regulated primary insurance rates are calculated on a gross basis, without regard to the existence of reinsurance, he said. In the ratemaking process, he explained, insurers and regulators look at gross premiums earned by the direct insurer, regardless of any part that may be ceded to a reinsurer, and at all losses incurred by the direct insurer, whether or not any was recovered from a reinsurer—"as though reinsurance didn't exist at all."

For example, he says, several primary insurance companies each offering to insure a particular risk at exactly the same rate, terms and conditions, probably will have very different reinsurance programs. One might have no reinsurance for that coverage at all, one might have some reinsurance, and one might be heavily reinsured.

"If you didn't charge enough going in, buying reinsurance isn't going to fix your problem," said Mr. Rondepierre.

In discussing other factors contributing to a shortage of reinsurance capacity, Mr. Reeves cited the incidence of insurer insolvency, the uncertainties over claims-made commercial general liability coverage and the strength of the U.S. dollar against other currencies, which forced London reinsurers—as well as other non-U.S. reinsurers—to assume a greater premium volume without actually writing more business.

Corporations that entered the insurance market during the period of high interest rates several years ago, offered "cheap prices for very volatile risks. . .where we had very naive underwriters that helped us fill things like medical malpractice," Mr. Reeves said.

It is partly because many of these companies "aren't playing any more" that primary insurers are being forced to deal with fewer—but more experienced—reinsurers today, he said.

The ongoing debate over claims-made coverage also is restricting capacity, Mr. Reeves said.

"For someone like me who's trying to arrange insurance for major U.S. corporations, the limits aren't there because half the world wants all liability insurance on a claims-made basis, the other half wants it on an occurrence basis, and there's always a few defectors in here. . .who'll do a little occurrence on the side for the right price," he said.

Mr. Reeves also told the legislators that another factor contributing to the shortage of reinsurance is that Lloyd's of London cannot mount new capacity as easily as stock companies can. To assume more risk, Lloyd's syndicates must either take on new individual members or ask existing members, like Mr. Reeves, to increase their participation at Lloyd's.

The U.S. reinsurance industry has raised more than $1 billion in new capital this year alone, largely through stock offerings, to support the writing of renewal business at higher rates and to increase loss reserves for business previously written at low prices, he explained. But to accommodate the continuing clamor for reinsurance, the industry has to raise about $2.5 billion more, Mr. Reeves says, basing that estimate on the industry maintaining a 2-to-1 net premium-to-surplus ratio. And, he says he suspects it will be difficult to attract that kind of new money in the current stock market environment.

"The appetite for insurance company stock in the investment community has been satisfied for the current time," he observed.

Continued on next page

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COIL elects Levin president, continues poll of legislators

By STEVE TARAVELLA

NASHVILLE, Tenn.—Rhode Island State Rep. Irving H. Levin is the new president of the Conference of Insurance Legislators, a national organization supporting a better understanding of the insurance industry.

Mr. Levin began his term at COIL's 18th annual meeting, held recently in Nashville.

Also at the meeting, Georgia State Rep. J. Crawford Ware was re-elected vp; Connecticut State Rep. Morag L. Vance was elected secretary; and Ohio State Rep. Mike Stinziano was elected treasurer. New York State Sen. Donald M. Halperin was chosen president-elect; he will succeed Mr. Levin next year as president of the organization.

These legislators will serve until COIL's next annual conference, Nov. 8-11, 1987 in Palm Springs, Calif.

COIL, which is 17 years old, works to avert federal intervention in the insurance industry by nurturing a greater understanding of the industry and of state insurance regulation and legislation.

For example, COIL voiced opposition at the conference to various congressional proposals that would require insurance companies to report financial and loss information to a federal-level agency. And, COIL plans to continue its effort to solicit the opinions of federal representatives on insurance issues, despite a poor response to its first attempt: Sen. Halperin reported that only six of 535 U.S. Congressmen returned a questionnaire on insurance-related topics that was prepared and sent out by COIL.

But the COIL committee chaired by Sen. Halperin plans to revise the two-page questionnaire and conduct a second mailing in the near future.

Among the revisions is the addition of a "no opinion" response option, which was suggested by a committee member who attributed the low response rate to the congressmen's fear of making mistakes when stating opinions on issues they may not know well.

COIL's annual conferences—and two seminars held between the conferences—are attended by state representatives and senators, insurance and reinsurance company representatives and state insurance regulators.

The Nashville conference drew approximately 375 people from at least 35 states and the District of Columbia. However, the official roster included no elected officials from California, a state with much insurance and tort reform legislative activity.

At the conference, discussions ranged from the nationwide push for tort reform to the state of life and health guaranty funds to financial guarantee business. In addition, the scarcity of reinsurance also was the focus of a panel discussion (see story, page 26).

For information about the organization, contact COIL at 1776 Churchview Drive, P.O. Box 217, Brookfield, Wis., 53005; 414-782-6669. ■

Reinsurance rates

Continued from previous page

Indeed, stock market conditions have forced the parent companies of at least two U.S. reinsurers—Home Reinsurance Co. and Reinsurance Corp. of New York—to abandon separate plans for public stock offerings (*BI*, Nov. 17).

Georgia's Mr. Evans suggested that a chief reason U.S. insurers are operating in such a turbulent environment is that they rely too heavily on non-U.S. companies for their reinsurance. U.S. insurers need "to declare their independence" from non-U.S. sources of reinsurance, like Lloyd's of London underwriters and other overseas reinsurance sources, Mr. Evans advised.

"I just don't think anything as vital to the American people as insurance should, in a sense, be left at the mercy of foreign companies," he said. "If the American industry doesn't correct this situation, then I think it's just a matter of time before Congress and all the state legislators will."

General Re, however, estimates that only about 25% of all the reinsurance purchased by U.S. insurers is bought from non-U.S. companies, Mr. Rondepierre said. ■

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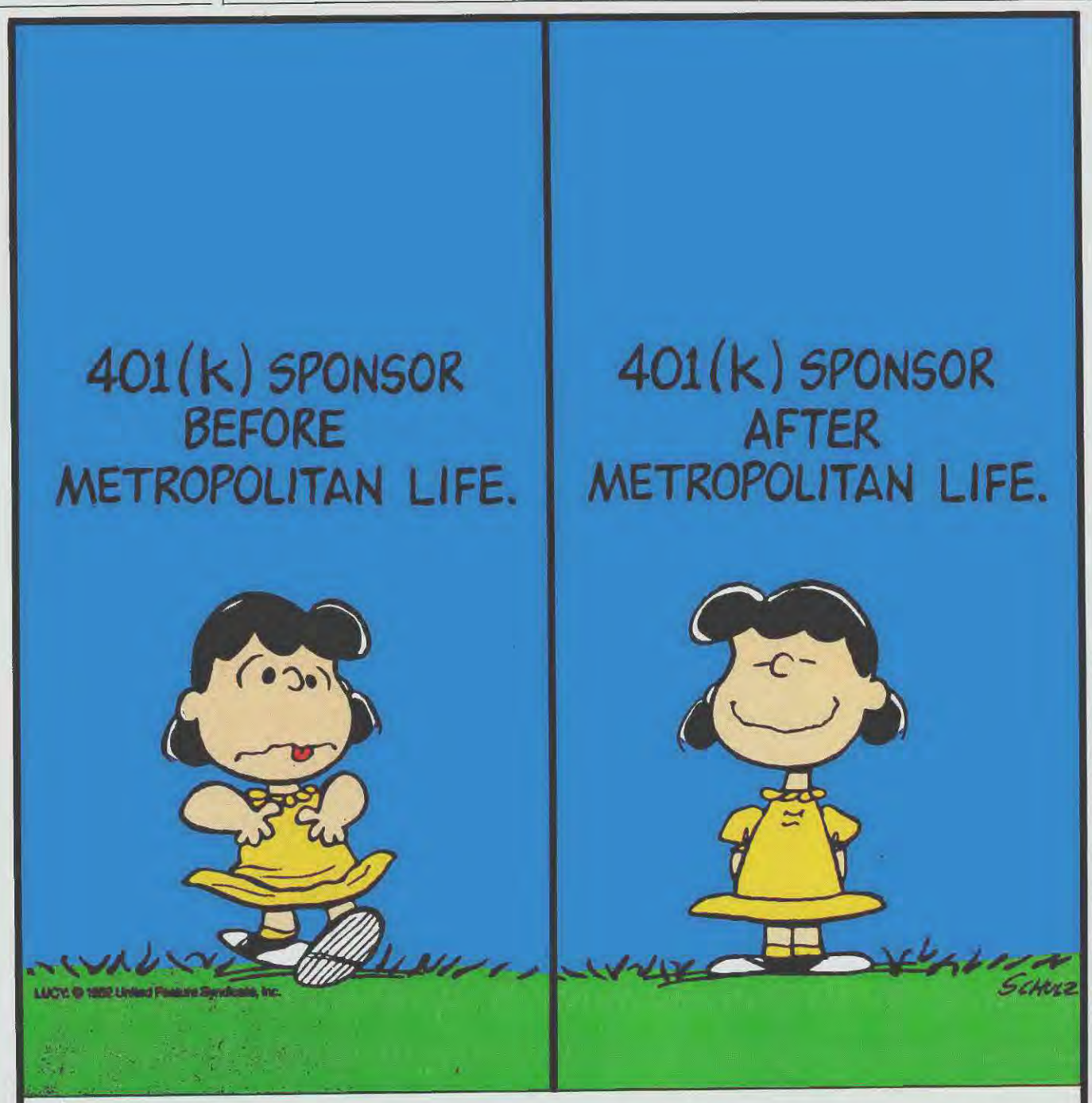

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With potential catastrophic loss, injury and risk all around us, no one would question the need to control financial uncertainty and make accidental losses manageable. In other words, the need for insurance. The problem arises when insurance is used as an entitlement mechanism to redress any loss, any injury, minor or major, imagined or real, no matter how ambiguous or arbitrary.

In recent years, the historic relationship between tort law and liability insurance has been radically distorted. This has resulted in a tidal wave of litigation that has clogged our courts, sent legal costs skyrocketing, and forced insurers to curtail their coverages and/or radically raise their premiums. At the same time, reinsurers are reluctant to share in the risks in such a volatile, unpredictable legal climate.

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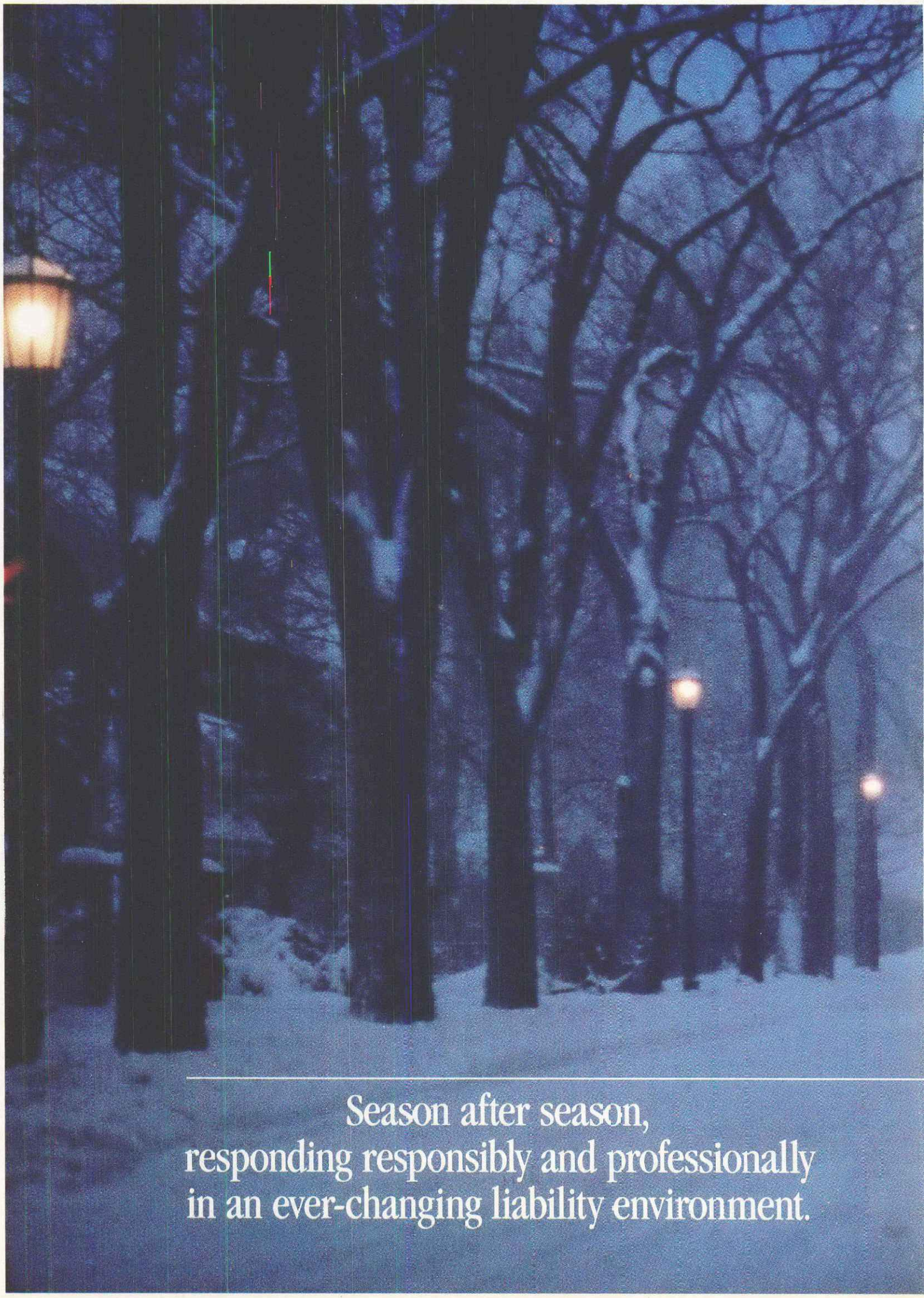


in higher consumer prices and higher taxes. Those who cannot obtain insurance go "bare" or curtail their business or service to a minimum.

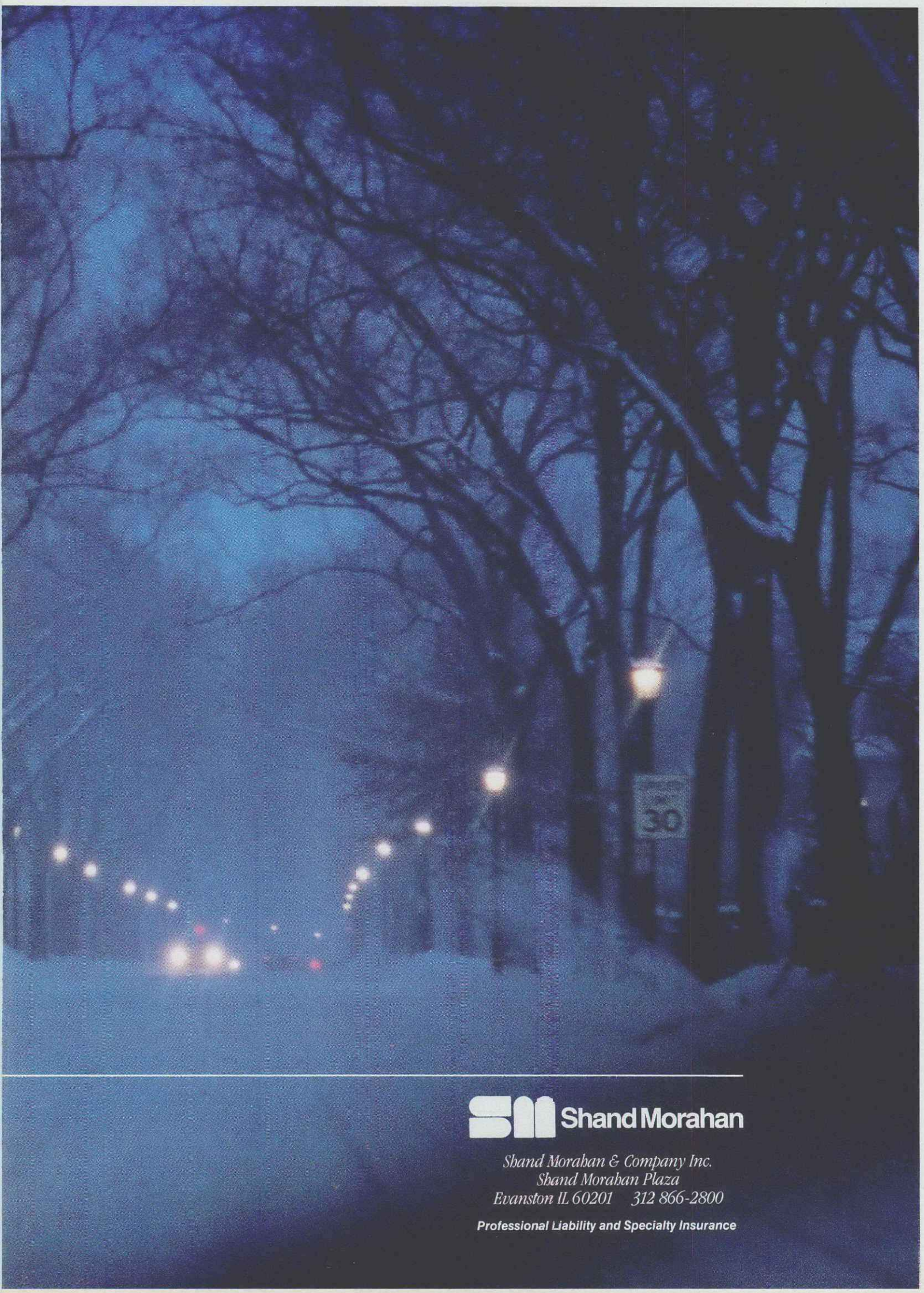
In short, when insurance doesn't work the way it is supposed to work, everyone suffers.

That's why it is everyone's responsibility to see that the problems which led to the current crisis are resolved and rectified.

First, this means we must all understand the complex issues involved. Then, we must communicate this understanding to others–to our friends, our colleagues and most importantly, to our legislators.

Shand Morahan & Company will continue to discuss and attempt to clarify the issues most in need of reform. We ask you to join us in seeking solutions. Individually and collectively, we have the potential to change things. We are most interested in your thoughts and in sharing ours with you. For more information, write to: Joseph J. Prochaska, Jr., Chairman and Chief Executive Officer, Shand Morahan & Company, Inc., Shand Morahan Plaza, Evanston, IL 60201.

As the liability environment continues to develop and change, Shand Morahan is committed to adapting to this change, responsibly and professionally, with products that you and your clients can count on.



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AUTOMATION

PCs could help relieve underwriters' current backlog

By W. Eric Meyer

THE POSSIBLE solution to the administrative logjam associated with the current hard insurance market is staring many executives in the face. The answer, in the form of personal computers, may already be sitting on our desks. And, the software to drive those computers is here and it is cheap.

There exists no logical reason today why both renewal and new-line coverage submissions cannot be prepared by brokers in relatively standardized formats using personal computers. These electronic packages then could be transmitted over telephone lines directly to the underwriters, making the market much more open and consistent for corporate buyers hungry for coverage.

Almost comically, underwriting of business risks still is done using paper methods adopted in mid-century. Automation—outside of small commercial and personal lines agencies—is virtually non-existent.

Although substantial investment has been made in management information systems to standardize and streamline data on claims and past premiums, very little has been done to automate the evaluation of commercial lines submissions.

Ironically, the underwriters' review of a commercial line submission is the fundamental insurance transaction, from which all future insurance company profits and losses will result. And, as such, it has an equally significant impact on the pricing and the security of risk protection being purchased by buyers.

Technological advancement in mini- and microcomputers has been largely ignored by the insurance industry as a possible aid in this fundamental step. It is time—quickly—to reverse the trend.

The widespread use and acceptance of personal computers, along with recent and dramatic advances in equipment technology, software and telecommunications, allow for the rapid and inexpensive transmission of large quantities of digitalized data from one office to the next.

Establishing basic computer communications does not require sophisticated programming, centralized management information departments or identical machinery. Rather, it is now possible for almost anyone with a personal computer, an inexpensive modem and several hundred dollars of software to communicate with another personal computer located virtually anywhere in the country—or the world.

W. Eric Meyer is a risk management consultant with The Wyatt Co. in Washington. He specializes in structuring risk-funding alternatives for association-sponsored property and casualty programs.

speaking out

This technological advancement should be put to use by the property/casualty insurance industry to benefit itself and to meet the needs of its buyers. Put simply, how much longer can the property/casualty industry afford to turn its back on the needs of buyers who expect efficient processing of submissions and rapid access to available markets?

What is needed is a uniform protocol to allow all brokers to "talk" easily with computers to all insurance companies. In fact, such electronic marketing probably will enhance competition in cases where such competition would exist, except for its inability to deal with the paper.

The insurance industry is operating today essentially as it did during the last market swing eight years ago. This is hard to imagine when you consider the incredible scope and pace of changes that have swept across most other financial industries, which are rapidly and gratefully adapting to office automation. But, insurance placement for most commercial risks remains a manual, laborious exchange.

Technological advancement in mini- and microcomputers has been largely ignored by the insurance industry. . . .It is time to reverse the trend.

The current ritualized approach guarantees a slow movement of essential information among buyer, broker, underwriter and insurance company management.

The question remains as to how this slow movement of information has contributed to the speed and severity of the current market downswing. Perhaps, someday we will find that much of the high pricing and lack of capacity today was simply a result of the failure to communicate easily true information about the nature of risk and past losses.

In the current property/casualty insurance crunch, many corporations have heeded the warnings of their brokers to ride out the first round of dramatic price shocks by biting the bullet and staying with their existing insurers. But, if the historical pattern learned in the last major down cycle repeats itself, these hold-fast strategies will be abandoned in favor of shopping.

As the property/casualty insurance crunch continues, simple economics will force corporations into the marketplace to aggressively seek out the lowest cost for their coverage.

Already in most cases, corporate managements are demanding that risk managers secure competitive bids for property/casualty insurance. The effect will be a continued flood of proposals to already-saturated underwriting markets.

At the same time, many buyers are now realizing that at least part of the capacity crunch is a result of pared-down underwriting staffs unable to handle "by-the-book pricing." This often has led to gridlocks in rating departments and cumbersome procedures for documenting underwriting files. These, in turn, have led to closed-off facilities, "zero hour" quotations delivered moments before renewal or "blind renewals," where a binder is signed without any type of premium indication or even confirmed finalization of limits.

In most underwriting systems, the processing chain is centered on the interpretive use of the underwriter. The underwriter relies on the broker's submission to make a final decision on policy terms and pricing.

Minicomputers and telecommunications systems can be adapted to enhance this interpretive process through a coordinated use of the broker to format a submission and the personal computer to assume many of the rating tasks.

All future submissions could be prepared using standardized formats. Paper submissions and questionnaires simply would be replaced by responses entered on a personal computer. The same multipage paper application easily can become a digitalized file on a diskette.

The broker would essentially be "pre-underwriting" the risk, using standards set by the industry and the particular data needs of the insurance company.

Data then would be mailed to underwriters in diskette form, or—even better—would be sent from PC to PC over modems using low-cost phone calls.

The underwriter, when receiving pre-formatted data, can manipulate information quickly and match the application responses to preset formulas to measure underwriting acceptability.

A quotation prepared on the underwriter's personal computer then would be sent over telephone lines to the broker's machine. If underwriting control is the objective of home-office management, then a copy also could be sent instantly to the company's mainframe computer to achieve centralized control and monitor any outstanding bids.

Better yet, submissions can be routed easily anywhere in the company to those underwriters specializing in a particular risk, business class or line of coverage. Most importantly, a uniform protocol won't limit access by requiring special hardware or software supplied by the insurance company.

In short, traditional marketing systems are hindering everyone's ability to recover from the crisis. Buyers lose by unexpected delays, and brokers have higher costs and frequently lose the confidence of buyers who receive incomplete renewal presentations at the last minute. Underwriters lose good opportunities and find their overhead is skyrocketing.

These outmoded methods are expensive, cumbersome, and limit the alternatives of corporate buyers. They also mean that underwriters function at much lower productivity. But, this apparently is not a concern of insurance companies, which find that current premium rates make underwriter productivity a moot issue.

Electronic marketing will not replace the famous broker lunch or face-to-face meetings. But, it should reduce delays caused by the mail and simplify the underwriter's task of sorting through thick packages of submissions.

It also would mean that brokers would have much easier access from remote cities to major underwriting markets in New York, Philadelphia, Chicago and Los Angeles, or to a particular underwriter specializing in a particular industry group or risk.

The solution to this paper nightmare will demand a new protocol to handle the submission and evaluation of commercial insurance risks. Buyers should demand a change in the way their risks are presented to a smaller and smaller supply of available insurance markets.

Ultimately, if the insurance industry is to hold down its overhead and avoid further erosion of consumer confidence, it must adopt a new means of streamlining the flow of communication between buyer and seller, and of opening doors to encourage more-efficient access to overburdened markets.

During the soft market of the early 1980s, few insurance companies focused on the means to control paperwork costs associated with underwriting. Most instead focused on controlling costs in the area of claims and loss control by implementing limited-purpose information systems.

During the soft market, funds rarely were allocated for this type of research and development. But now, in the retrenchment that has followed as part of the hard market, few companies are concerned with—or have time to—consider alternatives in their struggle to keep up with the avalanche of submissions.

Underwriting markets have proven more willing simply to close their doors to new submissions than to deal with customers clamoring for capacity and competitive quotations.

It is not hard to envision a transaction process that is virtually paperless until the client actually receives a printed proposal. A first step is a full industry task force of brokers, agents, underwriters, consultants, reinsurers and risk managers.

Isn't it time we got started?

ASK A RISK MANAGER

Problem-solving ability is key broker ingredient

Q **What qualities, abilities, knowledge or overall attributes do you look for in a prospective insurance broker?**

A Some might say your broker (the person that handles your account) is only as good as the brokerage house he or she represents. I prefer to say the local brokerage house is valuable to you only to the extent of the abilities and qualities of the individual local account representatives.

There is one caveat to this, however, and that is: The local brokerage house must provide better-than-average support to those account representatives if the service is to be valuable at all.

If the parts and pieces are more important than the whole in the direct value you are looking for, I could generalize my answer by saying I look for those qualities that would best assist me in doing a better-than-credible job for my company.

As I am judged on my knowledge of our business and on my ability to solve problems and am measured—or held accountable for—by how effective I am in doing this job, so should I look for those same qualities in a broker. How valuable is the end result?

Generalizing about this subject is good exercise to put you in a position of understanding the overall objective of your broker search, but you must get specific about these areas as time goes on. There is today a need, I believe, for broker representatives to possess all of these qualities if they are to give you positive assistance in handling your account.

Knowledge of your company's business together with the insurance marketplace would be foremost in my mind. The ability to solve problems is a close second. Where problems many times arise and where your broker representatives' true qualities are put to the test is in their ability to bring all these skills together to produce a satisfactory product.

With respect to knowledge, I like to see a seasoned individual with a wide range of experience. If that person possesses a specialized skill in one or two areas, that adds much value to the picture. Coupling experience in the marketplace with insurance theory, through risk management and insurance education courses, is mandatory.

A problem-solving ability in today's market environment probably answers a greater need for most risk managers than any other quality. Anticipating problems and finding workable solutions shows me more of the qualities I want to see in a broker than any other attribute.

Accountability can be a nebulous quality in some job descriptions, but it is probably foremost in a risk manager's mind when searching for a broker who will not only provide competent marketing service, but also take the responsibility to see that the everyday support staff provides the service for which the client has paid.

This service involves completing the analysis of insurance contracts purchased (or those you thought you purchased) and the efficient handling of amendments, corrections, additions and deletions to insurance contracts, which have become an ever-increasing frustration in our business.

Marketing insurance coverage may be the primary skill utilized in the risk manager-broker relationship, but what most of us look for is that "added value" that the broker can bring to your account needs.

These added values can take many forms; here are some I would look for:

- The ability to grasp the diverse operations of my company and analyze those operations in a clear and understandable way so that marketing discussions with underwriters can be positive and realistic. This ability should show itself not only in the oral presentation of your risk but also in the manner in which specifications are drafted.
- Willingness and ability to discuss and develop an untried approach to solve a particular problem. Answers to new marketing approaches today might get a quick negative response, but the need to continue with new, imaginative problem-solving techniques is always refreshing.
- I like to see a broker concerned about my need for an "arms-around" approach to the day-to-day servicing of my account. While he or she may be a marketing specialist, a willingness to also take responsibility for all members of their team in servicing the account brings high points to that senior broker.

In addition, some areas that may call for specialized problem-solving prowess in a broker include:

- Client claims-made policy statements.
- Analysis of the new tax law, especially regarding the continued value of fronted programs.
- Services available as they relate to managing self-insured programs.

Association activities offer added value to your work

Q **Can you measure your insurance and risk management association activities in a tangible way that shows management the value received from this outside activity?**

A An assumption I take for granted is that you yourself are convinced about the values associated with these activities. And, just as importantly, you are willing to bring these "added values" back to your company, sharing them with your department associates and fellow employees.

I suppose we could stop right there and say such a willingness on your part to participate beyond your regular job should be sufficient to permit your management to support your activities with time and money—but it doesn't necessarily work that way.

Your department's formal philosophy, assuming you have one, could state that the company encourages employee participation in industry activities and in leadership roles within risk and insurance management associations. However, while this is admirable, it is difficult for many people to attach a value to and show a return from outside activities without some help from you.

In today's corporate world, reducing these activities to a numerical return, measurable in dollars, is a continuing challenge for all—particularly for those who also want to help enhance their profession by contributing to it through association activities.

In a subtle but serious vein, insurance association work is one way you get some fun out of this business and, without that, one could ask why you are in it.

Start at home with Risk & Insurance Management Society activities in your local chapter. Probably the two most important values you develop through local RIMS chapter associations are contact with fellow risk management personnel and the use of these meetings as a forum for expressing and sharing ideas about your risk management and insurance problems. It's up to you to translate and communicate these values into direct benefits to your company.

There are no associations, other than your local RIMS chapter, that can provide you with this type of forum.

As an example, at last month's chapter meeting we saw a slide presentation, developed by our local and prestigious university's risk management department, for use in presenting an overview and understanding of their risks to underwriters. There were good ideas of value in that presentation that could be used by all of us in clearly helping to market our risks.

Take this sharing of ideas one step further into becoming a contributor and active participant in helping your chapter forum continue.

You can begin by assisting on local committees and eventually assuming director and officer responsibilities.

How can this activity help your day-to-day job? As an active participant you intensify and broaden your contacts (in this very personal business of ours) and find that the forum for problem-solving becomes more valuable. While you are gaining knowledge and experience in the organizational, educational, financial, research and leadership roles within your local chapter, your ability and confidence in using communication skills within your corporation—and for your profit-center clients—also grows.

As an example, a program developed for a workshop presentation to explain a retrospective rating/allocation system that was shared with RIMS members was the forerunner of a successful company controller's conference presentation some months later.

While RIMS activities are the specific area identified in this article, active participation in the Society of Chartered Property Casualty Underwriters, the Society of Chartered Life Underwriters, the Associate in Risk Management program of the Insurance Institute of America and other forum associations can bring rewards back to your company in tangible ways if you work at it and communicate these values to the boss.

One last thought that's good and bad all at the same time is the fact that you must continually keep up communicating the value of outside activities at work. The turnover in management personnel requires it.

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

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

Mr. Perry

This month's column, on risk management issues, is written by Ralph F. Perry Jr., vp and director of risk management at Amfac Inc. in San Francisco. Joseph W. Duva, director of employee benefits at Allied-Signal Inc. in Morristown, N.J., answers benefits management questions. William J. Miner, an actuary with The Wyatt Co. in Chicago, answers actuarial questions on benefits issues. And, Richard E. Sherman, a principal with Coopers & Lybrand in San Francisco, answers actuarial questions in the casualty field.

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

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

CARE liability facility sets March opening

By MICHAEL BRADFORD

YAZOO CITY, Miss.—Corporate America's Risk Exchange, an excess liability insurance facility being developed by a group of risk managers, is fine-tuning preparations that will allow it to become operational on March 1.

"We're quite certain by March 1 it will be licensed and fully capitalized," said Timothy B. Sterling, manager of risk and property taxation at Mississippi Chemical Corp. in Yazoo City.

Mr. Sterling and several other risk managers are developing the facility to provide up to $50 million in excess liability limits above a $1 million retention (*BI*, Sept. 15).

CARE's organizers are compiling information on the companies expected to become founding members of the facility and are putting the finishing touches on the occurrence policy form which CARE will use.

Capitalization plans require at least 200 investors for CARE to begin operations. The insurer's developers have been in touch with 600 to 700 prospective members and now are determining which 200 will be the initial founders of the facility, according to Mr. Sterling.

The group of risk managers, which has named its endeavor Project CARE, expects investor/policyholders to contribute initial capital of $500 million and projects that capital contributed by subsequent investor/policyholders will boost CARE's capitalization to $620 million.

No capitalization money has been raised so far.

Mr. Sterling explained earlier this year that tentative capitalization plans called for each of the 200 founders to buy 250 shares of stock for $2.5 million. This stock would include 50 shares of "founder's own stock" and 200 shares of "founder's redeemable stock," each with a value of $10,000 a share.

After CARE begins operations, new investor/policyholders would be required to purchase one share of common stock at $12,500 per share for each $1 million in coverage limits they purchase.

As the common stock is sold to new policyholders, CARE would redeem the founders' redeemable stock for $12,500 per share, allowing founders to recoup their initial investment.

Within the next two weeks, prospective policyholders will complete "what looks like an insurance application," Mr. Sterling noted. "It will ask for a good deal of information and will be reviewed by an underwriting consultant."

The underwriting consultant, yet to be named, then will provide to Project CARE's actuaries an estimate of each prospective member's premium.

Mr. Sterling explained that CARE will be domiciled in the United States, but the site is still undetermined. He said that CARE's holding company will be established in Delaware, and a subsidiary of that holding company, which will manage CARE, will likely be set up in another location.

CARE's progress is marked by revisions to the policy form the insurer will issue. The form, currently in its seventh draft, is an occurrence policy that has been shaped by the input of "any number of risk managers and consultants," Mr. Sterling said.

The form is in its last review by the New York law of firm of Baker & McKenzie, which is acting as a consultant to Project CARE, he said.

In the most recent revision of the policy, CARE developers have tried to precisely define when an occurrence begins by defining an occurrence as the commencement of personal injury, property damage or advertisement injury during the policy period.

Specifically, the form says commencement of personal injury and property damage takes place when the injury or damage is "readily apparent to the senses."

Personal injury not readily apparent to the senses is said to commence when the injury is "first medically diagnosed by a licensed physician."

The policy says that personal injury not immediately apparent that arises out of situations like false arrest, wrongful eviction, discrimination or other similar circumstances, commences "when the act which gives rise to such injury is or is alleged to have been first committed."

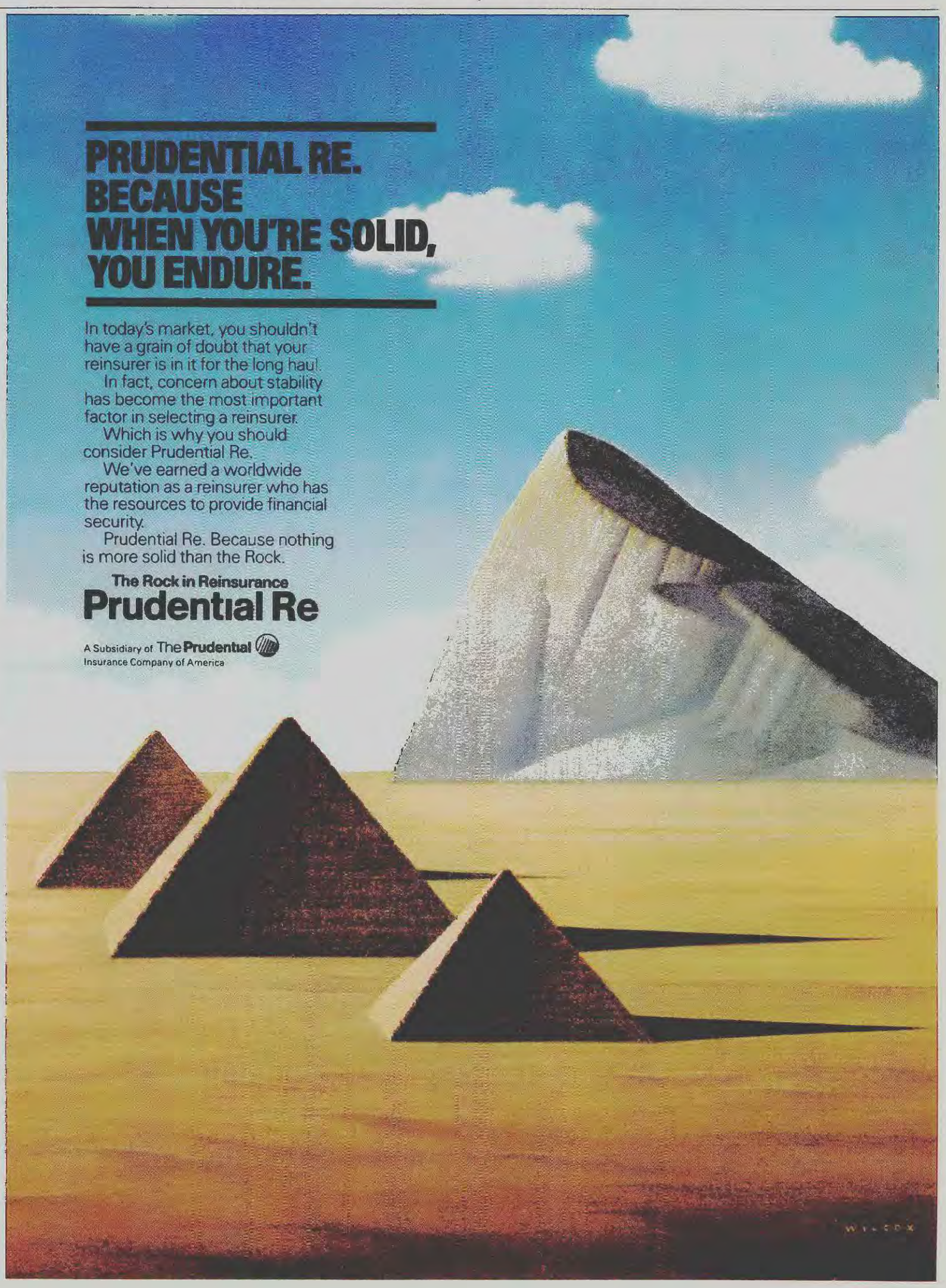
If property damage occurs but is not immediately apparent, the occurrence commences when the damage is "first scientifically determined," Mr. Sterling noted.

The policy states that advertising injury—which includes damages from cases of libel, slander and defamation—first occurs when the incident that gives rise to the injury is "first published, broadcast or telecast publicly."

CARE intends to pay dividends 39 months after the close of each fiscal year to investors of record on the date the dividend is declared if they also were investor/policyholders during the fiscal year for which the dividend is paid. The dividend is calculated according a participant's capital investment and earned premium volume during the year the dividend is declared.

In addition, CARE's developers are considering also paying an annual dividend that is tied solely to the insurer's investment income, according to Mr. Sterling.

Participants in CARE will not be required to make long-term commitments to the program like those asked for by other excess liability facilities. ■



Pollution insurance conference

Superfund changes to spur settlements: Official

By ROBERT A.FINLAYSON

WASHINGTON—Recent amendments to the federal Superfund law will prompt the government to settle pollution cleanup litigation, says a federal official charged with enforcing the Superfund law.

However, an attorney who often represents companies named in toxic waste cleanup lawsuits disagrees.

Nancy B. Firestone, deputy chief of the Department of Justice's Land and Natural Resources Division, told those attending a pollution liability insurance conference sponsored by Executive Enterprises Inc. on Nov. 13-14 that the government will likely be more willing to negotiate out-of-court settlements with those companies named in federal toxic waste cleanup lawsuits because of the recently enacted amendments to the Comprehensive Environmental Response, Compensation and Liability Act, known as Superfund.

"Superfund is (now) the only statute I know of that says people have to sit down and talk before they litigate," Ms. Firestone said, referring to the so-called settlement provisions in the amendments.

But Michael A. Brown, a partner with the Washington law firm of Schmeltzer, Aptaker & Sheppard, disagreed with Ms. Firestone.

"The bill provides an opportunity to make a difference," Mr. Brown said. "But its provisions do nothing more than incorporate things that are now memoranda or policy guidelines that have existed for the last two or three years," he added.

"The concern I'm expressing is that if this is nothing but a codification of what's already existed, and the same people are calling the shots, why would anybody think life is going to change?" Mr. Brown concluded.

The business community has long argued that the government should be forced to work out cleanup agreements with those responsible for creating a toxic waste dump before taking the responsible parties to court.

When the government sues companies to clean up a site under the Superfund law, it conducts its own cleanup activities at the site using Superfund money. The government then attempts to recover that money through the courts from the responsible parties.

Companies named in such lawsuits often argue that a government-sponsored cleanup is not cost-effective. These companies say they can clean up a site faster and cheaper if the government will negotiate with them before taking them to court.

However, few such pre-litigation settlements have been reached, partly because of the government's fear that such arrangements would be viewed by the Congress and the public as "sweetheart" deals and partly because the government's enforcement tools under the Superfund law are so powerful that officials feel little need to seek such settlements.

The insurance industry conducted an intense lobbying effort during congressional consideration of the Superfund amendments in an attempt to persuade lawmakers to include language that would require the government to attempt to negotiate with companies named in cleanup lawsuits before taking them to court.

Under heavy lobbying from the Department of Justice and the U.S. Environmental Protection Agency, Congress rejected mandatory settlement provisions in favor of discretionary settlement language. But the lawmakers did say in the conference report on the amendments that Congress would like to see more money going toward the cleanup of dump sites and less for litigation of Superfund lawsuits (*BI*, Aug. 4).

Ms. Firestone says the Justice Department got Congress' message. She said that while the settlement provisions in the amendments are not mandatory, "the administration really wants (the settlement provisions) to work."

She pointed to language included in the settlement provisions that imposes a 120-day moratorium on any government action at a Superfund site once the government determines that a period of negotiation may facilitate an out-of-court cleanup agreement.

Ms. Firestone also notes that the provisions include the codification of existing Justice Department policy to allow the Superfund to contribute money to a cleanup settlement if some of the responsible parties are defunct or bankrupt, so that companies prepared to settle do not have to pay more than their fair share of the cleanup.

This codification of existing policy—known as the "mixed funding" rule—should eliminate fears expressed by some companies that the policy may be overturned in the courts if it were challenged by environmental groups or Superfund defendants that choose not to participate in a settlement, Ms. Firestone maintained.

The codification of the mixed funding policy also helps to allay the fears of Justice Department and Environmental Protection Agency officials that such arrangements would be viewed by Congress as too lenient toward corporate polluters, she added.

Further, Ms. Firestone said, the Superfund amendments absolve companies that participate in settlement agreements from liability for claims for contribution brought by companies that do not settle and are subsequently taken to court by the government.

Companies named in Superfund cleanup lawsuits often have argued that government settlement offers are hollow because they argue that in separate contribution action brought by another defendant that chooses to litigate the government's cleanup lawsuit, a company later can be held liable for costs stemming from a site that it already has agreed to clean up.

Finally, Ms. Firestone said the amendments allow the government to reach quick settlements with companies that only contributed a very small amount of waste to a dump site. The government's authority to enter into so-called "de minimis" settlements had been questioned by some responsible parties prior to enactment of the 1986 Superfund amendments.

Overall, Ms. Firestone said, the

Continued on next page

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EIL underwriters hope to expand business

By ROBERT A. FINLAYSON

WASHINGTON—Officials of the two major markets now offering environmental impairment liability insurance say they are hoping to expand their EIL business, while sponsors of a proposed EIL risk retention group now expect to launch the facility with as much as $300 million in capital.

Both developments would be welcome news to buyers of EIL insurance, for which capacity has declined tenfold between 1981 and 1985.

Officials of American International Group Inc. and the Pollution Liability Insurance Assn., the two major markets for EIL insurance, told attendees of a pollution insurance conference last month sponsored by Executive Enterprises Inc. that while their underwriting standards continue to be strict, they are looking to expand the volume of EIL business they write.

John Amore, a vp with AIG's American Home Assurance Co. in New York, said AIG is planning to open new EIL underwriting offices in Dallas and Philadelphia, adding to its existing offices in New York, Chicago and Los Angeles.

AIG is making the move to improve communications with existing policyholders and to allow the insurer to meet the demand for EIL coverage and expand its share of the market, Mr. Amore said.

Mr. Amore also said, as reported earlier, that AIG is attempting to line up additional reinsurance support so that it can increase its current $10 million aggregate limit for EIL coverage (*BI*, Oct. 20).

While AIG will not know for certain whether it will be able to offer the additional capacity until January 1987, when its reinsurance treaties are renewed, Mr. Amore said he is hopeful based on preliminary discussions with the reinsurers.

Noting that AIG recently began offering EIL coverage to some hazardous waste cleanup contractors, he said the insurer is "looking to expand into other areas," though he did not elaborate.

Thomas E. Knowlton, president of PLIA, said the association is looking to expand its EIL program also.

PLIA is a voluntary unincorporated association that reinsures EIL policies written by its 24 member companies.

Mr. Knowlton said PLIA will begin offering EIL coverage to farmers early next year. The program initially will be written through American Agricultural Insurance Co. of Park Ridge, Ill., but will likely be picked up by other PLIA member companies in 1987.

Farmers face a variety of pollution exposures related to the use of pesticides and agricultural runoff and largely have been unable to obtain coverage for these risks.

AIG is hoping for reinsurance support so that it can increase its current $10 million aggregate limit.

The program will offer annual aggregate limits of up to $500,000 a year and may be expanded to include other types of agricultural businesses with pollution liabilities, Mr. Knowlton said.

For other policyholders, PLIA commonly offers limits of $2 million per occurrence and $4 million aggregate.

According to Mr. Knowlton, PLIA gets on average of 60 inquiries for EIL coverage a week. "About 80% to 90% of these have little commitment to environmental loss control," he said. "The other 10% to 20% don't have any difficulty obtaining (EIL) quotes," Mr. Knowlton added.

A third speaker, Paul M. Donovan, a senior partner with LaRoe, Winn & Moerman, was extremely optimistic about the future of North American Casualty Cooperative, a proposed risk retention group that would write EIL coverage (*BI*, Sept. 1; Oct. 20; Nov. 17).

Mr. Donovan said 85 companies attended an Oct. 29 meeting in Toronto to discuss participation in NACC. Because the response from that meeting and subsequent contacts has been so positive, Mr. Donovan said he believes the facility may raise as much as $300 million in capital. Original projections had put the initial capitalization at perhaps as much as $100 million.

The initial participation drive will end in mid-December, but Mr. Donovan says NACC's sponsors may open the facility to new members early next year.

Private sources close to the project say it is possible that NACC could eventually reach as much as $1 billion in capital.

LaRoe Winn, a Washington, D.C. law firm, proposed NACC 18 months ago. Recently, Johnson & Higgins and Chase Manhattan Capital Markets Corp., a unit of Chase Manhattan Bank, joined the effort. ■

Superfund

Continued from previous page

rules for Superfund settlements are much more clear than they were before passage of the amendments. And, the amendments make it clear that Congress prefers settlements to litigation because it results in lower transaction costs and more waste site cleanups, she said.

But while Ms. Firestone sees the Superfund amendments as shifting the government's policy away from litigation toward more settlements, Mr. Brown said he expects "business as usual" at the Department of Justice.

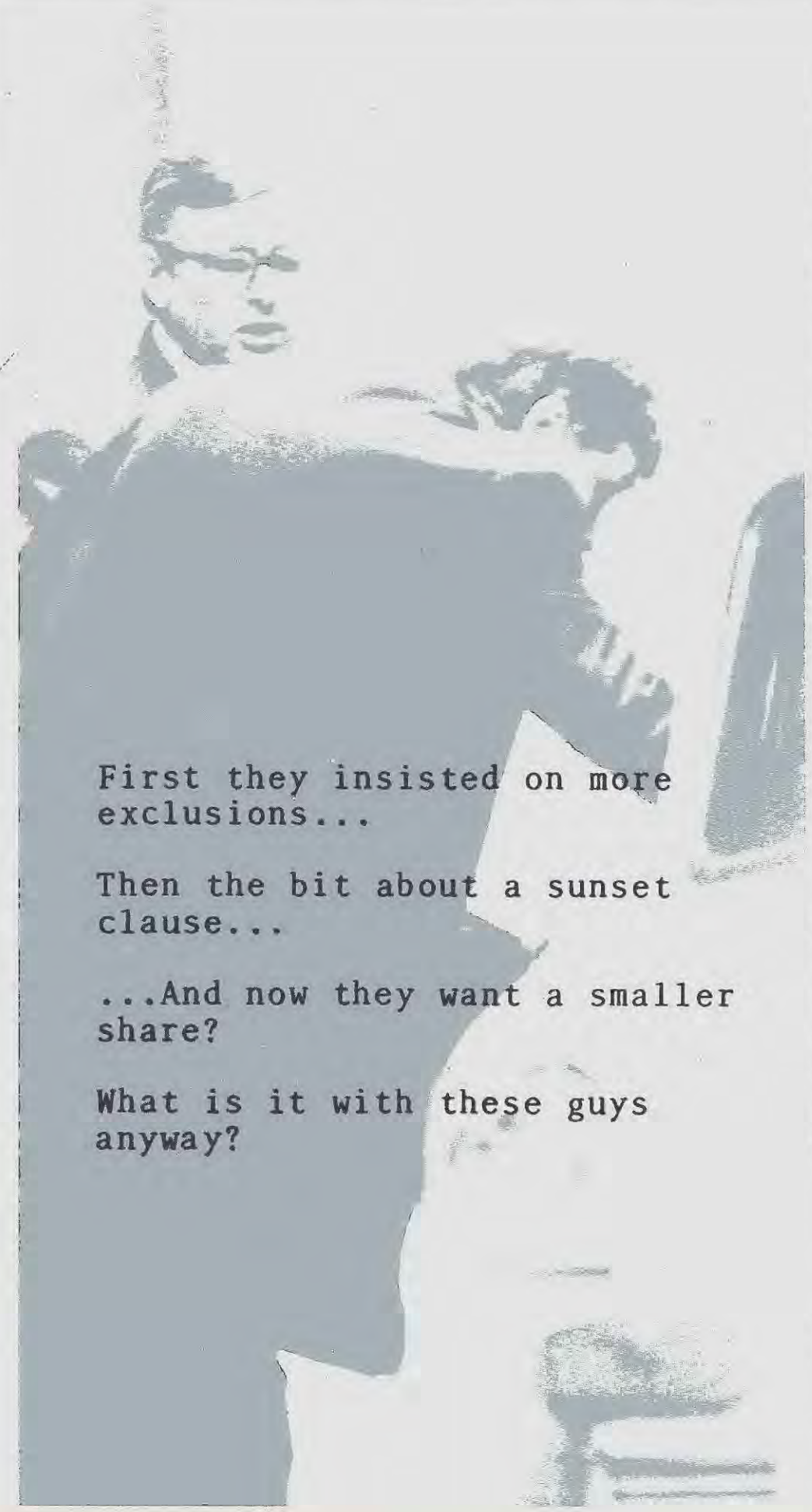
Even if the Superfund amendments do represent a policy change, Mr. Brown said he doubts that shift will have much of a practical effect on what happens at the staff level at the EPA's regional offices across the country.

"The people who are at the end of the pipeline, who are actually doing the negotiating, have yet to receive anything to indicate that there's any reason for them to be doing anything more for settlement than they've ever done before," he observed.

Mr. Brown noted that in several cases in which companies he represents have attempted to settle a Superfund cleanup lawsuit, the settlement offer was rejected "because the (EPA) people on the ground have no belief that the people at headquarters are really in favor of settlements."

"I'm very discouraged," Mr. Brown concluded.

However, Mr. Brown said he expects the government to eventually begin settling Superfund cases because the caseload will become too much for the Justice Department to handle. ■



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Tax reform

Continued from previous page

Although the industry has no "serious dispute" with the GAO on the tax figures, Mr. Broadie said, it does question how the GAO calculates income. He estimated that the $75.2 billion income figure was "high by one-third," because the GAO included in it items such as unrealized capital gains.

According to consolidated figures compiled by A.M. Best Co., the property/casualty insurance industry also has not paid taxes for the past three years but, rather, had tax credits amounting to $2.03 billion in 1985, $1.72 billion in 1984 and $1.19 billion in 1983.

During that period, according to Best's, insurers suffered net operating losses of $3.82 billion in 1985 and $1.79 billion in 1984, and produced net operating income of $3.35 billion in 1983.

Both the GAO and Best's figures are based on statistics from approximately 1,700 property/casualty insurers representing more than 90% of premiums for the industry.

Under the previous tax rules, "Very few people in the industry have paid taxes," noted Mr. Parker of Continental. "Cash taxes paid have been minimal."

Added Mr. Broadie, "Certainly there are companies that don't pay anything—because of investment in tax exempts for one thing. The industry now pays a fairly low effective rate."

While Mr. Broadie did not offer any statistics on the industry's tax rate, Lee Hupfer, vp-tax and financial planning for USF&G Corp., estimated that it had been 11% over the last 10 years, based on data gathered by industry organizations.

On an individual basis, the tax breaks from 1980 through 1984, according to the GAO, resulted in total negative income tax of $1.79 billion for six major property/casualty insurers:

- Allstate Insurance Group, $530 million, while income was $1.9 billion.
- Hartford Insurance Group, $622 million, while income was $1.4 billion.
- Fireman's Fund Insurance Cos., $489 million, while income was $715 million.
- The Home Group Inc., $69 million, while income was $450 million.
- CNA Insurance Cos., $49 million, while income was $288 million.
- Crum & Forster Inc., $27 million, while income was $437 million.

"When you look at who's not paying taxes and now will, it looks like a disaster," commented Lester Mantell, vp for tax matters at The Home in New York. "But will the industry collapse? I can't get my heart into that."

Among the major insurers who paid taxes in 1984, according to the GAO, were:

- Continental, $29 million.
- St. Paul Cos. Inc., $3 million.
- Chubb Corp., $2 million.

Some companies, such as Continental, CIGNA and USF&G, said that because of large operating loss carryforwards they won't be affected immediately by the new provisions—except that they would fall under the revised alternative minimum tax regulations. But, they anticipate feeling the impact in two or three years as loss carryforwards are used up.

CIGNA, for example, had more than $2 billion in loss carryforwards at the end of 1985, according to Mr. Abbot.

USF&G will have $1 billion at year-end, said Ms. Hupfer.

Kemper declined to reveal its anticipated carryforwards, and is not sure if it will fall under the AMT, said Robert Johnson, secretary of the Kemper Group.

Continental estimated its tax loss carryforwards for the end of 1986 at between $400 million and $500 million, and anticipates it will be subject to the alternative tax for the foreseeable future.

Gerald Lenrow, a partner with Coopers & Lybrand in Chicago, speaking at a recent National Assn. of Independent Insurers conference on tax reform, suggested insurers use as much as possible of any net operating loss carryforwards in 1986 when the corporate tax rate is higher—46%—than it will be for 1987—40%—or 1988 and subsequent years—34%.

On the other hand, "Hartford has very little loss carryforward. We are going to pay taxes under the regular tax base," said Joel Freedman, federal affairs counsel for Hartford in Washington, D.C.

The Home, too, will be subject to the regular tax, according to Mr. Mantell. He estimated 1986 taxes for the company at $15 million, and said that 1987 taxes could be $20 million more than that.

The discounting of loss reserves generally is agreed to be the new tax provision having the most impact on the industry. Congress hopes to raise some $4 billion from property/casualty insurers over the next five years from discounting, according to Mr. Freedman.

The rate that will be used to apply to loss reserves—the applicable federal rate (AFR), currently about 7%—"will be certain, but won't mirror reality," he commented.

The government will "force (companies) to discount by (the AFR) but that may have no relation to actual yields. They are setting how much they think (the reserve) will grow. We might end up fine or not so fine.

"This concept will be the strongest ingredient in raising rates in order to cover future losses, which no one can forecast."

Discounting will hurt commercial lines most, he maintained, especially long-tail risks, because traditionally a smaller initial reserve contribution is made for those lines and they have more anticipated growth over their extended life.

"The discount will be deeper (for longer tail lines)," Mr. Broadie noted. "The more you write, the more you're going to be hit."

Comparison of after-tax yields on investment alternatives under new tax law

	Funds to be invested Dividends Utilities-6.25%		Tax-exempt interest 10-year bond-6.10%		$10,000,000 (A) Treasury interest 10-year bond-7.27%	
	$10,000,000		$10,000,000		$10,000,000	
	@ 6.25%		@ 6.10%		@ 7.27%	
Income applicable	$625,000		$610,000		$727,000	
Regular tax rate	@ 10.88%		@ 5.1%		@ 34%	
Tax due	$68,000		$31,000		$247,000	
Income	$625,000		$610,000		$727,000	
Tax due	$68,000		$31,000		$247,000	
Net after-tax	$557,000	(B)	$579,000	(C)	$480,000	(D)
Effective after-tax yield	(B)÷(A) 5.57%		(C)÷(A) 5.79%		(D)÷(A) 4.80%	

Source: Peat, Marwick, Mitchell & Co.

Chart: Amy Palmer

As a result, it's possible some insurers will want to write more short-tail lines of business and less long-tail lines.

"All other things being equal, you would write more one-year than 10-year business," Mr. Mantell commented.

Ms. Hupfer agreed, "especially if interest rates are high," because that would mean a deeper discount.

The AFR for each accident year will be figured as an average of the midterm rate for a previous period beginning with August 1986, building up eventually to a 60-month average. However, Mr. Freedman pointed out, portfolios don't "rollover" at regular intervals and, added Mr. Broadie, "Companies don't normally buy and sell securities just to keep with a particular average."

There is some concern that many companies, especially smaller ones, will not earn the AFR rate. "Historically," noted Michael Dineen, director of federal relations for Kemper in Washington, D.C. "The AFR is higher on average than the industry has earned."

Over the last 15 years, Mr. Broadie said, property/casualty insurers have earned 60% to 65% of the moving average AFR. He added the industry is very unhappy with the determination that discounting will be at 100% of the AFR. It had hoped for a 70% or 75% figure, observers said.

Using the AFR, Mr. Broadie noted, "is a trade-off between certainty and fairness." If a company does not earn the AFR, its tax liability increases, he explained, because it would still be taxed as if it had earned that much.

While there had been some fear expressed by top industry executives—such as William Bailey, president of Aetna—and the National Assn. of Insurance Commissioners that reserve discounting might lead some companies to underreserve, most observers seemed to dismiss that possibility.

"There is no incentive for tax purposes to underreserve," Mr. Abbot of CIGNA said. And Mr. Freedman believes "the regulators will be watching," so it would be difficult to underreserve.

He added that while Congress believes the industry is overreserved, insurers believe it to be underreserved.

Mr. Broadie estimated the underreserving at between 10% and 20%.

Even with regulators looking over their shoulders, some insurers might be tempted to report the discounted reserve on their annual statements as well as to the Internal Revenue Service for tax purposes, to make their financial statements look better, Mr. Broadie said.

Although the tax law gives insurers a "fresh start" exclusion from income for the difference between the discounted and undiscounted reserves as of the end of 1986, it also provides that any bolstering of those reserves—by increasing the discounted ultimate incurred losses for accident years 1985 and before, or by changing methods and assumptions that would increase the 1986 accident year reserves—will be disallowed.

Reserve strengthenings' effects on taxes will be sharply monitored, Mr. Broadie noted.

"You can beef up reserves (for previous years)," USF&G's Ms. Hupfer explained, "but you get no tax benefit on the increase." Only reserves set for new business in 1986 or reserves for 1985 and prior years before any strengthening this year will be eligible for the fresh start dispensation.

"You can't adopt a new set of assumptions" in making adjustments to reserves, warned Mr. Jordan of Peat Marwick. He pointed out, also, that there was no definition of reserve strengthening in the new regulations, so that it was unclear what the IRS would and would not allow.

"The government may leave it up to the courts" to pass judgment on which activities are permissible, he said.

Mr. Lenrow advises insurers to be "meticulous" in accounting for all unpaid losses so as to maximize the fresh start deduction.

And, he notes, that even if a company were to make no change in its methodology for calculating the reserves, the IRS will still test them for reasonableness, so that if the reserves were to prove redundant for 1986, the service could retroactively deny the fresh start for the redundant amount.

The inclusion of 20% of unearned premium reserves in taxable income is expected to have almost as large an impact on insurers as the discounting of loss reserves, observers reported.

As of year-end 1986, the property/casualty insurance industry will show some $40 billion to $50 billion in UPR, Mr. Freedman noted. The charge on that amount will be phased in over a six-year period at a rate of 3⅓% a year. That, together with the yearly 20% charge on the increase in UPR, should garner more than $3 billion in federal taxes by 1992, Mr. Freedman predicted.

Companies will look for ways to lower their UPR, Mr. Broadie said. One often-heard suggestion is to write more—or all—policies as one-year—or even six-month—contracts, effectively eliminating any unearned premium income. However, most commercial business already is written on a one-year basis.

"There will be companies out there that will (write short-term contracts)," Mr. Mantell said. He added that The Home had looked at the possibility, but had not yet made a decision on its feasibility.

Other factors must be considered, he said, such as administration costs and how changing the policy period would affect retention of business. From a tax standpoint, an idea might be "spectacular," he commented, but it may not "wag the dog."

Mr. Lenrow points out that for 1986, companies should make sure that every dollar of premium on contracts that incepted this year be included in the unearned premium reserve at the end of the year. This is because the amount in the UPR at the end of 1986 will be included in income ratably over the next six years. If picked up in 1987, it would all go into 1987 income.

Proration—or taxation of 15% of interest received from tax-exempt securities—applies to obligations acquired after Aug. 7, 1986. Tax-exempts acquired before Aug. 8, 1986, are not taxed under the regular tax provisions.

Ms. Hupfer said tax exempts

Continued on page 36D

Tax law unlikely to hurt insurer stock popularity

NEW YORK—Property/casualty stocks will be just as attractive to stock investors despite insurers' increased tax liabilities under the Tax Reform Act of 1986.

Investment in insurance companies will hinge more on other factors, observers say, such as interest rates, the amount of regulation imposed on the industry and a general eroding of confidence in property/casualty insurer stocks (*BI*, Nov. 3).

In the short term, the tax act changes will not have any effect on the profitability of insurers, according to June Hoffer, an analyst with Prudential/Bache Securities, Inc. in New York, especially where companies have large tax loss carryforwards.

Her view is shared by David Seifer, vp-equity research at First Boston Corp. in New York.

Tax loss carryforwards—characteristic for many commercial insurers weighted toward writing long-tail business—would shield an insurer to some extent from the impact of the more onerous provisions of the tax law until they are used up. Therefore, the analysts say, the higher tax liability will have no immediate impact on how property/casualty companies are viewed for investment purposes.

While most observers agree there is still capital available for new or existing insurers, "the window of opportunity has partially closed," noted Ms. Hoffer.

"It would be more difficult to raise capital now than a few months ago.

"There have been so many insurance issues in the past six months—investors are saturated," she said.

In addition, insurance stocks "haven't performed well relative to other stocks" recently, she noted.

However, William Potvin, a partner at Touche, Ross & Co. in New York, predicts that despite the apparent shrinking of available investment dollars for property/casualty insurers, more insurers will go public next year to try to raise capital to offset the cost of their higher taxes under the new tax law.

He foresees the market for property/casualty stocks "will become a market a lot more in the public domain." And, with the increase in offerings, it would be "a buyer's market," he noted.

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Tax reform's effects

Continued from page 36B

would be less attractive to insurers because the lower yields on the instruments would no longer be offset by a 100% tax exemption, Ms. Hupfer noted.

The 15% proration of income from tax-exempt bonds was seen by the industry as a compromise with Congress, which was looking to end what it perceived as a double benefit for insurers, according to David Pustilnik, Travelers' associate general counsel.

"We told Congress if the proration was too high we would not be a buyer of tax exempts."

The effective rate on tax exempts, however, would be only 6% in 1987 (15% x 40%) and 5.1% in 1988 (15% x 34%). For companies subject to the alternative minimum tax (AMT), tax-exempt securities will be effectively taxed at 10%. For tax exempts purchased after Aug. 7, 1986, the rate in 1988 will be 5.1% under regular tax, 11.5% under the AMT.

Mr. Lenrow advises not trading tax-exempt securities between subsidiaries, because that would exclude them from the pre-Aug. 8, 1986, grandfather provision.

Approximately $500 million would be gained in taxes over the next five years from proration, Hartford's Mr. Freedman noted.

Another feature of the new tax laws is the treatment of income from foreign insurance activities as taxable even if that income is not repatriated. The applicable provisions, which expand the definitions of controlled foreign corporation (CFC) and Subpart F income, will act to dramatically decrease the incentive for starting up offshore captives or other overseas activities, observers agreed.

While Continental has "relatively large" foreign operations, Mr. Parker noted any increased taxes from offshore income should be offset by net operating losses. And the companies most substantially affected by the foreign insurance provisions—CIGNA and Aetna—have obtained a special exception allowing them to phase in the loss of tax deferment over a three-year period. The three-year phase-in transition rule "helps the medicine go down," CIGNA's Mr. Abbot noted, "but it's still bitter medicine."

Insurance companies also fear the alternative tax, which will be applied when book income—statutory pretax income that includes tax-exempt interest and dividend received income—exceeds taxable income.

Large tax-loss carryforwards, which lower taxable income, also work to place a company under the minimum tax. Depending on the size of their net operating loss, many insurers could be subject to the alternative minimum tax for the next two years, observers estimated. The higher a company's taxable income, the more likely it is to owe a higher tax under the regular rate than under the AMT; the lower the taxable income, the more likely the AMT would be higher than the regular tax.

Even those insurers with large tax-loss carryforwards are using them up rapidly as they generate more taxable income, observed Mr. Freedman of Hartford. He predicted that because of the taxation of tax exempts, the phasing-in of the unearned premium reserve into taxable income and the improved profit performance of property/casualty insurers, within two years all property/casualty insurers would be under the regular tax.

For now, "Almost everyone (in the industry) will be paying the AMT," Mr. Parker of Continental commented, referring to the alternative minimum tax. The AIA's Mr. Broadie termed the AMT the real "stinger" in the new tax law.

Ms. Hupfer predicted most companies heavily weighted toward commercial, longer-tail risks, and which therefore have large net operating loss carryforwards such as USF&G, would fall under the minimum tax at least initially.

USF&G will probably be subject to the minimum tax for 1987, Ms. Hupfer said.

And Mr. Jordan of Peat, Marwick commented that "even if a company comes up with the niftiest planning from the tax side (on how to minimize some of the effects of the new regulations), the ATM could be detrimental."

He pointed out, also, that book income would be figured differently for the stock and mutual companies. For the stock companies, it would be based on their filed statements of income with the SEC, based on generally accepted accounting principles; for mutuals, on their annual statements as filed with state insurance regulators, based on statutory accounting principles.

Overall, consequences of the new provisions might result in higher premiums, observers say, especially in the longer-tail liability lines, as companies attempt to compensate for the lowered return on income generated from investment of reserves.

"There will be attempts to raise rates," Continental's Mr. Parker foresaw.

Mr. Mantell agreed, but saw the increases needed to offset the impact of the new laws as "relatively modest."

Some observers feel, however, that competition will make premium hikes unlikely.

"I've heard talk of raising rates," Ms. Hupfer said, "But market forces could lower them."

Reduced cash flow, however, could translate into lower surplus, and therefore serve to reduce capacity for property and casualty lines. To some extent, this could be offset by increased profitability in the industry.

And, with capital gains being treated as ordinary income, the higher capital gains tax—to 34% from 28%—could make it more difficult to use income derived from assets to increase surplus. As a result, Mr. Lenrow advises companies to recognize capital gains to as great an extent as possible in 1986.

In addition, the new provisions might influence how favorably investors look at property/casualty insurers, and might drive down the prices of the companies—both their stock prices and acquisition price (see related story).

Reduced income could be offset by cost cutting and by more controlled underwriting practices, observers suggested, which would work to the insurers' benefit.

Any new attention to better administrative, pricing and underwriting practices is seen as a positive result of the new tax rules.

"One thing that could happen, and it would be the best thing that ever happened to the industry," Ms. Hupfer said, "is that without the 'tax subsidy' (the prior tax system as applied to property/casualty companies) to offset losses there may be less tendency to have rate wars. It may smooth (the cycles) out."

A re-evaluation of investment strategies is probably the first action companies will take, with a special view toward comparing the benefits of tax-exempt bonds with taxable securities under the new provisions.

No formulas as to what direction to take can be offered, Mr. Broadie at the AIA noted, because of all the variables, including whether or not the insurer will be subject to the AMT. Investment strategy will be very "company specific."

"There's a wide divergence of opinion on what the investment posture should be," Mr. Parker added. To increase returns on investments, insurers might "take more risk in their portfolios" than before, he suggested.

For investment planning, experts cautioned that minimizing taxes should not be the primary factor considered but, rather, maximizing aftertax income (see accompanying chart).

The best that insurance executives will say of the revised tax law, in the words of Mr. Johnson from Kemper, is: "We can live with it."

All in all, "the industry was hit harder than it should have been. The regulations are more stringent than we would have liked," Mr. Johnson said.

Added Ms. Hupfer of USF&G: "We have no friends in Congress."

But, "Given the climate—that Congress and the Treasury wanted to do something (regarding taxation of the insurance industry)—we came out as well as we could," noted Mr. Abbot of CIGNA.

Mr. Mantell at The Home was hopeful that, with some study, ways to "alleviate the implications" of the new laws would be found. "Tax lawyers don't get paid a lot of money to say to accounts payable 'Make out a check to the IRS.' "

But, the complexity of the new tax regulations, together with the lack of definition of some of the terms used, has left insurers uneasy over possible misinterpretations or retrospective legislative or regulatory reinterpretations.

A further concern the industry harbors is that the current tax provisions are not the final word—that following the filing of the clarifications and transitional rules, the release of the Joint Committee on Taxation's "blue book" summary due at year-end and the publication of the study scheduled to be completed by Jan. 1, 1989, from the Treasury Department on the impact of certain of the reforms, further refinements might again reconfigure the tax environment.

"There's fear the whole thing might be changed again," commented Mr. Dineen of Kemper.

At Travelers, Mr. Pustilnik pleaded: "Leave us alone for a few years so we can have some stability. The industry needs a significant period with a stable tax climate in order to price effectively." ■

Law forcing insurers to increase tax awareness

By AVRA WING

NEW YORK—"Don't tax you, don't tax me, tax that fellow behind the tree."

The property/casualty industry is the man peeping out from behind the willow, according to Michael Warren, tax partner with Ernst & Whinney in Dallas, who was quoting outgoing Sen. Russell B. Long, D-La.

The accounting firm held a seminar here recently to review how the changes in the Tax Reform Act of 1986 would affect property/casualty insurance companies.

The approximately 300 attendees—tax specialists, accountants, consultants, and analysts—were left with the unmistakable impression that insurers would have to pay more taxes, be extremely careful in how they calculate and report income under the new rules and almost certainly will face further revisions and modifications in the tax law in the near future.

Not only will insurers have to pay more attention to tax planning under the new regulations, the seminar made clear, but they also will have to do more in the way of tax accounting planning.

The major provisions of the Tax Reform Act and the Internal Revenue Code affecting property/casualty insurance companies that were reviewed at the seminar were:

- Discounting of reserves for unpaid losses (Act Section 1023, Code Sections 807(c), 832, 846).
- Inclusion in income of 20% of unearned premium reserves (Act Section 1021, Code Section 832(b)).
- Proration of dividends from affiliates and tax-exempt interest (Act Section 1022, Code Section 832(b)).
- The alternative minimum tax (Act Section 701, Code Sections 55-59).
- Determining U.S. control of foreign corporations (Act Section 1222, Code Section 957.
- Taxation of offshore insurance subsidiaries (Act Section 1221(b), Code Sections 952 and 953).

The discounting of loss reserves was adopted as a way of taxing insurers based on the "time value of money," since Congress perceived that insurers were overreserving by undervaluing the growth of investment dollars, according to Larry Buhl, an audit partner with Ernst & Whinney in New York. He and Steve Eldridge, a tax partner in the New York office, presented the session on loss reserves.

They urged insurers to be extremely specific in submitting loss reserve information in their annual statements that would be relevant to the new tax filings. "Stick it on with bubblegum if you have to," Mr. Buhl told the audience, referring to providing attachments if the annual statement cannot accommodate the relevant information.

Under the new regulations, he noted, property/casualty companies must discount their reserves for unpaid losses (which include reported-but-unpaid losses, incurred-but-not-reported losses, unpaid loss expenses, and resisted claims) for taxable years beginning after 1986.

The annual deduction for unpaid losses will be limited to the annual increase in the amount of discounted unpaid losses.

For any taxable year, the discounted unpaid losses equal the total of the discounted unpaid losses for each line of business for each accident year. The discounted unpaid losses for any accident year are calculated based on the total of undiscounted unpaid losses as shown on the annual statement, the applicable discount rate for computing the reserve discount and the elected loss payment pattern (see chart, page 36F).

Line of business refers to each line in Schedule O and Schedule P on the annual statement, although multiple-peril lines are bunched together.

In addition, international and reinsurance lines of business are treated differently, Messrs. Buhl and Eldridge explained. They are to be discounted based on industry payment patterns or, if allocated to a particular line of business, discounted according to the rules for that line of business. However, the Treasury Department is authorized to promulgate regulations limiting favorable allocations out of international or reinsurance lines.

Accident year is defined as the year in which the incident leading to the unpaid loss arises. Under an occurrence policy, the loss is the incident; under a claims-made policy, the claim is the incident.

If an insurer already has discounted its loss reserves—such as workers compensation—when reporting them on the annual statement, it can "gross up" the discounted losses if the size of the discount the company has taken can be determined from information contained in the annual statement. The losses would then be "grossed down" for tax purposes according to the discount rate.

The rate at which the reserves will be discounted is equal to 100% of the average of the applicable federal midterm rate (AFR), Messrs. Buhl and Eldridge noted. For accident years up to 1988, that average will be figured using the rates for August through December of 1986. Eventually, the rate will be figured on the previous 60 months' AFR.

The AFR is now approximately 7%, and Ernst & Whinney estimates it will be about 7.25% for 1987.

Turning to the loss payment pattern that will be used to calculate the reserve discount, they explained that there would be some choice for insurers between electing the payment pattern set by the secretary of the treasury for each line of Schedule O and P business, based on industry experience calculated from Best's averages, and a company's own historical payment pattern.

The Treasury's determination of a payment pattern is made for a five-year period. Thus, the pattern set for determination year 1987 will be in effect through 1991, and that set in 1992 will hold through 1996, they explained. The loss payment pattern applies to accident years ending with or within the determination year and the four succeeding years.

For lines under Schedule O, the pattern assumes all losses are paid during the accident year and the three years following; losses paid after the first year following the accident year are assumed to be paid equally over the two succeeding years.

For Schedule P, losses are assumed paid during the accident year and the next 10 years. Losses actually paid after year 10 following the accident year are considered for tax purposes as having been paid during year 10.

If the amount assumed paid in year 10 is greater than that treated for tax purposes as paid in the ninth year after the accident year, however, the payment period can be extended—for up to five years—with the amount of losses deemed paid in year 10 and each following year treated as if equal to the amount of losses paid in year nine.

In order to use its own payment pattern for a line of business, a company's historical experience must be statistically significant, Messrs. Buhl and Eldridge explained, which means the company must be in the top 90% of business for the industry for that particular line of business. This means, they said, that the company must have a portion of business in at least the tenth percentile of industrywide reserves for a line of business for the determination year.

The Treasury is to promulgate regulations on how to determine this percentage, they noted.

The election to use one's own payment pattern is "vintaged" for five years (the determination year and four subsequent years), they added, so a company must look ahead five years and try to determine what its losses will be in the next five years compared

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with the industry's to decide which payment pattern is more advantageous.

Problems could arise in establishing a loss payment pattern where a claims-made policy is in effect because the history of the risk probably would be based on an occurrence policy, but the loss theoretically would be paid out faster under a claims-made form.

Offsetting some of the effect of the reserve discounting is the "fresh start" provision that applies to a company's reserves for taxable years beginning before Jan. 1, 1987.

Under the fresh start, loss reserves for new business in 1986 and business written in 1985 and earlier will have to be revalued according to the new discounting rules. The difference between the reserves under present law and the revalued reserves will result in the fresh-start adjustment—an amount that will permanently be excluded from income.

It's considered a double deduction because the 1987 reserves will start out with the difference already deducted from them.

In addition, there will be strict rules to prevent "reserve strengthening" for a taxable year beginning in 1986, they warned. While acknowledging that reserve strengthening had not been clearly defined in the new regulations, Messrs. Buhl and Eldridge said that "any formula which would yield higher reserves for 1986 than for prior years would be considered reserve strengthening."

Any beefing-up of reserves for a taxable year beginning in 1986 will be treated as if it occurred in the first taxable year after 1986, and so be subject to discounting.

In a session on unearned premium reserves, Howard Rosell, tax partner in Chicago, and Ed Tepper, tax partner in New York, explained that while under the previous tax law property/casualty insurers were allowed to deduct the full amount of any annual increase in unearned premiums from gross premiums, they would be required under the new regulations to reduce the unearned premium deduction by 20% for all years after 1986.

The new rule reflects the overall philosophy behind the changes in the tax regulations, Mr. Tepper said: Income is taxable when received.

The effect of this is to bring that 20% of unearned premiums into income, leaving only 80% of the increase as deductible. Conversely, only 80% of any annual decrease in unearned premiums is includible in income.

Turning to other aspects of the provisions, they explained that the portion of unearned premiums that consists of life insurance reserves will not be subject to the 20% reduction, and there is a 90% (rather than 80%) deduction for unearned premiums for insurance against default in paying principal or interest on corporate or government securities with more than five-year maturities.

Title insurers will not have to reduce unearned premiums by 20%, they said, but must discount them based on the period over which the premiums are recognized under state law at a rate equal to that used to discount property/casualty insurance loss reserves (which is based on a moving average of the applicable federal midterm rate).

In addition, a transitional rule has been adopted under which property/casualty insurers must include in gross premiums 20% of unearned premiums (except for life insurance reserves and title insurance unearned premiums) as of the end of 1986. That amount will be taken into income over six years at an annual rate of 3⅓%. For insurance against default on securities, the rate is 1⅔% a year.

For unearned title insurance premiums, instead of the phase-in period, a "fresh start" exemption exists for the first taxable year after the end of 1986. These premiums will be discounted in a manner similar to that applied to loss reserves.

If a company ceases to operate as a property/casualty insurer for any taxable year before 1993, any remaining unearned premium balance from the six-year phase-in must be included for the taxable year preceding the taxable year in which the company ceases to be taxed as a property/casualty insurer.

Discussing proration, Messrs. Rosell and Tepper pointed out that Congress was attempting to remove what it perceived as a "double benefit" from untaxed investment income. In effect, a portion of what previously would have been

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Tax awareness

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tax-exempt income will be allocated to loss reserves, making it taxable, they explained.

The deduction for incurred losses will be cut by 15% of the total of a company's tax-exempt interest and the dividends-received deduction from stock or obligations acquired after Aug. 7, 1986.

Those dividends received from subsidiaries, which fall under the 100% dividends-received deduction, will be subject to proration to the extent that they are attributable to tax-exempt interest or to non-affiliate dividends received by the subsidiary.

Although it is unclear under the new provisions whether the 100% dividends are meant to apply to only insurance company subsidiaries or all subsidiaries, it seems that the regulation is meant to apply to dividends received from all affiliates, they said.

Only dividends from stock or obligations acquired by the subsidiary after Aug. 7, 1986 are subject to the proration. However, if the subsidiary itself is acquired after that date, the securities held by that subsidiary will be treated as if acquired after Aug. 7.

There will be no double proration where the subsidiary is also an insurance company.

The 85% dividends-received deduction for non-affiliate dividends has been changed to 80%, they noted.

Tax exempts acquired before Aug. 8, 1986, are not taxed under the regular tax provisions. For companies subject to the alternative minimum tax (AMT), tax-exempt securities will be effectively taxed at 10%. For tax exempts purchased after Aug. 7, 1986, the rate in 1988 will be 5.1% under regular tax, 11.5% under the AMT.

The audience was urged to pay particular attention to the alternative minimum tax because Ernst & Whinney predicts that many property/casualty insurers, particularly stock companies, will be subject to the AMT at least for the next couple of years.

"It's generally considered undesirable to be in the AMT," Mr. Warren noted, because, by definition, if a company is paying the AMT it is paying higher taxes than it would be under the regular tax.

While the tax rate is lower—20% for a company with taxable income exceeding $15 million—it is paying taxes on more income than it would be under the regular tax.

If a company is subject to the AMT, Mr. Warren said, any decisions it makes as to how it does its accounting—such as those pertaining to depreciation and amortization of assets—will affect not only book income, but taxable income as well.

Basically, any company whose book income is more than its taxable income will be subject to the AMT, he explained. For 1987, if a corporation's taxable income is less than 33.33% of its pretax book income, it would be subject to the AMT; in 1988, if taxable income is less than 41.67% of pretax book income, the corporation would fall under the AMT, he said.

A company's alternative minimum taxable income (AMTI) would be calculated, roughly, by taking the regular taxable income, plus or minus adjustments as provided for in the new rules, adding tax preferences and subtracting the stipulated exemption.

(The exemption is $40,000, but is reduced by 25% of AMTI over $150,000.)

The AMTI would then be multiplied by the 20% AMT tax rate and the AMT foreign tax credit subtracted from it to get the tentative minimum tax. The regular tax minus the regular foreign tax credit would then be subtracted from the tentative minimum tax, and the resulting amount would be the company's alternative minimum tax.

(The AMT foreign tax credit can offset up to 90% of the tentative minimum tax. Any excess credit is carried forward. Investment tax credits may offset up to 25% of the tentative minimum tax, and excess credits can be carried over to other years.)

The adjustments to income under the revised tax law include an alternative tax net operating loss (NOL) deduction, and a book income adjustment for 1987 through 1989.

The alternative tax NOL is the regular NOL adjusted for certain preferences, and will generally be lower than the regular NOL, Mr. Warren said. The alternative NOLs cannot be used to offset more than 90% of AMTI.

For purposes of figuring the book income adjustment (also called the business untaxed reported profits or BURP preference), the adjusted net book income is first computed by taking the applicable financial statement net income (SEC financial statements for registered stock companies, the annual statement for mutuals) plus all federal income taxes, plus or minus any pertinent tax-year adjustments if different years are used for tax and financial reporting, plus or minus any consolidated group adjustment if different companies are consolidated for financial and tax purposes.

From this, the AMTI (before net operating losses) is subtracted. Half of any excess in adjusted book income must then be added to taxable income. The other adjustments include: an alternative depreciation for real and personal property put into service after 1986; and other provisions relating to installment sales, completed contract accounting, mine exploration and development costs, pollution control facilities, and capital construction funds.

Preferences, which Mr. Warren said he felt would have a minimal impact on insurers, include: excess percentage depletion, excess intangible drilling and development costs, excess charitable contribution deduction, tax-exempt interest on certain bonds, bad debt reserves of certain financial institutions, and excess depreciation and amortization of pollution control facilities.

"The difference in tax rates for capital gains for 1987 (34% vs. 40% for ordinary income) is not a tax preference under the new AMT rules," he noted.

There is a minimum tax credit, Mr. Warren explained, which can be applied against a company's regular tax in later years to the extent the regular tax liability exceeds the tentative minimum tax. The tax credit may be carried forward indefinitely, but not back.

Alternative minimum tax calculation

	Regular taxable income
+	Tax preferences
−	Exemption amount
=	AMTI
×	20%
=	Tentative minimum tax
−	Applicable credits
=	AMT

Source: Peat, Marwick, Mitchell & Co. Chart: Amy Palmer

Schedule P—Loss patterns at December 1985

	Auto liability	Other liability	Medical malpractice	Workers compensation	Multiple peril
Accident year	34.3%	9.2%	3.0%	25.9%	55.7%
Accident year +1	30.9	16.2	10.0	28.6	23.4
Accident year +2	15.0	14.7	10.4	13.3	7.3
Accident year +3	8.8	15.1	12.2	7.7	4.7
Accident year +4	4.8	11.0	9.9	4.5	3.1
Accident year +5	2.7	8.9	8.3	3.5	2.4
Accident year +6	1.2	5.1	7.0	1.9	1.1
Accident year +7	.6	4.3	6.5	1.7	.4
Accident year +8	.2	2.2	5.1	1.5	.7
Accident year +9	.3	1.0	2.7	.6	.3
Accident year +10	.3	1.0	2.7	.6	.3
Accident year +11	.3	1.0	2.7	.6	.3
Accident year +12	.3	1.0	2.7	.6	.2
Accident year +13	.1	1.0	2.7	.6	.0
Accident year +14	.0	1.0	2.7	.6	.0
Accident year +15	.0	7.2	11.2	7.6	.0
	100%	100%	100%	100%	100%

Applying the above loss payment patterns and assuming an applicable interest rate of 7.25%, the estimated discount factors to be applied to unpaid losses on Schedule P lines of business are as follows:

Schedule P—Estimated discount factors

Accident year	Auto liability	Other liability	Medical malpractice	Workers compensation	Multiple peril
Prior to 1976	.9250	.7811	.8001	.7650	.9371
1976	.8949	.7479	.7702	.7280	.9068
1977	.8657	.7178	.7426	.6946	.8773
1978	.8309	.7107	.7352	.6849	.8715
1979	.8298	.7282	.7317	.6774	.8386
1980	.8428	.7378	.7253	.6699	.8403
1981	.8653	.7611	.7202	.6846	.8606
1982	.8759	.7725	.7167	.6983	.8590
1983	.8831	.7822	.7155	.7269	.8587
1984	.8849	.7758	.7029	.7621	.8586
1985	.8911	.7666	.6873	.8091	.8878

Source: Ernst & Whinney Chart: Amy Palmer

Tax act to affect mergers and acquisitions

By AVRA WING

NEW YORK—Property/casualty insurers are advised to complete any mergers or acquisitions before Jan. 1, when less liberal provisions of the revised tax law go into effect.

Not only are there radical revisions in the tax act pertaining to loss reserves and unearned premiums—which must be taken into account in valuing an existing company—but also there are dramatic changes in the taxation of insurers when they are liquidated or sold.

Also, other changes in the law establish new rules limiting the way net operating loss carryforwards from an acquired company may be used to offset future profits, and the capital gains tax preference has been repealed—raising the tax to 34% from 28%.

These provisions could negatively affect the attractiveness of property/casualty insurers to investors (see related story).

However, a substantial, favorable revision on the taxation of smaller property/casualty insurers might spur the formation of such companies.

Specifically, according to Peter Gentile, a partner with Peat, Marwick, Mitchell & Co.'s insurance practice in New York, the new act repeals the so-called general utilities doctrine.

This means, primarily, that a corporation must now recognize gain or loss—both at the corporate level and at the shareholder level—upon the distribution of its assets to its shareholders in complete liquidations; non-liquidating distributions to shareholders; or dispositions of its assets in liquidating sales or deemed liquidating sales.

In other words, if a corporation decides to liquidate its insurance subsidiary, it would, with certain exceptions listed below, be liable for a double tax.

With the demise of the general utilities doctrine, a two-tier tax exists on any sales of corporate assets and distribution of the proceeds to shareholders. If the corporation liquidates, it is taxed on the difference between the fair market value of its assets and its adjusted base, and the shareholders are taxed on the difference between the proceeds they receive and their basis in stock, according to Craig Larsen, manager for Coopers & Lybrand in Chicago, speaking at a National Assn. of Independent Insurers' conference recently.

In addition, under certain conditions in a sale, the buyer will assume a new tax liability due to the repeal of the general utilities doctrine.

Companies had in the past made use of a related election under Internal Revenue Code Section 338, Mr. Gentile explained, which allows a corporation that purchases at least 80% of a target corporation's stock within a 12-month period to treat the stock purchase as an asset sale by the target.

The Section 338 election allowed the buyer to set off the excess of the purchase price over the book value of the target company against future profits from the acquired company, noted Gerald Lenrow, tax partner with Coopers & Lybrand in Chicago.

The section states that, with the election, the "target is

Continued on next page

The provisions pertaining to overseas operations, which are effective for taxable years beginning after 1986, basically expand the definitions of a controlled foreign corporation (CFC) and Subpart F income, according to Jonathan Chapman, a tax partner in Ernst & Whinney's Boston office.

U.S. taxpayers pay tax in the current year on income earned by a CFC, reported as Subpart F income, while income earned by a company that falls outside the definition of a CFC is not taxable until repatriated.

Under prior law, he explained, a foreign corporation was considered to be a CFC if U.S. shareholders, each owning at least 10% of the combined voting power, owned more than 50% (or more than 25% where a corporation received over 75% of its gross premiums from reinsurance or issuing insurance or annuity contracts on U.S. risks) of the corporation's total combined voting power.

Under the new act, he said, a foreign corporation is considered a CFC if U.S. shareholders each with at least 10% of the combined voting power own more than 50% (or 25% for certain companies) of either the total voting power or the value of the corporation.

In addition, whereas under the old law there was no Subpart F tax if there were no U.S. shareholders with at least a 10% interest in a foreign corporation, under the revised law each U.S. shareholder in a foreign corporation that is at least 25% U.S. owned —regardless of how large each shareholder's interest is—is taxed on its share of the foreign corporation's income arising from insuring risks of the U.S. shareholders and related parties. Similar rules apply to mutual insurance companies.

There are three exceptions, Mr. Chapman said. The foreign insurance company can elect to treat its related party insurance income as "effectively connected" with its U.S. operations—thereby making the foreign insurer subject to tax at the corporate level rather than having the shareholders taxed on the Subpart F income. If the election is made, premiums paid to the insurer are exempt from the excise tax on insurance and reinsurance premiums, whether or not a tax treaty is in place.

Also, there is no Subpart F income if the related person insurance income is less than 20% of gross income, or if the primary policyholders or related parties own less than 20% of the voting power or value of stock of the foreign insurer.

Finally, Mr. Chapman said, under the new law the definition of Subpart F income has been expanded to include any income attributable to the insuring or reinsuring of any insurance or annuity contract connected to risks outside of the nation in which the insurer is created or organized.

The exclusion from personal holding company income of income derived from an insurer's investment of unearned premiums, ordinary and necessary reserves, and certain other funds has been repealed, as has the exception for income from insurance of U.S. risks if such premiums constituted 5% or less of total premiums. ■

NOL carryover

Insurer is acquired on Jan. 1, 1988, for $1 million when the applicable long-term tax-exempt rate is 10% and insurer has $10 million of net operating loss carryforwards:

	1988	1989
Taxable income before NOL	$50,000	$200,000
Section 382 limitation ($1 million × 10%)	$100,000	$100,000
Plus unused limitation from prior year	$0	$50,000
Total limitation	$100,000	$150,000
Limitation used	$50,000	$150,000
Limitation carried forward	$50,000	$0

Source: Peat, Marwick, Mitchell & Co.

Chart: Amy Palmer

Continued from previous page
treated as having sold at fair market value all of its assets in a tax-free liquidation. If an election is made, target is treated as a new corporation as of the day after the acquisition and all of the assets are 'deemed sold by target.' "

Even though the new tax law retains the Section 338 election, it dramatically limits its benefits because the buyer, if it makes the election, pays the corporate-level tax, Mr. Gentile said. Any future benefit from tax write-offs probably would not offset the negative effect of the up-front tax.

However, he suggested, it might be possible to negotiate for the seller to pay the taxes incurred under a Section 338 election after Jan. 1 by making a Section 338(h)10 election. A seller could agree to this if it could offset the taxes with net operating loss (NOL) carryforwards from other operations.

Several exceptions to the revised regulations provide that no gain or loss will be recognized by a corporation in a liquidation where:

- 80% or more of its stock is owned by a domestic corporate shareholder.
- The liquidation is part of a tax-free corporate reorganization to the extent there would otherwise be no gain or loss recognition to the distributee shareholder.
- The liquidation is of a small, closely held corporation and is completed by Jan. 1, 1989.

The repeal of the general utilities doctrine does not apply to liquidations completed before Jan. 1, 1987, or those completed before Jan. 1, 1988, where the plan of liquidation was adopted before Aug. 1, 1986; Section 338 elections where the 80% stock purchase occurs before Jan. 1, 1987; and Section 338 elections or actual liquidations of companies acquired pursuant to a binding contract entered into before Aug. 1, 1986, provided the date of the 80% purchase or the liquidation is prior to Jan. 1, 1988.

As for net operating losses, Mr. Gentile continued, the IRS will continue to allow the target company to carry over any NOL if its book of business remains substantially unchanged, and where there has been a greater than 50% shift of shareholders. But, under the new rules, the NOL may only be used to shelter a limited amount of future income under the annual Section 382 limitation.

The limitation is calculated by multiplying the value of the acquired corporation (generally its purchase price) by the long-term applicable federal rate (AFR) on tax-exempt bonds. For example, if the corporation were purchased for $25 million and had a $10 million NOL and the AFR were 5%, then only $1.25 million in earnings ($25 million x 5%) could be sheltered by the NOL in any one year.

Small property/casualty insurers, however, benefit under the new law.

Previously, only mutual property/casualty insurers with gross amounts (total premiums and gross investment income) of no more than $150,000 were exempt from tax.

Under the new law, both mutual and stock companies with annual net written premiums (or direct written premiums, if greater) less than $350,000 are exempt from tax.

Also, property/casualty insurers with net written premiums between $350,000 and $1.2 million can elect to be taxed only on investment income. ■

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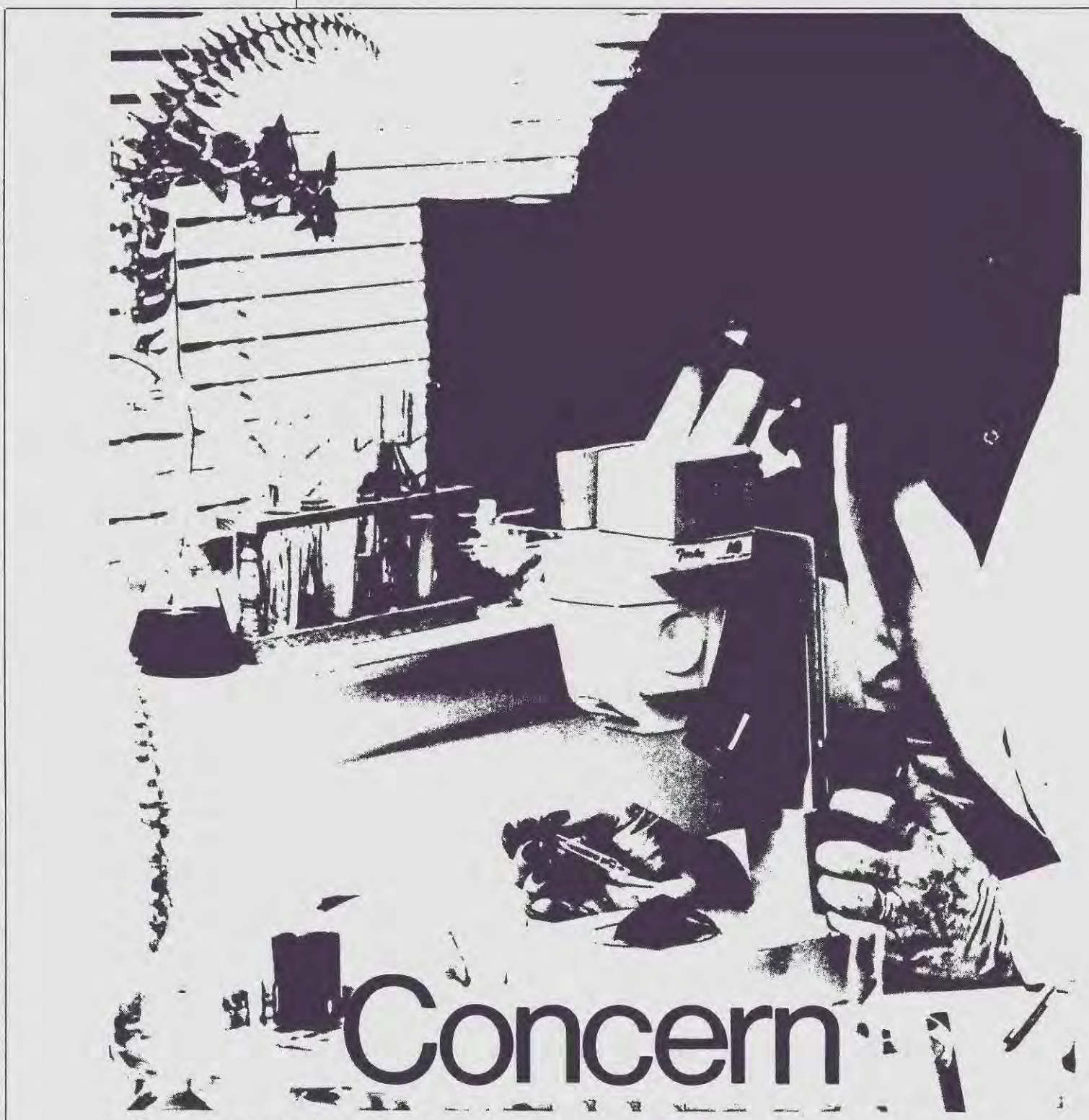

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Insurers may become cheaper to acquire

By AVRA WING

NEW YORK—Property/casualty insurance companies may become cheaper to buy as a result of increased tax liabilities under the Tax Reform Act of 1986.

With reduced cash flow and potentially less income the selling price of an insurer will be about 5% to 10% less, predicted Harold Sandstrom, managing director of Bankers Trust Co. in New York. Mr. Sandstrom spoke at a recent Executive Enterprises Inc. seminar on mergers and acquisitions.

"All other things being equal, the (selling price of the company) would go down," agreed New York merchant banker Bruce Schnitzer at the seminar. "But I can't say what the market will be like in six months."

Panelists agreed, however, that profitable opportunities for buying insurance companies will still exist after tax reform.

The property/casualty industry "provides very large amounts of investable assets," Mr. Schnitzer said at the conference. "Over time, the (return on investment) enjoyed by successful insurers has looked quite good relative to other investment opportunities."

Property/casualty insurers "will be capital-short for quite a long time to come," he continued. "Problems associated with the past will continue to emerge. That should create substantial opportunity for those with capital and staying power."

In addition, Mr. Schnitzer said opportunities exist for insurance companies that expand into the financial services area, an evolution he sees as natural and past due.

"The big opportunity in the insurance industry will be reserved for those who can think of insurance capital as one of several forms of financial capital. The insurance system is conceptually the mirror image of the bank system. Financial markets and insurance markets are, in large part, alternative sources of funding, and the line between risk decisions and financial decisions should blur over time."

Although the best strategy for getting into the property/casualty insurance business is not clear-cut, potential buyers are looking for specific kinds of businesses.

According to Lewis Williams IV, a corporate finance associate with the First National Bank of Boston, who spoke at the conference, what acquirers want are both specialty companies serving attractive markets and "well-situated general underwriters."

While some experts advocate starting a new company, sometimes as a joint venture with other investors, others advise buying the licenses of an existing company—exclusive of the book of business.

When acquiring a standing company, Mr. Schnitzer emphasized, "Avoid buying someone else's tail! The first key rule of making money is not to lose the money. There are few easier places to lose the money up-front than to acquire a property/casualty carrier."

Mr. Sandstrom at Bankers Trust added that most acquisitions are not done with companies "with a large amount of long-tail business." He advised the audience to try to "segregate that business and spin it off," or "reinsure it out if you can find someone."

William Potvin, a partner at Touche, Ross & Co., said in an interview that buying an existing business is a "risky proposition" because there might be "skeletons in the closet"—residual liabilities from long-tail business that are not readily apparent and against which it is extremely difficult to get indemnification.

"There are about five shells (of property/casualty companies) that have been around for a while that are offered to everyone. The word for them is 'Buyer, beware!' The clean shells don't (stay on the market) very long," he noted.

On the other hand, starting an insurer from scratch can be a problem, Mr. Schnitzer said at the conference, because "it's a clubby business. Fresh capital, even with licenses, must find a way to get accepted as a credible market."

The cost of acquiring a license for a property/casualty company currently averages $100,000 a state, Mr. Schnitzer said, ranging anywhere from $50,000 to $800,000. Balanced against that is the time involved in obtaining new licenses, he noted, which can be between five and seven years for all 50 states.

Bertram Harnett, counsel for Dreyer & Traub in New York, spoke emphatically at the conference: "In the end, the general wisdom is it's better to buy than to form a company—if you can find it."

The cost of buying an insurance company, Mr. Sandstrom suggested, is now 1¾ to two times book value. If an insurer does not appear adequately reserved, however, that multiple would drop to 1¼ to 1½ times book value.

He cautioned that it might not always be possible to determine the exact state of the reserves even with a "due-diligence" investigation. The seller "may be trying to disclose" the proper information in good faith, but "may not know of claims still coming in."

Setting a price for a property/casualty insurer entails determining not only current assets and liabilities, but the current value of future profits, seminar panelists noted. That requires projecting future rates of return and establishing different rates at which to value various kinds of new business—which would vary according to renewals, new business from established agents and new business from new agents, according to Orin Linden, director of merger and acquisition services for Coopers & Lybrand in New York.

Participants at the conference stressed four major areas that potential investors should thoroughly investigate before deciding to buy into an insurer: investments, reserves, distribution channels and management.

They noted, too, that acquirers would have to deal with regulators' approvals and restrictions pertaining, for example, to minimum capital requirements and investments by insurers.

Speaking at the conference from the lender's point of view, William Bagby, vp-insurance mergers and acquisitions for the Bank of Boston, said his bank is usually willing to lend half the book value of a company as senior lender.

"We have to get behind the balance sheet," he said, in terms of looking into where the company invests its money. ■

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Comp reform

Continued from page 1

the Kentucky workers compensation system is in the hands of legislators, awaiting further action.

In a handful of other states, special commissions or task forces now are studying their workers compensation laws. Some of those studies are perpetual, but a few states, like Maryland, are expected to deliver reports soon so legislation may be introduced in 1987.

Among other states expected to look closely at their work comp laws next year with reform in mind are: Arkansas, Colorado, Georgia, Illinois, Maine, Michigan, Minnesota, Mississippi, Montana, New Mexico, Ohio, Pennsylvania, Texas and Wisconsin.

Those reforms may be slight, or a fine-tuning of recently overhauled systems, like in Minnesota. However, in other states, such as in Maine where about 80% of employers are in the assigned risk plan because workers compensation insurers say they can't make a profit, a major reform effort is advocated. Some are calling for the establishment of a monopolistic state fund, which would exclude insurers from selling workers compensation in the state (*BI*, Sept. 22).

Congress, too, may again consider creating another federal workers compensation program, now that tax reform is no longer a priority and the Democrats control both houses. Current federal workers compensation programs include the Longshoremen's and Harbor Workers' Compensation Act and the black lung program established by the Federal Coal Mine Health & Safety Act.

Among the several pieces of federal legislation that failed to gain momentum in the last Congress but may re-emerge are the Asbestos Workers' Recovery Act, which had been introduced by Rep. Austin Murphy, D-Pa., and the Occupational Disease Compensation Act, which had been introduced by Rep. Pat Williams, D-Mont.

To be considered by the 100th Congress, either act would have to be reintroduced.

The previous Asbestos Workers Recovery Act, H.R. 1626, called for abolishing third-party tort actions in asbestos cases and replacing them with no-fault compensation. Asbestos claims first would have been handled by state workers compensation systems, and then a federal program would have provided a supplemental benefit.

The previous Occupational Disease Compensation Act, H.R. 3090, called for the establishment of a federal fund to compensate asbestos victims.

Anticipating all this activity, many experts are urging lawmakers and others to study the roots of workers compensation before attempting to change the system.

Paying medical bills, returning injured employees to work and concern with the tort process are the kinds of problems that led to the creation of the work comp system and "are the same issues today," said John H. Lewis, a Florida-based attorney, who in recent years has advised state officials, businesses and labor organizations in several states on workers compensation reform. Last week, for example, he was in Hawaii, American Samoa and California.

Today, the issue is not as often whether the employer must pay the medical bill—although the definition of compensable injury continues to be disputed—but how to control the cost of care. Nor is the issue whether to return the worker to a job, but how to do so most quickly and efficiently.

The involvement of the tort process, however, has become a major issue as the exclusivity of the workers compensation system as the sole remedy for workplace injuries has come under attack.

Other reform issues include coverage for occupational diseases and rehabilitation programs, said J. Howard Bunn Jr., an Illinois-based work comp consultant.

Too many occupational diseases are not covered by workers compensation, critics contend, while rehabilitation programs are too narrow and inefficient.

Benefit levels—the amount of compensation an injured worker should receive and whether benefits should be scheduled or based on wage loss—is a perennial issue.

And, states now are focusing on ways to make administration of the system more swift and efficient.

While these are not new issues, many are more complicated than they were 75 years ago, like occupational disease claims.

"When the system was started, perhaps some of the visionaries saw occupational disease as playing a role, but not like today," Mr. Bunn said. "When we get into discussions of getting back to basics, these are some of the issues that should be looked to."

"It's always important to go back," notes James Ellenberger, assistant director of the AFL-CIO's Department of Occupational Safety, Health & Social Security in Washington. "People who work in a system ought to have some appreciation of how it got the way it is."

Continued on next page

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Comp reform

Continued from previous page

But too often, those in work comp—from claim handlers to adjudicators—are unaware of its history and often have a layperson's view of the system, said S. James Brainerd, vp and general counsel of the Florida Chamber of Commerce in Tallahassee.

"Workers compensation is one of the systems, I think, that is taken for granted by those involved in it," Mr. Bunn said.

By studying the system, "it gives an appreciation of what was behind it, what was the thinking of those who created it, what they were trying to achieve. . .and to see if it is living up to those objectives," Mr. Bunn said.

"The system met a need at the time and that was to provide injured workers with quick and immediate relief both from the standpoint of medical aid and economic loss," said Robert Hilton, senior vp with the National Council on Compensation Insurance, a New York-based workers compensation research, statistical and ratemaking organization.

The work comp system today is a "real solid, sound program, and does serve those people it was originally designed for," Mr. Hilton said. "We don't have a perfect system, but it's a helluva lot better system than when we started out."

"Workers compensation certainly has played a valuable role, and if we didn't have it, we would have had to create it," Mr. Ellenberger said.

"It's one of the most important social programs in place today," said Steven D. Millikan, vp and director of workers compensation for the Alliance of American Insurers in Schaumburg, Ill.

It is an important part of the economy, he said, adding, "It's the only social program that we have that uses private industry to deliver a social program."

The work comp system is a "valuable program, notwithstanding some rough spots," agrees Eric Oxfeld, senior congressional officer for the U.S. Department of Labor and former manager of health care and employee benefits with the U.S. Chamber of Commerce.

Unlike other kinds of programs, "with workers compensation we had a clear example of what would have been if we didn't have it." Mr. Oxfeld said, referring to the common law solutions to workplace injuries prevalent in the late 1800s (see story, page 39).

"It's important not to forget that lesson—that the legal approach was not sufficient," said John F. Burton Jr., professor of labor relations at Cornell University in Ithaca, N.Y.

Compromise was the essence of the first workers compensation laws and still is at the heart of those laws today. The concept hinges on a trade-off: Employers assume liability for all the costs of work-related injuries and disease, regardless of who is at fault. In return, the employee relinquishes the right to sue.

"It was a major trade-off, but it happened so long ago that people tend to lose sight of it," said Fred Krebs, director of employer relations for the U.S. Chamber.

"What the comp system was designed to get rid of is back again," notes Charles Coakley, counsel to the American Insurance Assn. in New York.

He cited numerous state supreme court rulings that have "weakened" the exclusivity of workers compensation as the only remedy for injured workers.

The courts now "are allowing employees to sue employers under various theories," he said. In some states, employees can sue employers alleging an injury resulted from a "willful act" by the employer.

Or in other cases, employees can sue under a dual-capacity doctrine. Such cases often involve employers that also have manufactured a piece of equipment involved in a workplace accident. In these instances, employees file a work comp claim against the employer and then file a product liability lawsuit against the same employer as manufacturer.

And in other states, employees sue a third party, which sues the employer, Mr. Coakley said.

This erosion of the exclusive remedy concept is a major concern to employers, as well as workers compensation insurers.

"When you undermine the exclusive remedy rule, you undermine the basic concept of workers compensation," the U.S. Chamber's Mr. Krebs said.

And though it has different reasons, organized labor also believes the basic concept of workers comp has been lost through time.

"It doesn't seem to work the way it idealistically ought to work," the AFL-CIO's Mr. Ellenberger said.

"It's not just back pains and lung diseases that wind up in litigation. There are simple cases of broken bones and smashed fingers that become contested day in and day out," he said.

"The logic applied in the early days still has application today," said NAII's Mr. Sorich, referring to a no-fault approach.

"Getting back to that logical argument would help us today, especially with all the litigation," Mr. Sorich said.

"I think the expectations of the framers (of the first U.S. workers compensation laws) were naive," Professor Burton said. Just creating a no-fault program to end litigation could not, in and of itself, guarantee success in fairly compensating workers, he maintains.

Once a workers compensation system is in place, "it is not self-run," Professor Burton stressed, advocating the "need for a very active workers compensation agency" to administer the system.

Instead, however, most states have agencies that model "quasi-courts," he said.

Under a better system, the agency would administer payment of valid claims with fewer delays than occur under today's system characterized by adjudicators, hearing officers and arbitrators.

States, however, "are doing an improving job," notes Glenn L. Schilling, a member of the Kentucky Workers' Compensation Board and immediate past president of the International Assn. of Industrial Accident Boards & Commissions.

And he, like most of the other IAIABC members, believe the administration of work comp should remain with the states, rather than be taken over by the federal government—a proposal that gains momentum every so often.

"Workers compensation basically is a local problem that does have regional and even national implications in some instances, but any fair observer would have to say has improved" in the past 15 years, Mr. Schilling said.

Another improvement, however, would be a name change, according to the Alliance's Mr. Millikan.

"We made a major, major mistake by calling it workers compensation," Mr. Millikan said.

That title "implies that they (injured workers) are due something for being injured in the workplace. Add on top of that the idea of entitlement that came about in the '70s. Now it's like the lottery—rewarded for being injured."

Instead, he suggests: "workers rehabilitation program. That implies something altogether different. If I'm injured on the job, their goal should be to get me back to work."

The 75-year-old workers comp system is a good one, according to Mr. Millikan. But, "from here on out," it needs to be thought of as a "back-to-work program." ■

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Ancient nations, pirates devised comp plans

By CAROL CAIN

The first U.S. workers compensation laws are marking their 75th anniversary this year, but historians recount pirate tales and biblical passages when tracing the beginnings of programs that compensate injured workers.

For instance:

• Buccaneers in the 18th century had a system that included a schedule of awards for the loss of a limb or an eye. A pirate who lost a right arm would be awarded 600 pieces of eight, an obsolete Spanish dollar, while one who lost a left arm would receive 500 pieces of eight, according to Dr. Rodney K. Beals, writing in the February 1984 Western Journal of Medicine.

In "The Buccaneers of America," a compilation of pirate accounts, author J. Esquemeling included this passage: "Our surgeon (evaluated) the wounded, (finding) four crippled and six hurt, to whom we gave 600 pieces of eight a man and a thousand to those who were crippled, as was our custom."

Such an award—600 pieces of eight—was more than a year's wage for a pirate back then, maybe even two or three times a pirate's annual salary, said Eugene White, an associate professor of economics at Rutgers University in New Brunswick, N.J. That award would be equal to an award of about $120,000 today, he said.

But, under the the pirates' compensation system, there were no death benefits, no retirement benefits and no appeal rights. In addition, the benefit was only a lump sum payment, Dr. Beals wrote.

"Vocational rehabilitation was available for some," he added, citing that peg-legged pirates earned half share of the spoils as cooks, even if they did not have any culinary skills.

• Under Babylonian law in the reign of Hammurabi—between 1945 B.C. and 1902 B.C.—compensation was partially substituted for retaliation, according to Monroe Berkowitz, another economics professor at Rutgers.

That code included both specified monetary payments for particular injuries and direct "eye-for-an-eye, tooth-for-a-tooth" penalties, with the choice dependent upon the relative social ranks of the aggressors and the victims, Professor Berkowitz said.

• The Hebrew Bible quotes the law of retaliation (an eye for an eye), but also notes that non-fatal physical injuries became a matter for monetary compensation to the injured party.

Professor Berkowitz said a clear illustration of how compensation replaced retaliation is found in Exodus (21:18-19): "And if men contend, and one smite the other with a stone, or with his fists, and he die not, but keep his bed; If he rise again and walk abroad upon his staff, then shall he that smote him be quit; only he shall pay for the loss of his time and shall cause him to be thoroughly healed."

• It is claimed the Egyptian bedouin (desert nomads) until recently had a set of fixed payments for assaults and wounds, dealing with loss of limbs, broken bones, wounds on the face and wounds elsewhere on the body.

All of these ancient systems are not direct ancestors of modern programs, but scholars enjoy tying them into any discussion about the rudiments of work comp law.

Workers compensation is the oldest form of social insurance in the United States. According to Department of Labor statistics, it assures about 86% of the civilian employees that, if injured on the job, they will receive prompt payment of benefits, regardless of who is at fault and with a minimum of legal formality.

The other estimated 14% of the working population not covered under work comp laws generally fall under three categories: agricultural workers, domestic workers and employees of firms with fewer than three employees.

And, some employees of firms in Texas, New Jersey and South Carolina also may not be covered because those states have elective, rather than mandatory, work comp laws. However, most employers participate in the workers compensation systems in those states rather than be at risk for injuries under tort law.

The latest statistics from the Social Security Administration show that in 1984, 82.6 million employees were covered under workcomp programs and received about $19.5 billion in benefits.

The history of the U.S. work comp system begins in this century and parallels the shift to an industrial economy from an agricultural one.

This pace of industrialized America had many declaring: "Nothing must stand in the way of progress." That meant that an injured worker who could not return to the job was relegated to private or public charity work.

Before the advent of state workers compensation laws, employees injured on their jobs usually had only one recourse: to sue their employers under common law for medical expenses and wages. To recover damages, injured workers had to prove in court that their injuries were entirely due to an employer's negligence before they won compensation.

But the chances of recovery were slight. Prevailing common law generally operated against injured workers, according to information compiled by Liberty Mutual Insurance Co. in Boston.

Liberty Mutual notes that three defenses were available to the employer:

• Contributory negligence—when employee's own negligence contributed to injury.

• Fellow-servant doctrine—when injury resulted from the negligence of a co-worker.

• Assumption of risk—when injury resulted from an inherent risk about which the employee had, or should have had, advance knowledge.

For most injured workers, this undertaking proved to be costly, time-consuming and often futile.

It has been estimated that not more than 15% of injured employees ever recovered damages under common law, although an estimated 70% of the injuries were related to working conditions or employers' negligence, according to material compiled in 1972 by the National Commission on State Workmen's Compensation Laws.

It became apparent that these common law defenses "operated too harshly on claims of disabled workers," notes the introduction of "Analysis of Workers' Compensation Laws," compiled annually by the U.S. Chamber of Commerce in Washington.

"As a result, between 1900 and 1910, so-called employer's liability

Continued on next page

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Comp history

Continued from previous page

laws were adopted by many states," the Chamber's analysis notes. But, under these laws, which modified employers' common law defenses, employees still had to prove employer responsibility and negligence for work injuries.

However, even those modifications did not prove satisfactory, and historical accounts of the plight of injured workers prior to work comp laws tell of desperate and inhumane situations.

For instance, the Wainwright Commission in New York in 1909 analyzed industrial fatalities in Erie County and the borough of Manhattan and confirmed the widespread belief that employer's liability statutes were inadequate to the task, said Kevin M. Ryan, president of the National Council on Compensation Insurance.

The commission's study showed that in 79% of the closed cases involving a married man killed on the job, the family received less than $500. And, in 37% of those cases, the family received nothing.

"The average annual salary of the men was $791, so even a full recovery of $500 would have been a pittance, especially after the cost of an attorney's fee and funeral expenses were deducted," he said.

"Protracted lawsuits almost always put a severe strain on family resources," Mr. Ryan said. "For many, delayed recovery was as disastrous as no recovery, and often the injured employee settled with his employer, taking less than his medical and economic loss."

By the end of the 19th century, there was growing public pressure for a compensation system that would treat workers in a fair and equitable manner.

Employer liability laws were declared unconstitutional. But, ironically, the courts said the laws deprived employers of due process of law and were in direct violation of the 14th Aendment.

However, Progressive Era reformers were not going to be halted. They began pushing for a "no-fault" compensation system.

Beginning in 1909, one state after another abandoned employer liability laws in favor of a workers compensation system.

These early laws were extremely limited. In many initial laws, only hazardous situations were covered, and the only benefits to injured workers were lost wages for a brief period of time.

By 1911, after nearly a decade of debate and several constitutional challenges of state efforts, nine states enacted the country's first enduring workers compensation statutes. Four of those laws took effect that same year (see chart).

Maryland passed the first law in 1902, which provided benefits for workers injured on the job, but it was Montana that passed the first compulsory compensation act in 1909. The Maryland and Montana law, as well as a 1910 New York law, were declared unconstitutional.

Historians give the distinction of the first work comp law "that stuck" to Wisconsin. Its statute was approved May 3, 1911, and most of the law's provisions took effect that same day.

Other states that in 1911 enacted work comp laws that held up in court were New Jersey, California, Washington, Kansas, New Hampshire, Ohio, Illinois and Massachusetts.

The laws adopted by those states provided workers with a guarantee that they would receive payment for lost wages and medical bills if they were injured on the job, regardless of who was at fault for the accident that caused the injury.

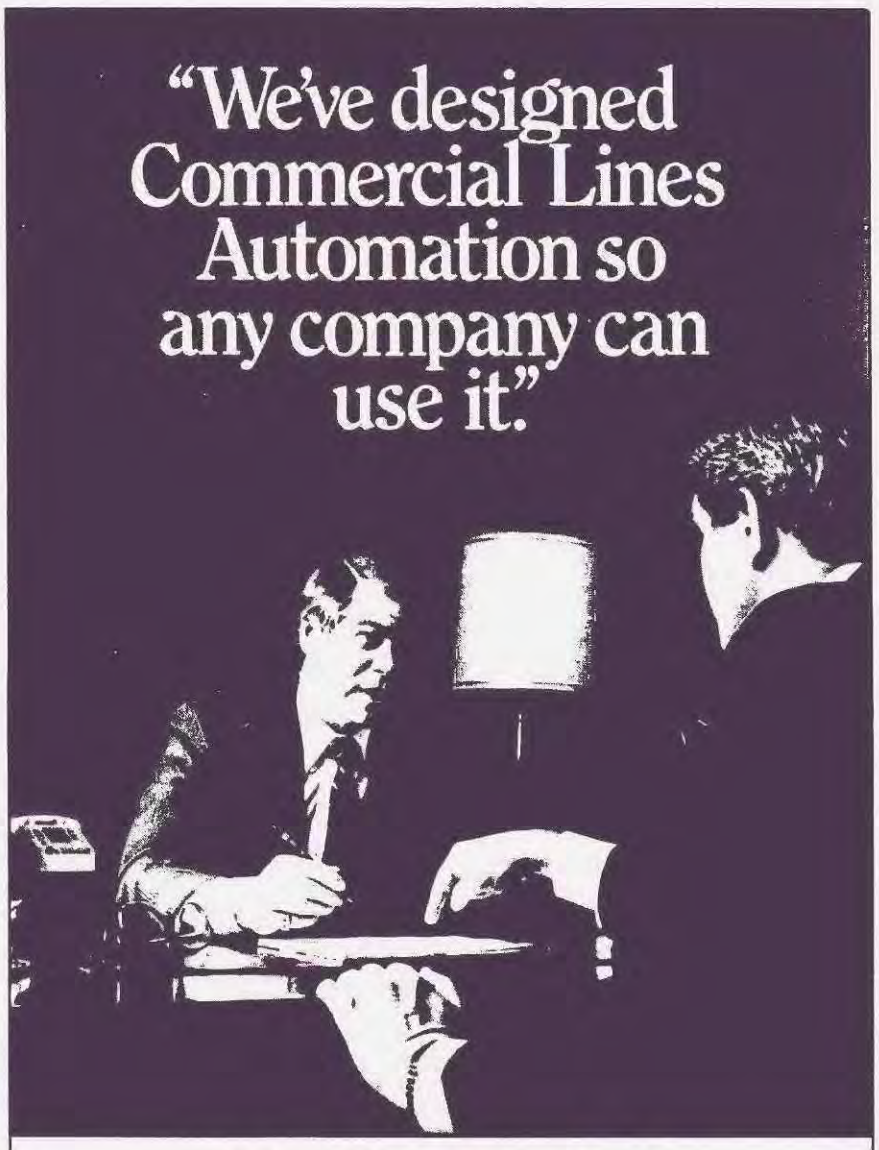
In exchange for paying for this protection, the employer legally was exempted from most negligence suits resulting from occupational injury or death.

And these same concepts, known as quid pro quo, remain the essential elements of current workers compensation systems, experts note (see story, page 1).

State	Approved	Effective
Wisconsin	May 3, 1911	May 3, 1911
New Jersey	April 4, 1911	July 4, 1911
California	April 8, 1911	Sept. 1, 1911
Washington	March 14, 1911	Oct. 1, 1911
Kansas	March 14, 1911	Jan. 1, 1912
New Hampshire	April 15, 1911	Jan. 1, 1912
Ohio	June 15, 1911	Jan. 1, 1912
Illinois	June 10, 1911	May 1, 1912
Massachusetts	July 28, 1911	July 1, 1912
Arizona	June 8, 1912	Sept. 1, 1912
Michigan	March 20, 1912	Sept. 1, 1912
Rhode Island	April 29, 1912	Oct. 1, 1912
Nevada	March 15, 1913	July 1, 1913
Nebraska	April 21, 1913	July 17, 1913
Texas	April 16, 1913	Sept. 1, 1913
Minnesota	April 24, 1913	Oct. 1, 1913
West Virginia	Feb. 22, 1913	Oct. 1, 1913
Connecticut	May 29, 1913	Jan. 1, 1914
Iowa	April 18, 1913	July 1, 1914
New York	Dec. 16, 1913	July 1, 1914
Oregon	Feb. 25, 1913	July 1, 1914
Maryland	April 16, 1914	Nov. 1, 1914
Louisiana	June 18, 1914	Jan. 1, 1915
Maine	April 1, 1915	Jan. 1, 1915
Wyoming	Feb. 27, 1915	April 1, 1915
Montana	March 8, 1915	July 1, 1915
Vermont	April 1, 1915	July 1, 1915
Hawaii	April 28, 1915	July 1, 1915
Alaska	April 29, 1915	July 28, 1915
Colorado	April 10, 1915	Aug. 1, 1915
Indiana	March 8, 1915	Sept. 1, 1915
Oklahoma	March 22, 1915	Sept. 1, 1915
Pennsylvania	June 2, 1915	Jan. 1, 1916
Kentucky	March 23, 1916	Aug. 1, 1916
South Dakota	March 10, 1917	June 1, 1917
New Mexico	March 13, 1917	June 8, 1917
Utah	March 15, 1917	July 1, 1917
Idaho	March 16, 1917	Jan. 1, 1918
Delaware	April 2, 1917	Jan. 1, 1918
Virginia	March 21, 1918	Jan. 1, 1919
North Dakota	March 5, 1919	July 1, 1919
Tennessee	April 15, 1919	July 1, 1919
Alabama	Aug. 23, 1919	Jan. 1, 1920
Georgia	Aug. 17, 1920	March 1, 1921
Missouri	April 30, 1925	Nov. 2, 1926
Longshore and Harbor Workers	March 14, 1927	July 1, 1927
North Carolina	March 11, 1929	July 1, 1929
Florida	May 25, 1935	July 1, 1935
South Carolina	July 17, 1935	Sept. 1, 1935
Arkansas	March 15, 1939	Dec. 5, 1940
Mississippi	April 13, 1948	Jan. 1, 1949
District of Columbia	July 1, 1980	July 26, 1982

Source: Alliance of American Insurers

Chart: Amy Palmer



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Endowed chair to honor workers comp scholar

By CAROL CAIN

DURHAM, N.C.—Scholarly legal analysis of the U.S. workers compensation system is the product of only one man: Arthur Larson, professor of law at Duke University.

But now, Duke and one of its alumni are raising money to fund a chair at the law school in his honor. The chair is intended to expand Professor Larson's efforts and bring workers compensation experts and practitioners together to improve the system.

The establishment of the Larson chair "is an important gesture for a person who has contributed more than any single person in the country, for pulling the workers compensation laws together to serve the whole system," said J. Howard Bunn Jr., an Illinois-based work comp consultant.

Professor Larson is known best for his continuing work on a 10-volume treatise, "The Law of Workmen's Compensation," which he first published in 1952 in two volumes. Now, each quarter he updates the analysis of work comp laws and court decisions.

The treatise "has been cited as the authority in workers compensation law by virtually every state and federal court," noted John H. Lewis, the Duke alumnus who is spearheading the fund-raising effort for the chair.

"In many instances, courts have simply adopted, without modification, principles set forth by Dr. Larson, recognizing the depth and accuracy of his commentary," Mr. Lewis said.

Professor Larson, who at 76 is one year older than the U.S. workers compensation system, says he is "overwhelmed and deeply touched" by the chair. But more important, he wants to see the study of workers compensation elevated from what he perceives as a stepchild.

"Workers compensation is not just a stepchild of the legal justice system. It's one whale of a pig," he said.

"I am very anxious that the country as a whole will wake up to the fact that something has happened and that workers compensation is no longer this ragged little stepchild that so many people have gotten in the habit of thinking of it as," he said in a September speech to the annual meeting of the American Assn. of State Compensation Insurance Funds.

It is a "tragedy" that law schools are "so slow to catch up" with work comp issues, Professor Larson said recently, commenting on the creation of the chair. There is a "very serious blind spot in legal education," he added.

Workers compensation is "an extremely active field," but "a lot of lawyers," particularly those in law school, "just haven't gotten the word," Professor Larson said.

However, one lawyer—Mr. Lewis—did "get the word" some 20 years ago as a law student at Duke and an assistant to Professor Larson.

Mr. Lewis accepted the assignment to lead a nationwide campaign for funds from employers, organized labor, insurers and others for the chair. An estimated $1 million over the next 10 years is needed to fund the chair.

Mr. Lewis, who began the fund-raising earlier this year, says he's about one-third of the way to the goal, counting pledges.

"A chair simply provides financing for the university to establish a teaching chair and bring in a first-rate educator," said Mr. Lewis, a Florida-based attorney who has been called into several states in recent years to assist in rewriting workers comp statutes.

"The vision that we have for it is that the person who occupies the chair might have the responsibility of convening a small conference from time to time on workers compensation law reform and related subjects," said Paul Carrington, dean of the Duke Law School.

After discussions with officials from the Duke Law School, Mr. Lewis said the chair is expected to educate those in the workers compensation field, provide them with a resource and and encourage labor-management commitment to better workers compensation laws.

"There is the role that the law school, through the Larson Chair, will be able to play ir assisting the

Continued on next page

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Larson chair

Continued from previous page
community in reaching meaningful solutions to its workers compensation problems," Mr. Lewis said in a letter to William L. Mather, administrator of risk management for The Gillette Co. in Boston and president of the Risk & Insurance Management Society.

"As many RIMS members well know, one of the greatest problems we often face in state workers compensation reform efforts is the inability of labor and management to discuss real issues, because of the pressures of public debate and, in some instances, the absence of knowledge and information," Mr. Lewis wrote.

RIMS has not yet encouraged its membership to contribute to the chair, Mr. Mather said in an interview, noting the letter has been referred to several committees.

Mr. Lewis envisions the Larson Chair as assisting in the creation of "a space" or forum outside of that political arena in which leaders can hear information from workers compensation experts and calmly discuss "the concepts" of a workers compensation system for their state.

There are currently "lots of seminars" throughout the country on workers compensation, "but no mechanism to allow both parties to sit down and discuss," Mr. Lewis said.

"Using the Larson Chair as a catalyst, it will be possible to identify states in which workers compensation is becoming an issue, or where law changes are necessary," Mr. Lewis wrote.

"In addition, there are some overall workers compensation issues that need to be dealt with nationally," Mr. Lewis told *Business Insurance*. He added the efforts at Duke will not duplicate other programs, such as the Workers Compensation Research Institute in Cambridge, Mass.

One such effort already is in the planning stage, Mr. Lewis said, referring to a symposium slated for next year for members of the legal and medical professions.

The latest information on "diagnostic techniques" will be the focal point of the symposium, Mr. Lewis said. Representatives from both the legal and medical fields are expected to share information about which techniques are good, what these diagnostic techniques can or cannot do and how they can be used to determine the extent of orthopedic injuries.

But this symposium can be held only if there is a $1 million financial commitment to the Larson Chair, Mr. Lewis said.

Contributions, some as much as $100,000, already have been sent or pledged, he said. "But what I'm really shooting for is for companies to commit $500, $1,500 or $5,000 a year for the next 10 years," Mr. Lewis said.

Organized labor, notably the AFL-CIO, has made a contribution, as well as several individual employers, Mr. Lewis noted.

"But I m extremely disappointed with several major workers comp carriers," he said, explaining these large insurers have been slow in agreeing to participate.

However, several smaller work comp insurers, notably those that are members of the Des Plaines, Ill.-based National Assn. of Independent Insurers, have made contributions, pointed out Sam Sorich, assistant vp.

As word of the fund-raising effort spreads, however, Mr. Lewis believes more will participate to honor Professor Larson, as well as to financially support "quality legal education."

"It's particularly fitting that this honor be bestowed on Dr. Larson at the university where he devotes so much time and effort to academic excellence," said James N. Ellenberger, assistant director of the AFL-CIO's department of occupational safety, health and Social Security.

Although he is noted for his work in the area of workers compensation, Professor Larson also has accomplished a great deal in the fields of international affairs and politics.

He was an undersecretary of labor between 1954-56, director of the U.S. Information Agency in 1956-57 and a special assistant in charge of speech writing and later a special consultant for President Eisenhower from 1957-61.

In addition to the workers compensation treatise, Professor Larson also has written "Eisenhower: The President Nobody Knew," "A Republican Looks at His Party" and "When Nations Disagree."

Professor Larson, who was born on the Fourth of July in Sioux Falls, S.D., attended Augustana College in his home town and later the University of South Dakota Law School. He also was a Rhodes scholar and received a doctorate of civil laws, Oxford University's highest degree.

'A lot of lawyers just haven't gotten the word' about workers comp, Professor Larson says.

Several honors and awards have been bestowed on Professor Larson, including the World Peace Award by the American Freedom Assn., the Henderson Memorial Prize from Harvard University, the Fulbright Advance Research Award, the Honorary Fellow of Pembroke College from Oxford and the Horovitz Award from the American Trial Lawyers Assn.

In between writing, teaching and lecturing, Professor Larson collects and plays ancient musical instruments. He also collects, arranges and performs folk music. ■

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U.S. comp laws' roots lie in Austria, Germany

Historians frequently trace today's U.S. workers compensation system to laws enacted in the early 19th century in mining industries in Austria and Germany.

Initially, those countries adopted "employers' liability laws" to provide compensation for workers injured on the job, while recognizing the personal fault concept.

However, this early modern method of compensation failed to adequately and quickly compensate injured workers and many called for a more equitable treatment, say work comp experts.

In the early 20th century, framers of the first U.S. workers compensation laws looked to the European systems, specifically those in Germany and Great Britain.

Germany often is considered the pioneer of workers compensation systems in modern society. But only two states—Washington and Ohio—modeled their workers compensation systems on the German scheme, while the other states looked to the British system.

According to material compiled by the National Commission on State Workmen's Compensation Laws in 1972, Prussia took the initial step in 1838 in recognizing the then-new principle of the liability of employers for industrial accidents with a statute making railroads liable for injuries to both employees and passengers.

This law made the railroad's only defense to prove an accident was caused either by negligence of the person or an act of God.

In years that followed, Germany enacted other laws that required certain employers to contribute funds for compensation of injuries.

These compensation theories developed years earlier with Prussian monarch Frederick the Great, who believed the state had the duty "to provide sustenance and support of its citizens who cannot provide sustenance for themselves."

Several socialist philosophers drafted an insurance plan in Germany built on the idea that a large proportion of the misfortunes, illnesses, accidents and effects of premature age are social in origin, not individual, and that a vast portion of these "evils" spring not from the fault of the individual, but from sources over which the individual has little or no control.

They made strong arguments pointing to industrial insurance as the only viable solution to the problem of workers' injuries.

During the years following the Franco-Prussian War of 1870-71, the Prussian government became increasingly concerned over the influence of the Marxist-Socialists.

In a political move to counteract this influence, Chancellor Otto von Bismark introduced an elaborate scheme of compulsory insurance for the working classes.

His plan was enacted in steps between 1883-1887, though 1884 often is cited as the date of the first modern work comp law, the model for the Washington and Ohio laws.

According to Bismark's plan, coverage was paid for by both workers and by employers, with workers paying two-thirds of the cost of the "Sickness Fund," and employers one-third. However, only employers contributed to the Accident Fund, and both workers and employers paid an equal share of the Disability Fund.

Great Britain in 1880 passed the Employer's Liability Act, which, according to one historian, was the "first legislative protest against the sweeping favoritism of the common law." Although the act looked good on paper, it flopped.

In 1897, Great Britain enacted a workers compensation act that differed considerably from the German law in that it was "a reluctant response to a bad situation," according to a 1979 Florida State University Law Review article.

The British system is weighted heavily in favor of the employer, and in contrast to the German system, the British law was careful to cover only "personal injury by accident arising out of and in the course of the employment"—a phrase incorporated in many of the U.S. state work comp laws.

This initial British workers compensation act was regarded as experimental, and was subject to review in 1903. It has been extended and amended several times.

Although Germany and Great Britain are the often cited as forerunners of today's work comp systems, Switzerland is the first country in modern times to protect workers from the occupational disease, says Peter S. Barth, professor of economics at the University of Connecticut in Storrs.

In 1877, the Swiss Federal Council prepared a list of 45 substances that, if used in industry, were recognized as the cause of occupational diseases, he says.

It is difficult today to equate U.S. workers compensation laws with those in Europe because much of the foreign workers compensation systems are coordinated with other social benefits programs.

"Workers compensation has been integrated into the more universal social system of pensions, health and illness insurance; its benefits are slightly higher than those for an ordinary unwork-related illness, but only slightly," said Chicago attorney Douglas F. Stevenson, executive director of the National Council of Self-Insurers.

Mr. Stevenson spent three weeks in Europe this spring studying workers compensation in Great Britain, West Germany, Sweden, Czechoslovakia and Belgium.

In all five countries, employee representatives have an equal voice with management in all matters involving safety and workers compensation, Mr. Stevenson said in October, during a joint meeting in Louisville, Ky., of the National Council of Self-Insurers and the International Assn. of Industrial Accident Boards & Commissions.

"Aside from England, even all OSHA regulations are arrived at by a consensus of union and management," Mr. Stevenson said, referring to the British equivalent of the Occupation Safety and Health Administration. "In Sweden and Germany, we were told that if union and management cannot agree on an issue of safety, nothing happens until they do agree."

And, "workers compensation simply is not a controversial subject in any of these countries. The principal reason is that they all have cradle-to-grave income protection and free medical care. These mechanisms have enveloped workers compensation and diminished its importance," he said.

The administration of workers comp abroad falls in one of three categories: a tripartite agency, as in England—the government, management and labor; or a joint employer-union administration, as in Sweden, West Germany and Belgium; or solely by the unions, as in Czechoslovakia, he said.

—By Carol Cain

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Employers Mutual Liability Insurance Co. of Wisconsin, the forerunner of Wausau Insurance Cos., was created to fund the new employer exposure under the first constitutionally upheld workers compensation law in the United States.

That law was enacted by the Wisconsin Legislature on May 3, 1911, and, for the most part, was effective that same day.

Two other states—Montana and New York—enacted workers compensation legislation before Wisconsin, but only the Wisconsin law stood up under court challenges because it was elective, rather than compulsory.

The Wisconsin law gave employers a choice: continue to deal with workplace injuries under common law defenses (see story, page 39), or accept the new law and come under its provisions of statute-established benefits.

However, as an incentive, the Wisconsin law eliminated two valuable defenses for employers—the "fellow servant" and "assumption of risk" rules.

The remaining major employer defense—contributory negligence—would disappear within the decade.

Wisconsin employers closely followed the political debate over workers compensation in 1911. Many saw the new law as a solution to administrative hassles and legal injustices.

And some, notably that group of employers and lumbermen from Wausau, paid particular attention to a legislative report that cited "strong mutual insurance companies" as having been the "cheapest, safest and most reliable method" to handle workers compensation risks.

By late summer 1911, Employers Mutual Liability Insurance was up and running in a rented room above a Wausau cigar store. "Policy No. 1" was written on Sept. 1, 1911, to insure Wausau Sulphate Fibre Co., which today is the Mosinee Paper Corp., located in Mosinee, Wis.

The insurer's liability under that first policy was limited to $3,000 of compensation "on account of accident resulting in injuries to or in the death of one employe (sic), in addition to the medical and surgical treatment required under the law."

And, the insurer's liability for any single accident, resulting in injuries to or the death of more than one employee, was limited to $12,000 in addition to medical costs.

"Policy No. 1" remains in force even though the names of the insured and insurer have changed, according to a spokesman for Wausau.

Wausau is now an affiliate of Nationwide Insurance Cos. in Columbus, Ohio.

Wausau Insurance Cos. began celebrating its 75th anniversary and the anniversary of the Wisconsin workers compensation in May 1985 with the placement of a historical plaque just outside Mosinee.

In September, Wausau presented a $75,000 grant—"$1,000 for each year since 1911"—to its hometown toward the renovation of the Grand Theatre.

The grant, which is payable over three years, was matched by Nationwide.

"To us, the Grand Theatre is an important symbol of the Wausau spirit and the Wausau heritage," said Lee Weinberger, president and chief executive officer of Wausau Insurance Cos.

"Consistent with our own company beginnings, this landmark is uniquely Wausau. Its renovation asserts an optimism for the future—an effort to take a past resource and make it a future resource," he said.

The first U.S. work comp policy was written by Employers Mutual Liability Insurance Co.

Also part of the celebration was the presentation of a video of the company's history, with cake and coffee, at many of Wausau's regional offices nationwide.

And on Sept. 4, Wausau Insurance Cos. went to Madison, Wis., to honor the Wisconsin Legislature and present the University of Wisconsin with a $15,000 grant for the "John R. Commons Lectureship."

Mr. Commons, an economist with the university in the early 1900s, is credited with conceptualizing a workers compensation system during a 1908 meeting of the Merchants & Manufacturers Assn. of Milwaukee—a model closely resembling the Wisconsin law. ■

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CEBS

Choosing among HMOs a challenge to employers

By DONNA DiBLASE

CHICAGO—Benefit managers in Chicago must be savvy when shopping for health maintenance organizations and preferred provider organizations in the city's exploding marketplace, according to benefits experts.

"One of the most important things to look at in the Chicago marketplace is the sheer number of HMOs now available," noted Steven Kraus, director of employee benefit plan for the Metropolitan Chicago Healthcare Council and a Certified Employee Benefit Specialist, during the "HMO/PPO Shoot-Out" here Nov. 19.

The one-day conference was cosponsored by the Chicago chapters of the International Society of Certified Employee Benefit Specialists and the Midwest Business Group on Health.

HMOs in the Chicago market have grown dramatically, Mr. Kraus said, pointing out that there now are 30 HMOs in the market, compared with nine in 1983.

And, PPOs also have taken off, with 28 plans now available to area employers, he added.

So many HMO and PPO choices in any market can make evaluating health benefit plans very difficult, so developing a clear-cut strategy to evaluate and negotiate with these alternative delivery systems is the key to effective decision-making, benefits experts say.

For example, Dearborn, Mich.-based Ford Motor Co. uses an evaluation strategy it developed in the 1970s, when the company first offered HMOs to its employees, according to Tom Kilarski, supervisor of employee insurance.

"The rapid escalation of costs moved Ford to begin offering HMOs in the '70s. Our guidelines for reviewing these plans have worked well," Mr. Kilarski told attendees.

In its evaluation, Ford reviews:

- The model of the HMO under consideration.

There are several different HMO models. In the group model, a group of physicians contract with an HMO to provide health care for plan members.

In the staff model, which is similar to the group model, physicians and health professionals are directly employed by the HMO.

In the individual practice association model, physicians in private practice contract with an HMO to provide care for members, but they also continue to provide care for non-HMO patients.

- The state certification of the HMO.
- Whether the HMO is federally qualified.

If an HMO is federally qualified by the U.S. Department of Health and Human Services' Office of Prepaid Health Care, the plan must provide certain basic services outlined by the federal Health Maintenance Organization Act of 1973.

Federally qualified HMOs also must set their premium rates based on the experience of the entire membership of the plan. But, under this rating system—known as community rating—employers often complain that they are charged rates that do not accurately reflect the experience of their employee groups.

Non-federally qualified HMOs usually offer many of the same benefits that federally qualified HMOs offer, but they are not required to develop community ratings. Therefore, they can offer more employer-specific premium rates.

- The enrollment status of the HMO.

Ford examines when the HMO began operating, the total membership of the plan and how many employer groups are members, Mr. Kilarski explained. The company also talks with other employers that have contracted with the HMO to find out what their experiences have been with the particular plan.

- The HMO's financial liability and solvency.

Ford investigates issues such as how the HMO would cover the costs of outstanding medical claims if the HMO ceased operating.

- How the HMO sets its premium rates.

Ford determines whether the rates are appropriately calculated

Continued on next page

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Evaluating an HMO

Continued from previous page

for the benefits included in the premium rate, Mr. Kilarski noted.

- The cost-effectiveness of the HMO.

The company evaluates whether the plan really will contain or trim health benefit costs, he said.

- Availability to retirees.

"The plan has to have a Medicare carve-out," Mr. Kilarski said, referring to whether the plan offers coverage to retirees who also are covered by Medicare.

- Administrative costs.

The company also examines the plan's costs for administration—such as costs for day-to-day operations—and what portion of the plan's operating expenses these costs represent, Mr. Kilarski said.

Administration costs should not exceed 20% of operating expenses, he said later.

- The reimbursement mechanisms of the plan.

Ford examines the financial risks and incentives to physicians and hospitals in the plan, he said. The plan must offer some incentive to medical personnel to provide quality, cost-effective care to patients.

- The cost-containment programs and quality assurance.

The company looks at the utilization review procedures and utilization data of the HMO, according to Mr. Kilarski.

- The grievance and complaint procedure.

Ford makes certain that employees have an opportunity to voice complaints and that action will be taken to correct problems, he said.

- The HMO's facilities.

Ford visits the HMO's clinics and hospitals to evaluate the quality of the facility and the treatment of the patients by receptionists as well as medical personnel, he said.

- The type of benefits offered by the HMO, compared with Ford's traditional indemnity plan.

"We try to design a program that is comparable with our traditional plan," he said. This is to ensure that employees opting for HMO coverage will have access to the same types of benefits as employees in the traditional plan, such as psychiatric and substance abuse benefits.

And, according to a survey of Chicago HMOs and PPOs conducted by the Chicago chapter of the ISCEBS, other issues to consider in evaluating alternative delivery systems include:

- The service areas of the HMO or PPO.

This is to ensure that employees in all areas will have convenient access to the plan's facilities.

- The hospitals with which the plan has contracted.

Both the quality and quantity of hospitals are important to ensure that employees opting for HMO or PPO coverage have access to several quality institutions.

- Any unique coverages included in the plan.

These include the availability of prescription coverage, vision coverage, substance abuse benefits, dental coverage, wellness programs, health education, home health care coverage and coverage for emergency care when employees are outside the plan's service area.

- The sponsorship of the plan.

HMOs and PPOs can be owned and operated by hospitals, insurance companies, physician groups or other privately owned corporations.

In addition, several plans now are sponsored by national corporations, such as Humana Corp.'s Care Plus or HMO America's Chicago HMO.

- The administrative staff of the plan.

Employers should evaluate the size of the support staff—such as receptionists—and how well it can accommodate the number of members in the plan.

- Financial information.

This information includes the plan's total revenues, operating expenses and marketing expenses for the current year compared with the previous year.

- Enrollment information.

Employers should examine the plan's membership in the previous year compared with the plan's current membership.

- The number of Medicare and Medicaid beneficiaries enrolled in the plan and what percent of the plan's total enrollment this represents.
- The number of employer groups enrolled in the plan.

Employers should compare the increase in the number of employer groups enrolled in the plan over the previous year.

- The number of physicians participating in the plan and the increase in this number compared with the previous year.
- The percentage of physicians that are board-certified and the percentage that are foreign medical graduates.
- Hospital inpatient utilization data.

This data includes the average length of hospital stays and the rate of admissions per 1,000 members.

- The types of data reports provided by the plan to the employer.

Reports employers may be interested in include cost reports, general utilization review statistics and summary reports.

Careful and organized evaluation of HMOs and PPOs is important to both employers and the plans themselves as the market continues to expand, the experts say.

"I believe the industry will become increasingly competitive," said Ford's Mr. Kilarski. "But, the HMOs and PPOs that respond to employers' needs will be the ones that grow and prosper." ■

Harleysville earnings rise

HARLEYSVILLE, Pa.—Operating income at Harleysville Group Inc. 88.7% in the first nine months of the year to $6.5 million from $3.45 million in the corresponding period of 1985.

During the third quarter, Harleysville's operating income rose 66.9% to $3.3 million from just less than $2 million last year.

Net income rose 116% to $8.6 million in the first nine months from just less than $4 million in last years first three quarters. Third-quarter net income rose 70.5% to $3.4 million in 1986 from just less than $2 million the previous year.

Net earned premiums ballooned 269.5% in the first nine months of 1986 to $102.5 million from $27.7 million in the corresponding period of 1985.

B.R.I. lawsuit

Continued from page 3

While denying any wrongdoing connected with Resources' collapse, B.R.I. also agreed to pay the New York department an additional $125,000 (*BI*, Jan. 20).

Another reason for Mr. Cottone's disenchantment, court papers say, was B.R.I.'s " 'force-out' of partners who had been in the business for 20 years."

The memorandum provides no further details of these events. However, two former B.R.I. partners—Allen Birnbaum and Arthur Ostrofsky—last month filed a petition in New York State Supreme Court to dissolve B.R.I., its holding company and two related entities.

The petition named Mr. Ferrarini, Mr. Miller and six other B.R.I. executives as respondents.

The status of the petition is not known; on Oct. 24, Justice Thomas J. Hughes granted B.R.I.'s motion to seal court records in the case.

A third reason for the disaffection, the memorandum adds, was "the fact that several major insurance companies now refused to do business with B.R.I."

The memorandum does not say which insurance companies have refused and for what reasons.

Mr. Miller declined to comment on Mr. Cottone's memorandum.

In its complaint against Mr. Cottone, B.R.I. says that its former employee signed a "letter of confidentiality and a restrictive covenant" intended to safeguard the brokerage's "customer lists, files, trade secrets and other confidential information."

In addition to agreeing not to disclose any confidential information, Mr. Cottone also agreed that for five years after termination of his employment with B.R.I., he would not solicit business from any B.R.I. clients, the complaint says.

Before he quit the brokerage to join NIA, however, Mr. Cottone photocopied B.R.I. files and took the copies with him, along with some original B.R.I. records and files, the complaint charges.

Mr. Cottone then started to "systematically solicit" insurance business from B.R.I. clients, the complaint alleges. Since joining NIA, Mr. Cottone has "lured away nine B.R.I. accounts and has contacted several others," according to court papers filed by the brokerage, which claims it has lost client premiums of more than $356,000 to Mr. Cottone and NIA.

B.R.I. reported handling total gross premiums of $225 million in 1985, producing gross revenues of $20.1 million for the brokerage.

One client lost by B.R.I. was Jocama Construction Corp., an account originally produced by Mr. Cottone, according to the complaint.

B.R.I. placed property and casualty coverages for Jocama at a minimum premium of more than $30,000 payable at inception of coverage and non-refundable, the complaint says. At Mr. Cottone's request, B.R.I. paid the minimum premium on Jocama's behalf, and Jocama in turn gave B.R.I. a current check for $15,000 and a post-dated check for the balance.

On about Nov. 4, Mr. Cottone and NIA took over the Jocama account, and the construction firm stopped payment on its post-dated check, causing B.R.I. a loss of more than $15,000, the complaint charges.

Mr. Cottone and NIA have not yet filed answers to B.R.I.'s complaint.

In other court papers, however, Mr. Cottone denied raiding B.R.I.'s stable of clients.

"Since Cottone left B.R.I., he has not actively solicited any B.R.I. customers," papers filed on his behalf state.

Mr. Cottone also denied that he had taken any B.R.I. records and described as "total conjecture" B.R.I.'s accusation that he had done so. Mr. Cottone took two cartons of personal belongings but rejected a secretary's suggestion that he took a "tickler file" of B.R.I. clients, court papers say.

While B.R.I. claims that Mr. Cottone signed a confidentiality agreement and restrictive covenant when he joined the firm in 1979, Mr. Cottone denies that he signed such an agreement until 1981, when Mr. Miller told him that he would be terminated as an employee if he did not sign, court papers say.

In papers opposing B.R.I.'s motion for a preliminary injunction, Mr. Cottone also argues that the restrictive covenant is not enforceable since the information that he is accused of using does not qualify for trade secret protection.

The names of the brokerage customers in question are readily available from public sources—such as business directories or phone books—that any broker could use, Mr. Cottone argued.

In addition, Mr. Cottone produced all but three or four of the 50 to 60 accounts he handled at B.R.I. through recommendations from friends, family members, longtime acquaintances and neighbors, according to court papers filed on his behalf.

"He accumulated a client base almost entirely from his own network of friends and acquaintances, not from leads or prospects supplied or suggested by B.R.I., making it especially inequitable to suggest that he be enjoined from dealing with customers that he identified and developed himself," court papers say.

The operations of B.R.I. itself are not so unique as to qualify for trade secret protection, Mr. Cottone argues.

While B.R.I. contends that it enjoys special relationships with underwriters, the only evidence of those relationships offered by Mr. Miller in a deposition were the facts that B.R.I. spends $100,000 a year "wining and dining" insurers and another $100,000 a year on advertising intended to be seen by insurers, according to court papers filed by Mr. Cottone.

Mr. Cottone testified in a deposition that the NIA's methods of brokering business are similar, if not identical, to B.R.I.'s, court papers say.

Mr. Cottone also argues that he does not possess any "unique or extraordinary skills or abilities" that would make a non-competitive covenant enforceable.

Judge Ward has ordered discovery proceedings in the case to be completed by Feb. 27, with motions for summary judgment or pretrial orders due one month later. ■

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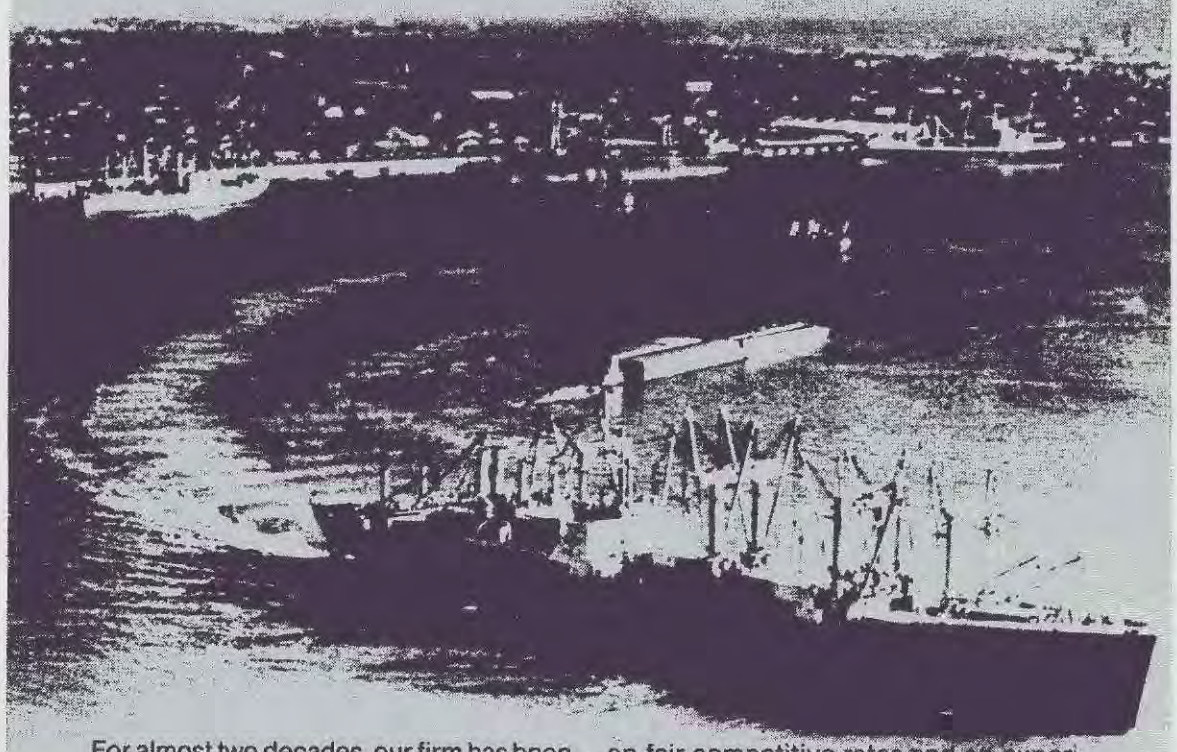

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D&O lawsuits also increasing in Europe

By JOHN PARRY

PARIS—While European corporate directors and officers are not as affected by the D&O liability insurance crunch as their U.S. counterparts, D&O lawsuits in Europe are increasing, observers say.

However, different laws and attitudes in most European countries preclude a deluge of D&O litigation like that in the United States, said experts at a recent symposium organized by the International Chamber of Commerce.

Moreover, they said there are indications that litigation against U.S. directors and officers has peaked and coverage will be more obtainable in the next few years.

Corporate directors and officers, attorneys and insurers attended the one-day seminar, held last month in Paris, to discuss the growing frequency of D&O liability suits in Europe.

According to a report prepared by the ICC Secretariat for the meeting, European managers increasingly will face the possibility of litigation, as well as higher costs incurred to defend such lawsuits.

U.S. corporations particularly are at risk because it is virtually the only developed nation that allows class-action litigation, said Ewald Lederer with Peat, Marwick, Mitchell & Co. in Paris.

But, despite the lack of a class-action system, European directors and officers are facing increased litigation, he said.

"Although we in Europe are most often blessed by the absence of the class-action system, the level of litigation observed by us in the United States can, unfortunately, be seen as inciting litigation in Europe also," he said.

The D&O litigation explosion, Mr. Lederer said, has had a potentially damaging effect on U.S. productivity and economic vitality.

And, he said, it has had an effect in Europe, where people are now hesitating to become outside directors of companies.

"After all, outside directors generally have a small personal economic interest in the companies on whose boards they sit," he said. "Why would anyone like that take on a liability that puts his personal assets at risk? Yet the outside director is one of the pillars of our corporate governancy system.

"The absence of vested interest, combined with a wealth of experience and fresh perspective on management decisions, makes the outside director an important check on the conduct of business."

Regarding U.S. litigation, Mr. Lederer said the U.S. legal system has two very real failings: the absence of a clear standard of liability and "a system that is less concerned with putting wrongs right than redistributing wealth from defendants to attorneys."

Dieter Spielberger, managing partner of Gradmann & Holler International GMBH of Stuttgart, West Germany, said that as a broker he is particularly concerned about the availability of D&O coverage for European companies.

In West Germany, he said, the insurance market is strictly regulated, in which only legally approved insurance companies can operate. Until two months ago, none of these insurers had been licensed to offer D&O coverage, but he said in recent months at least one company as received a license.

Such insurance previously was offered through the London market or by U.S. underwriters, Mr. Spielberger said.

"Certainly the exposure is there—a remarkable amount of claims have been litigated—but there seems to be one important obstacle: Those who are more interested in the coverage are not the people on the advisory board who represent the shareholders or the workforce, but the management, which certainly stands farther up front.

"But the management seems to have difficulties to explain to the shareholders why they should bear the cost for satisfying claims that the management incurs by its own fault," Mr. Spielberger said.

"As the public claims-mindedness is still growing and as the reluctance on the industry side in filing claims against their directors and officers in order to avoid detrimental publicity is declining, coverage for this liability will gain momentum and the demand (for D&O coverage) will grow," Mr. Spielberger predicted.

"Unless the single market which now exists is hit by disasters—which is quite unlikely—the markets will open up for competition.

"At any rate," he said, "it can be recommended to those insurance carriers who lost their capacity in the American market to make up for that by underwriting European risks because in this type of liability area—compared to a situation in the United States—we still have here a paradise."

But this position was disputed by Tor Kvarnbaeck, head of the legal department at Swedish conglomerate Procordia.

Too many European companies, Mr. Kvarnbaeck said, "think that since they have elected a director or officer, they have to protect him against all evil, even when he has brought it on himself."

But, he said, "Under Swedish law someone who accepts a seat on the board of directors thereby accepts full responsibility for his qualifications.

"If directors and officers are caught in Europe (in illegal acts), they have been either stupid, ignorant or disloyal and companies are not going to protect them against any of these things," he said.

British common law supports this view, according to Peter Blackmore, technical director of Directors & Officers Ltd., a British recruiting firm.

"In the past, it has been the common view that the duties imposed on directors in the U.K. are not particularly onerous and that there is little risk of personal liability attaching," Mr. Blackmore said.

"There is increasing evidence that this view is changing and this is supported by recent trends in the U.K., such as the requirement for higher standards of professionalism by management generally and the increasing tendency for those who have suffered loss to search for someone to blame and, if possible, to sue," he explained.

Corporate directors' exposure to personal liability in the Britain generally arises when a company enters liquidation, Mr. Blackmore said. But, he noted the British Companies Act of 1985 allows shareholders to bring action against directors for misstatements in prospectuses that have led shareholders to lose money.

"The successful defense, by accountants, of negligence claims must expose the directors to a greater liability," he said. "This must, in turn, increase the attraction of (D&O) insurance." ■

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Mission liquidation discussion

Continued from page 2

"would be irresponsible" if the regulators did not consider the possibility that the plan might not save the insurer.

The San Francisco meeting was held "to figure out all the different things that can happen and have a plan for each of those different scenarios," said Mr. Rubinstein, who practices law with the Dallas firm of Freytag, Perry, LaForce, Rubinstein & Teofan.

"Liquidation is never the only alternative. We're only going to go to liquidation if no other reasonable solution that protects the policyholders can be found," he noted.

A liquidation of Mission, a major workers compensation and commercial liability insurer, would trigger state guaranty funds in states where Mission wrote policies on an admitted basis.

The chief obstacle to Mission's reorganization plan continues to be the insurer's inability to collect outstanding reinsurance payments it says it is owed. A team of actuaries, accountants and attorneys is working to increase the flow of incoming reinsurance proceeds, Mr. Rubinstein notes.

Since the pending financial restructuring of Mission's parent, Mission Insurance Group, depends on the success of the insurer's plan, the inability to collect Mission Insurance Co. reinsurance proceeds also threatens MIG's viability.

Negotiations have taken place since Mission was placed in conservation among companies that ceded reinsurance to Mission, companies that reinsured Mission, MIG's corporate debtholders, regulators in several states and a host of attorneys. A tentative agreement reached by the parties—and approved by Los Angeles Superior Court in March—led many to believe that an end to Mission's financial woes was only as far away as putting the final touches on the reorganization's legal documents (*BI*, March 17).

Basically, that plan calls for companies that ceded reinsurance to Mission to accept "surplus notes" in lieu of reinsurance recoverable and for all direct business that Mission wrote to be transferred to the new Mission America Insurance Co. But MIG officials announced in late September that the decreasing amount of reinsurance proceeds recovered by Mission and growing underwriting losses could thwart the plan's success.

Yet, the California department was determined to proceed with reorganization despite Mission's assessment, and the definitive version of the reorganization agreement was signed by all parties in mid-October (*BI*, Oct. 27).

It still must be submitted for court approval.

Mr. Rubinstein essentially is now in charge of the Mission conservation.

Joseph A. Morton continues to be involved with Mission but retired last month from his position as California's chief of conservation and liquidation. In that position, Mr. Morton had supervised Mission since it was placed in conservation.

Mr. Rubinstein said representatives from only about five guaranty funds were invited to last month's meeting, but he declined to say which guaranty funds were represented.

Among those represented was the Washington Insurance Guaranty Assn., *BI* learned. Mission wrote $4.5 million in premiums on an admitted basis in Washington in 1984.

The California Insurance Guarantee Assn. referred all inquiries about Mission to California Insurance Commissioner Roxani M. Gillespie. In a statement released by her office, Ms. Gillespie would only say that the department continues to pursue rehabilitation and will announce any developments as they occur.

Mission wrote most of its premiums in California, with $205 million in direct written premium in the state in 1984 out of total 1984 premiums of $311.7 million.

Representatives from Mission were not invited to the meeting; neither were officials from the National Committee on Insurance Guaranty Funds in Schaumburg, Ill.

Representatives of several guaranty funds in states where Mission wrote significant premiums on an admitted business —including Missouri, Florida, Georgia and Ohio—say they were not even aware the meeting was held.

Officials representing the Oklahoma Property/Casualty Insurance Guaranty Assn. said they were not at the meeting. Mission wrote $10.5 million in premiums on an admitted basis in that state.

Officials of guaranty funds in other states where Mission wrote significant premiums on an admitted basis—New York, Texas and Louisiana—could not be reached for comment. ■

School insurers

Continued from page 2

Ltd. and X.L. Insurance Co. Ltd.

Coverage under this form, also known as a "reported occurrence" form, is triggered when notice of occurrence or a claim is filed by a policyholder (*BI*, July 21).

When excess facilities use the same form, it is easier for policyholders to build limits.

Meanwhile, University College Mutual Insurance Co., which was formed following a Wyatt Co. feasibility study, does not plan to start writing business until it has accumulated at least $2.5 million in capital from the 200 schools in the University Risk Management & Insurance Assn.

Initial capital required will range from $5,000 for small schools to $300,000 for schools with 30,000 or more students, said Gary R. Harris, director of risk management and insurance at the University of Cincinnati. Capital requirements in excess of $75,000 can be half funded by a letter of credit.

UCMIC plans to use the same educators legal liability claims-made policy form as SCUUL, although it has dubbed it "wrongful acts" coverage, noted Mr. Harris, who has been active in the development of both programs.

Deductibles will begin at $5,000, said Mr. Walker.

Officials of both groups say the programs are needed because commercial coverage is too expensive or not available.

With some exceptions, Ms. Calais said, if such institutions can get coverage at all, they are being asked to pay as much as 400% more for restrictive coverage despite the fact that educational institutions' claims history is better than that of the market overall.

Mr. Walker noted the University of Alabama at Birmingham has self-insured its educators legal liability risk for the last two years since it lost its D&O coverage two years ago when CNA Financial Corp. pulled out of the market.

Both groups developed, despite the overlap, because "no one was sure either concept would get off the ground," said Ms. Calais.

Mr. Walker and Mr. Harris also suggested that the two groups are not duplicative because public and smaller schools might be more attracted to UCMIC, as a non-profit mutual that does not require a significant amount of capital. Meanwhile, as a stock, for-profit insurer, SCUUL would be more attractive to large, private schools as an investment opportunity.

No reinsurance has been secured by UCMIC or SCUUL.

UCMIC is negotiating with Corroon & Black Management Inc. for management services, said Mr. Walker. M&M in Bermuda will manage SCUUL and independent underwriters will be hired. ■

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Wyatt survey

Continued from page 3

senting a broad cross-section of American business and industry.

In addition, some 263 employers —the so-called core group—were also surveyed in Wyatt's 1984 and 1982 studies to give a clear picture of trends in health care cost-containment techniques and practices among the same group of companies.

Of the 1,418 employers, about 25% were relatively small, with between 10 and 249 employees. Medium-size employers—those with between 250 and 1,000 employees —comprised one-third of surveyed companies, while the remaining companies had more than 1,000 employees.

"The participation of more small and medium-size employers makes the sample more nationally representative in terms of employer size and industrial categories than prior surveys," Wyatt said.

One health care cost-containment technique growing in popularity is self-funding. Some 60% of the core employer group reported that they self-funded their medical plans this year, up only slightly from 59% in 1984 but up sharply from 40% in 1982.

"Employers are much more willing to assume a greater share of the risk," Mr. Menefee said, noting that by self-funding, employers often can cut health care costs substantially.

While a majority of the core group reported that they now self-fund medical care benefits, self-funding is much less common for other popular employee benefits.

For example, among the core group, just 12% said they now self-fund basic life insurance, while 7% said they self-fund optional life insurance and 34% reported self-funding long-term disability benefits. However, 63% of the core group said they self-funded short-term disability benefits.

All the employers surveyed in 1986 reported dozens of ways of funding their medical care programs. But the most widespread funding arrangements included: self-funding through Voluntary Employee Beneficiary Assns., also known as 501(c)(9) trusts, 15%; self-funding without a trust, 15%; buying coverage from a commercial insurer, 9%; funding through a minimum premium plan, 9%; and buying coverage from a Blue Cross/Blue Shield plan, 7%.

Among the core group surveyed between 1982 and 1986, the use of a 501(c)(9) trust has soared.

This year, some 30% of the core group said they self-funded medical benefits through a 501(c)(9) trust, up from 22% in 1984 and 10% in 1982.

"We are seeing a much more educated consumer," Mr. Menefee said, noting that years ago some employers were not aware of what a 501(c)(9) trust was and the opportunities for cost containment that such a trust offers.

Under a 501(c)(9) trust, an employer can take an immediate tax deduction for contributions—up to certain limits laid down by the 1984 tax law—to the trust. Reserves, which must be used to pay for employee benefits, accumulate interest tax-free.

Although the most-common use of 501(c)(9) trusts is the funding of medical benefits, the popularity of the trusts for non-medical benefits clearly also has risen, according to the survey.

For example, this year, 22% of the core group reported self-funding LTD benefits through a 501(c)(9) trust, up from 16% in both 1984 and 1982, while 9% used the trust to self-fund short-term disability benefits, up from 6% in 1984 and 5% in 1982.

In addition, 5% of the core group self-funded basic life insurance through a trust this year, unchanged from 1984 and up from 1% in 1982, while 3% in 1986 use a trust to fund optional life insurance, compared with 2% in 1984 and 1% in 1982.

In benefit plan design trends, the survey reveals that a deductible of less than $100 in comprehensive medical care plans has become an anachronism.

For example, in 1982, some 40% of the core group said their medical plan deductible ranged between $50 and $99. But by 1984, the $50 to $99 deductible had slumped to 8% and now is offered by just 3% of employers.

In addition, some 39% of the core group said their medical plan has a $100 deductible, down from 41% in 1984 and 46% in 1982.

And annual deductibles under $50 have been just about extinct for some time. Just 3% of employers now include such a deductible, a percentage that has remained virtually constant over the last four years.

At the other end of the spectrum, some 55% of employers in the core group now require employees to pay an annual deductible of more than $100, up from 39% in 1984 and 9% in 1982.

"That old under-$100 deductible is gone. There is a conscious effort on the part of the employer to shift more costs onto employees," Mr. Menefee said.

When employers raise deductibles, "employees become more aware of the cost of the program," he added.

While the overwhelming majority of surveyed employers provide post-retirement health care benefits, few companies prefund such programs, according to the survey. About 75% of **all the surveyed?** employers said they use some type of pay-as-you-go funding arrangement such as purchasing a group insurance contract.

However, about 15% of the employers said they used a 501(c)(9) trust to fund post-retirement health care benefits even though the 1984 tax law has reduced the appeal of such a funding technique. Under that law, known as the Deficit Reduction Act of 1984, investment income earned on reserves to pay for post-retirement health care benefits is taxed.

As is the case with employees' health care programs, employers are using a wide variety of techniques to control retirees' health care costs.

The most popular techniques to control retirees' health care costs among all surveyed employers in 1986 include coverage for: outpatient surgery, provided by 92% of employers; preadmission testing, 80%; home health care, 77%; alcohol abuse treatment, 69%; drug abuse treatment, 65%; extended care facilities, 65%; and hospice care, 63%.

In addition, employers are taking more steps to monitor and reduce retirees' health care costs. More than 60% of the employers said they now keep separate medical cost records for employees and retirees.

At the same time, 9% of the employers said they were considering reducing post-retirement health medical care coverage, while 1% said they were considering the elimination of coverage.

However, 5% said they are now evaluating the implications of expanding retiree medical care coverage.

Although flexible benefit programs often are trumpeted as the benefit program of the future, the survey reveals that such plans, which give employees the opportunity to choose from a menu of benefits, continue to be the exception in corporate America. Just 11% of the surveyed employers said they now offer a flexible benefit program.

Flexible benefit programs offered vary considerably in design. For example, 19% of the employers with flexible benefit plans give employees a choice among different complete benefit packages, while 31% offer a core group of benefits plus optional benefits, and 26% allow employees to create their own program from a pool of benefit options. Some 24% of the employers with flexible benefit plans did not specify how they structure their programs.

When flexible spending accounts were offered, typically they were funded by employees, such as through salary reduction, rather than by employer contributions.

For example, 70% of FSAs used to pay for medical expenses were funded by employee contributions only, 26% by employer contributions only and 4% through a combination of employer and employee contributions.

For a wide group of FSAs used for other benefits—dependent care, prescription drugs, vision care and dental care—funding in about three-quarters of the cases was through employee contributions only.

On the other hand, in the case of FSAs covering group legal expenses, employee contributions only were found in just 56% of plans, while in 19% of plans, employer contributions funded group legal expenses and in 25% of plans, funding was through a combination of employer and employee contributions.

According to the survey, employers' health care costs varied by size of company, with the smallest and largest companies having the highest expenses, but costs being more moderate among midsized employers.

For example, companies with

Continued on next page

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Continued from previous page
fewer than 100 employees reported average health care costs of $1,554 per employee in 1986—the highest of any size group. Giant companies—those with more than 5,000 employees—were just behind with an average health care cost of $1,522 per employee.

But health care costs were much lower among medium-sized employers. For example, companies with between 250 and 499 employees reported the lowest health care costs—$1,382 per employee—followed by companies with between 500 and 999 employees, where the average cost per employee was $1,385.

Health care costs per employee in 1986 among other size categories of employers include: employers with between 100 and 249 employees, $1,461 per employee; between 1,000 and 1,999 employees, $1,415 per employee; between 2,000 and 4,999 employees, $1,462 per employee.

The Wyatt Co.'s Mr. Menefee said health care costs are high among smaller employers because they may be too small to self-fund and because they don't produce enough premium to have much buying clout in the group health insurance market.

On the other hand, while bigger companies have more clout in the market and the size to self-fund, their health care programs tend to be more generous than those of smaller companies, Mr. Menefee said.

Medium-sized companies are large enough to win discounts in the group market and also can self-fund, but their benefit programs tend to be less rich than the biggest companies—hence their lower health care costs compared with big and small employers, Mr. Menefee said.

●

A limited number of single, free copies of "1986 Group Benefits Survey: A Survey of Group Benefit Plans Covering Salaried Employees of U.S. Employers," are available from The Wyatt Co., Research and Information Center, 1850 M St., N.W., Suite 400, Washington, D.C. 20036; 202-887-4600.

European court backs freedom of trade issue

LUXEMBOURG—Corporate insurance buyers in European Community nations now may purchase coverage from insurers in any EC nation following a decision by the European Court of Justice.

The court ruled last week regulations in West Germany, France, Denmark and Ireland that block the cross-border placement of insurance are illegal under the European Economic Community Treaty, known as the Treaty of Rome.

The court's decision means that a policyholder anywhere in the European Community now can place business directly with Lloyd's of London underwriters without first fronting the risk through a domestic insurer and then reinsuring with Lloyd's underwriters.

Lloyd's Chairman Peter Miller said he believes the judgment will result in a steady increase in premium volume for Lloyd's rather than a quick burst. "We do not anticipate, nor do we seek, an overnight bonanza arising from the judgment. Rather, we look forward to a steady increase in the volume of our European business from clients attracted by flexibility, security and competitiveness of Lloyd's policies."

The ruling ends a three-year battle by the European Commission, backed by Britain and the Netherlands, to break down trade barriers in the European insurance market.

In cases filed in 1983 and 1984, the commission challenged the requirement imposed by the four countries that the lead underwriter of an insurance program be both established and authorized to operate in the country in which the risk is located.

In May, Sir Gordon Slynn, the court's senior advocate general, supported the commission in a preliminary opinion; however, the European Court of Justice was not obligated to follow the advocate general's opinion (*BI*, May 26).

Mr. Miller said he believes the ruling will solve only some insurance-related problems in the EC.

"The judgments do not solve all the problems, but they constitute a step forward in the development of a true common market for insurance services," Mr. Miller said. "Lloyd's has long believed that proper freedom of insurance services will be beneficial in the wider context of the completion of the common internal market." ■

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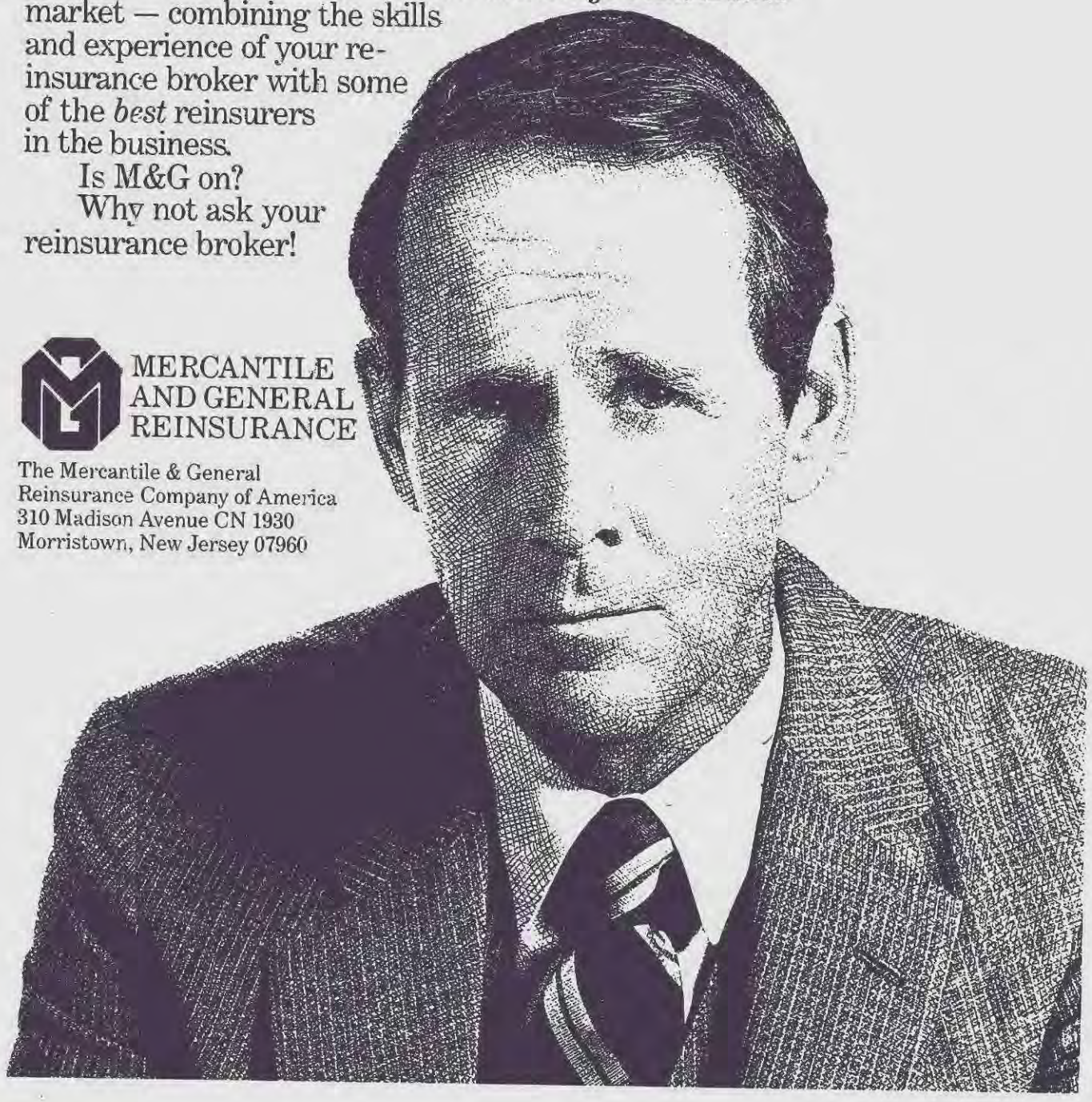

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• The latest Settlement Services newsletter from Merrill Lynch Settlement Services Inc. features **"Why Assignments Should Be Considered in Structured Settlements."** The article appearing in the newsletter includes a chart of the number of options available with pertinent information regarding those assignee companies. It also contains articles covering the use of structured settlement assignments by self-insureds, government agencies and in workers compensation cases. For a free copy, contact Ann LaBruna, Merrill Lynch Structured Settlement Services Inc., 225 S. Lake Ave., Suite 700, Pasadena, Calif. 91101; 818-793-1800.

• DIGEST, a quarterly review of **workers compensation issues** published by the National Council on Compensation Insurance, is being distributed without charge to insurance professionals, regulators, legislators, academics and libraries. To be placed on the mailing list, contact Kathleen Spicer, Public Affairs, NCCI, 1 Penn Plaza, New York, N.Y. 10119; 212-560-1014.

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Vice-presidents, General Managers and Other Administrative Personnel 2,601

Financial:

Chief Financial Officers and Vice-presidents of Finance 1,890
Secretaries, Treasurers, controllers and other Financial Personnel.. 6,127

Risk/Employee Benefits:

Vice-presidents, directors, managers, and other related department personnel of: insurance, risk, employee benefits, personnel, compensation, pension, safety, security, industrial relations, human resources and employee/labor relations.... 7,471

Sub-total 20,892

Associations 477
Government, Unions and Educational Institutions 1,357

Commercial Consumers

Sub-total 22,726

Insurance Agents and Brokers 10,795
Insurance Companies 7,168
Financial Institutions 897
Actuaries, Attorneys, Adjusters, Appraisers and Consultants 4,536
Others Allied to the Field 1,505
TOTAL 47,627

* Source Business/Occupational breakdown of qualified circulation, May 26, 1986 issue, as submitted to BPA for June 1986 BPA Publisher's Statement.

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HOLIDAY NOTICE

Due to the holiday season, the Professional Marketplace will have the following closings:

Monday, December 29
closes
Friday, December 19

Monday, January 5
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Wednesday, December 24

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~~Dec 8~~	~~Nov 25~~
Dec 15	~~Dec 3~~
Dec 22	Dec 9
Dec 29	Dec 16
1987	
Jan 5	Dec 23
Jan 12	Dec 30
Jan 19	Jan 7
Jan 26	Jan 13
Feb 2	Jan 21
Feb 9	Jan 26
Feb 16	Feb 3
Feb 23	Feb 11
Mar 2	Feb 18
Mar 9	Feb 25
Mar 16	Mar 4
Mar 23	Mar 10
Mar 30	Mar 17
Apr 6	Mar 24
Apr 13	Mar 31
Apr 20	Apr 8
Apr 27	Apr 15
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Reinsurers' results

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catastrophes this year has obviously helped us, and helped all reinsurance companies."

"This year has been particularly good to reinsurers, and of course one of the large reasons for it is catastrophe losses have been minimal," said Frank Haftl, president and chief operating officer of Metropolitan Reinsurance Co. in New York. "It was of great assistance to what people call the 'turnaround.' "

Met Re, which ranked as the 21st-largest reinsurer in the nine-month RAA survey with $102.9 million in net premiums written, posted a 97.7% combined ratio for the period, compared with 129.9% in last year's comparable period.

"Met Re has maintained an excellent reserve position, and as as result of a lack of natural catastrophes and increasing primary and reinsurance rates, there was a substantial reduction in our combined ratio," Mr. Haftl noted.

The entire group of 70 reinsurers surveyed by the RAA reported a 79.8% loss ratio for the nine-month period, while the Top 20 alone posted a 80.1% ratio. However, the Top 20 edged slightly ahead of the overall group on the expense side, posting a 24.7% expense ratio compared with the overall group's 25.1% expense ratio.

The Top 20 reinsurers also edged ahead of the industry overall in growth in net reinsurance premiums. The Top 20's net premium volume increased 56.1% during the first nine months to $7.4 billion, while the overall industry's volume grew 51.4% during the same period to $9.2 billion.

Several reinsurance executives said that while they expect improved underwriting results to continue at least through next year, they do not anticipate the same dramatic year-to-year comparisons during 1987.

"I certainly don't see the same improvement in '87 over '86 as we saw in '86 over '85, but most likely there'll be some further improvement in '87 for the market in general," said Mr. Bunaes, whose company, Constitution Re, posted a nine-month combined ratio of 101.9%, an improvement from 110.8% for the comparable period of 1985.

"Reinsurers should continue to see improvement through 1987," agreed Norman M. Wayne, president of the CIGNA Corp. Property & Casualty Group's reinsurance division, whose responsibilities include INA Reinsurance Co. in Philadelphia.

The current cycle will not peak this year "by any means," Mr. Wayne said.

Other reinsurance executives were less optimistic.

Michael Fitt, chairman and chief executive officer of Employers Reinsurance Corp. in Kansas City, Mo., said, "I can already see a leveling off of this cycle, which obviously is not going to stay level very long."

People already are talking about winning market share, and there has been some softening of rates for property lines, Mr. Fitt noted.

Edward Jamison Jr., chairman and president of Buffalo Reinsurance Co. in Woodland Hills, Calif., said, "I'm concerned that if the industry shows too much profitability in 1986, it will provide the incentive to cut rates again, which I think would be highly premature."

Other potential problems are looming as well, according to James E. Dwane, president of the Prudential Reinsurance Group in Newark, N.J.

"I think 1987 should be a reasonably good year," but only if reinsurers maintain adequate reserves for environmental pollution and asbestos losses, he said.

Richard White, senior vp and chief financial officer of Skandia America Group in New York, whose combined ratio improved to 114% from 129.3% in the first nine months of 1985, attributed his company's higher-than-average combined ratio to its reluctance to "release prior year reserves to income. We're taking a little bit more conservative view" than other companies, he said.

Some companies could be making the decision that they are over-reserved for some years and are using this perceived excess reserve to bolster their current results, Mr. Dwane agreed.

"I would say that's a possibility. I would hope that companies did not take that approach prematurely," he added.

But reinsurers, on the whole, were generally optimistic about their own companies' prospects for the rest of the year and 1987.

"We improved very significantly, and we continue to be very conservative in our assumptions," said N. David Thompson, president and chief executive officer of North American Reinsurance Co./Swiss Reinsurance Co. in New York.

"We expect the trend to continue for a time, barring the things that can always disrupt the insurance results," he added.

Mr. Thompson noted that North American Re is keeping a close eye in particular on inflation in both claims and the economy because of their impact on reserving practices.

"It pays to remain conservative these days," he said.

North American/Swiss Re posted a 109.1% combined ratio in the first nine months, compared with a 117.7% ratio in the same period of 1985.

Continued on next page

Injured athletes

Continued from page 3

have an influence on similar cases brought in other states.

"Any place a state looks for guidance, New York has always led the way," Mr. Coopermar. explained, adding the decision against Mr. Turcotte is "a hook the state courts can hang their hats on if they are favoring operators" of an event instead of participants.

Marshall Cox, an attorney with Cahill Gordon & Reindel in New York, which represented the NYRA, said the decision clarifies the question of the duty of care "owed to one who chooses to participate in an athletic event."

The appellate court's opinion states that Mr. Turcotte, by participating in the race, "consented that the duty of care owed him by defendants was no more than a duty to avoid reckless or intentionally harmful conduct. Although a sport's safety rules are an important consideration in determining the scope of plaintiff's consent, the alleged violation of the rule in this case did not constitute reckless or intentional conduct and the complaint against defendants Fell and Reynolds was properly dismissed," in a prior ruling.

David P. Reynolds owned the horse ridden by Mr. Fell.

The appellate court opinion further states that the "NYRA's duty is similarly measured by plaintiff's consent to accept the risk of injuries that are known, apparent or reasonably foreseeable consequences of his participation in the race."

If a professional athlete in a sporting event "makes an informed estimate of the risks involved in the activity and willingly undertakes them, there can be no liability if he is injured as a result of those risks," the opinion reads.

Martin Lieberman, an attorney with the NYRA, said he believed the Turcotte decision "would appear to curtail the initiation of such litigation" in the future.

He said the Court of Appeals spent almost equal time considering whether the injury was caused by the carelessness of a coparticipant in the race and the scope of care owed by the operator of the track to riders.

In its ruling, the court "recognized our position all along," said Mr. Lieberman, and confirmed that the "nature of the contest and the voluntary participation" of the jockey meant the rider was aware of the risks of his profession.

Mr. Cox praised the ruling, saying that, although there have been a number of cases brought by injured athletes over the years, this case is the first to adequately clarify the question of duty of care.

"I think this one, in terms of dealing with that particular subject, does certainly clarify that area in New York," he said.

The case is "important to athletes and athletic facilities for that reason," Mr. Lieberman added. "The opinion goes far beyond thoroughbred horse racing."

And Mr. Cox agreed that the ruling could have an effect on similar cases in other states.

"It's hard to predict" what kind of sway the ruling might have on a case in another area, he said. But, he added that the New York Court of Appeals is regarded as "one of the stronger state courts of last resort. . . .It is and ought to be, well-regarded."

Mr. Lieberman said the unanimous decision of the judges sends a strong signal to other states that are faced with similar cases.

"Our sister states have always exercised great deference to the New York Court of Appeals, and I think they will continue to do so," he said.

If a similar suit surfaces in a state other than New York, the court handling the case "may well be influenced" by the ruling against Mr. Turcotte, Mr. Cox noted.

Mr. Cox would not say whether the NYRA had insurance that would respond to any settlement from a suit such as the one brought by Mr. Turcotte, but the attorney hinted that the association's coverage was not substantial.

"I'm reluctant to discuss the whole question of coverage," said Mr. Cox, but he noted that, "the general proposition is that liability insurance is even harder to get" now than it used to be.

Mr. Cox added that, "One of the things that is a matter of public record, at least with respect to various public sporting fields and arenas in New York state," is the concern of state officials that there is a lack of liability insurance for such facilities.

While exact figures were unavailable, Mr. Cooperman said Mr. Turcotte has been receiving only a small workers compensation payment each week since the accident.

One insurer that specializes in providing permanent disability insurance for athletes says the New York decision may increase the awareness of the need for such coverage.

Steven Kurlansky, director of group special projects at State Mutual Life Insurance Co. of America in Worcester, Mass., said, "If an athlete is capable of generating a large income, that income should be protected," from a career-ending injury.

"This may create an awareness for protecting that income," he remarked. ■

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Largest U.S. reinsurers' nine-month 1986 results

(All amounts in thousands of dollars) (Ranked by net reinsurance premium written)

Reinsurers	Policyholders' surplus (reinsurers only)	Net reinsurance premiums written 1986	Net reinsurance premiums written 1985	Net reinsurance premiums earned	Losses & loss adjustment expenses	Loss ratio	Underwriting expenses	Expense ratio	Combined ratio 1986	Combined ratio 1985
General Re	$1,603,672	$1,805,093	$1,098,311	$1,541,397	$1,249,457	81.1%	$415,949	23.0%	104.1%	112.7%
Employers Re	630,977	880,573	496,198	762,505	639,627	83.9	190,953	21.7	105.6	114.9
American Re	374,407	702,666	493,741	666,957	490,816	73.6	175,007	24.9	98.5	118.9
North American/Swiss Re	360,504	545,019	404,097	483,678	376,488	77.8	170,563	31.3	109.1	117.7
Prudential Re	302,932	457,476	362,995	417,366	314,767	75.4	134,566	29.4	104.8	129.0
Munich Re	228,363	450,540	307,844	415,418	290,811	70.0	132,601	29.4	99.4	110.1
Kemper Re	215,253	307,237	185,167	293,713	260,551	88.7	54,940	17.9	106.6	122.0
National Re	132,333	256,268	143,299	238,172	219,137	92.0	34,122	13.3	105.3	116.8
USF&G	N/A	218,561	58,654	168,455	121,873	72.3	58,431	26.7	99.0	108.0
INA Re	153,505	211,783	166,081	203,326	157,937	77.7	61,711	29.1	106.8	127.4
Continental Re	106,057	209,864	136,435	190,587	146,804	77.0	56,348	26.8	103.8	112.8
Transatlantic Re	103,693	201,732	117,249	172,384	146,975	85.3	49,667	24.6	109.9	128.1
St. Paul Re	N/A	175,896	115,741	163,182	116,721	71.5	46,753	26.6	98.1	121.7
Constitution State Mgt.	N/A	166,121	89,809	135,305	115,121	85.1	39,551	23.8	108.9	118.9
Constitution Re	94,210	160,534	101,096	131,107	101,857	77.7	38,859	24.2	101.9	110.8
Skandia America Group	248,434	155,693	107,512	146,252	124,228	84.9	45,374	29.1	114.0	129.3
New York Ins. Ex.	N/A	150,287	157,202	159,333	148,586	93.3	53,591	35.7	129.0	149.8
Home Re	55,257	131,567	50,373	98,493	78,925	80.1	23,375	17.8	97.9	111.0
Buffalo Re	130,293	130,503	125,215	136,849	126,399	92.4	21,486	16.5	108.9	123.2
Continental Casualty	N/A	124,823	52,114	120,597	98,111	81.4	31,980	25.6	107.0	121.3
Totals for top 20	**4,739,890**	**7,442,236**	**4,769,133**	**6,645,076**	**5,324,591**	**80.1**	**1,835,827**	**24.7**	**104.8**	**118.6**
Total for all companies	**6,217,606**	**9,217,694**	**6,087,785**	**8,261,666**	**6,589,990**	**79.8**	**2,312,813**	**25.1**	**104.9**	**119.3**

Source: Reinsurance Assn. of America

Continued from previous page

Employers Re's Mr. Fitt, although not overly optimistic about the state of the market, noted that his company is "continuing to grow."

"I am very bullish on the next couple of years," he said. He added that even if the market again begins to soften, "you don't have to lose money on the downturn. You just don't make as much, if you manage the business well."

Mr. Fitt noted that for the nine-month period, Employers Re had a 105.6% combined ratio, compared with the 104.9% average posted by the 70 reinsurers surveyed by the RAA, because it has "done a good job strengthening reserves" this year for business dating back to the early 1980s.

"I feel this was not a time to give up on strengthening loss reserves," he said. But he would not say by how much reserves have been strengthened except to note "it's a large number."

David B. Mathis, chairman and chief executive officer of Kemper Reinsurance Co. in Long Grove, Ill., said his company's combined ratio "improved over what it was last year, and I expect it to continue to improve, barring some unforeseen catastrophe, which is obviously a potential in the reinsurance business."

Kemper Re posted a 106.6% combined ratio in the first nine months, compared with a 122% ratio for the comparable period a year ago.

Mark Hinkley, executive vp of Trenwick Reinsurance Corp. in Westport, Conn., whose company posted a 99.4% combined ratio in the first nine months of the year, said he was pleased with the results. "We're still in the midst of a good, functioning reinsurance market," he noted.

"We think this is to the advantage of well-positioned reinsurance companies," he said.

As for the future, he said, "We view the market as pretty resilient." He added that while there are opportunities, there also are negative "cross-currents" in the industry, including losses produced by previously written business.

Mr. Hinkley also noted that Trenwick is rapidly increasing its premium volume. The company reported net written premiums of $37.5 million in the first nine months of 1986, more than triple the $11.1 million reported in the comparable period a year ago.

Trenwick's parent, Trenwick Group Inc., received net proceeds of $81.8 million from the sale of 3.3 million common shares and an overallotment of 495,000 shares in June (*BI*, Nov. 10).

Walter Gross, vp and treasurer of Continental Reinsurance Corp. in New York, noted that his company, with a 103.8% combined ratio, is not yet posting an underwriting profit. But he said, "It's something we'd like to see. Whether we will or not remains to be seen. We have a way to go yet, and I would say the last quarter has been encouraging.

"We're just hoping it's going to sustain itself for the remainder of '86 and into '87."

Mr. Gross noted that rates hikes for international reinsurance business, an area in which Continental Re is active, have "taken a little bit longer to find the bottom line" than domestic reinsurance rate hikes.

Martin Jackson, president of Home Reinsurance Co. in New York, said, "I would nthink we'd certainly maintain our performance for the rest of the year."

Home Re posted a 97.9% combined ratio for the nine-month period, compared with 111% for the comparable period a year ago.

As for 1987, Mr. Jackson noted that the market is improving in some areas but shows signs of weakening in others. "It's a question of our being flexible" and adapting to the attractive parts of the market as they become available, he explained.

Mr. Jackson said Home Re has an advantage over other reinsurers because it started writing reinsurance business only in 1983 and does not have to cope with low-priced business from earlier years.

A spokeswoman for Continental Casualty Co. in Chicago, a unit of CNA Financial Corp., said the company's 107% nine-month combined ratio "is indicative of CNA's mix of reinsurance business," which includes lines such as medical malpractice "that tend to be more volatile."

However, the 107% combined ratio for the first nine months of the year is a vast improvement over a 121.3% combined ratio for the comparable period in 1985. ■

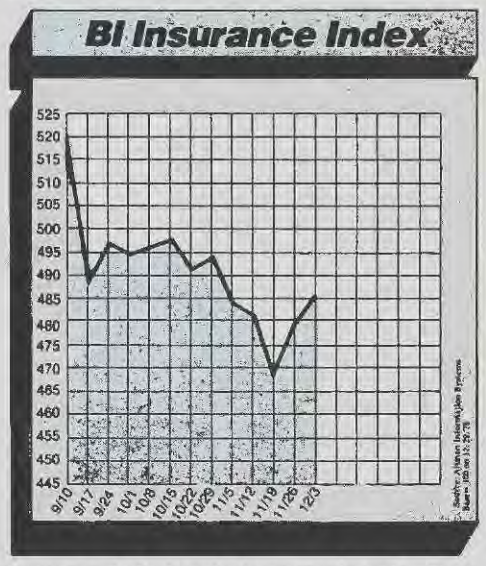
BI Industry Stock Report

December 3, 1986 11/27/86 thru 12/3/86

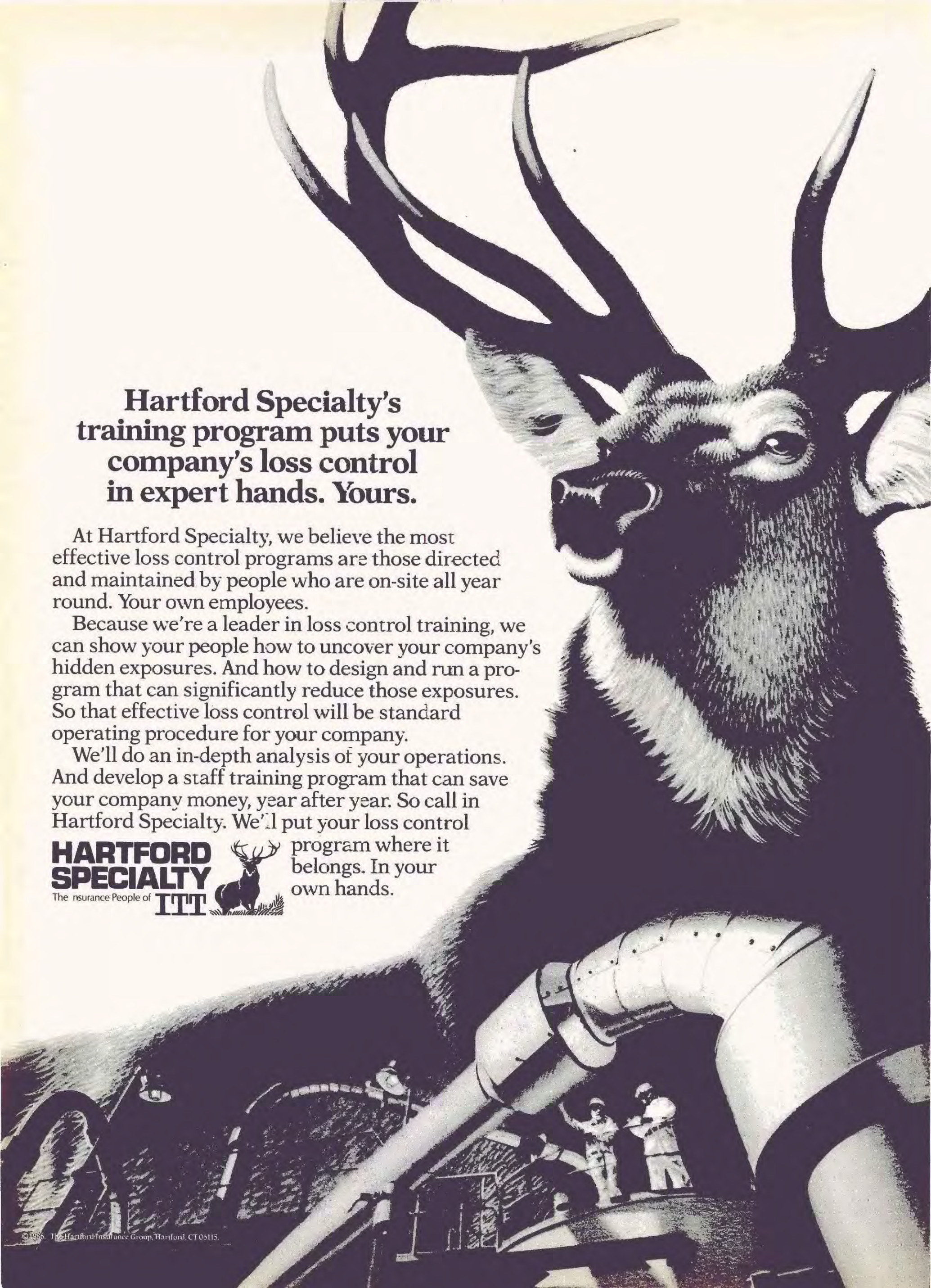
		Price	% Chg.	P/E	$ Div.	% Yld.	High	Low	Vol.(000)
Brokers									
Alexander & Alexander Svcs	NYSE	27.75	-1.3	396.4	1.00	3.6	27.75	27.25	1,030.7
Baldwin & Lyons Inc	OTC	24.50	11.4	19.9	0.20	0.8	24.50	24.50	0.0
Corroon & Black Corp	NYSE	36.13	0.3	16.3	0.65	1.8	36.13	35.13	163.2
Crump E H Cos Inc	OTC	32.75	0.0	31.5	0.25	0.8	0.00	0.00	0.0
Gallagher Arthur J & Co	OTC	28.50	-0.9	20.8	0.20	0.7	29.25	28.25	200.9
Hall Frank B & Co Inc	NYSE	15.63	-3.8	0.0	0.00	0.0	16.00	15.38*	216.9
Marsh & McLennan Cos Inc	NYSE	61.63	-1.0	19.7	1.90	3.1	61.75	60.00	588.6
Poe & Assoc Inc	OTC	11.75	0.0	14.9	0.32	2.7	11.75	11.25	14.3
AGENTS/BROKERS	AVERAGE			22.7		2.0			
Conglomerates & Holding Cos.									
American Express(Fireman's Fd)	NYSE	59.75	3.9	10.9	1.44	2.4	59.75	57.50	2,450.3
Anderson Clayton(Ranger/PanAm)	NYSE	65.63	0.0	47.9	0.00	0.0	0.00	0.00	0.0
Amaco Inc	NYSE	5.38	2.4	0.0	0.00	0.0	5.38	5.25	1,011.2
Berkley W R Corp	OTC	27.25	10.1	15.1	0.24	0.9	27.25	24.50	413.9
Berkshire Hathaway Inc Del	OTC	2740.00	-0.9	158.9	0.00	0.0	2740.00	2740.00	1.9
CIGNA Corp	NYSE	57.00	4.8	0.0	2.60	4.6	57.00	54.63	795.3
CNA Finl Corp (CNA)	NYSE	56.50	5.4	14.2	0.00	0.0	57.00	53.63	181.8
General Re Corp	NYSE	57.50	8.2	24.8	0.88	1.5	57.50	53.25	992.5
ITT (Hartford Group)	NYSE	55.75	1.4	26.4	1.00	1.8	55.75	54.50	1,807.6
Sears Roebuck & Co. (Allstate)	NYSE	45.00	3.4	12.3	1.76	3.9	45.00	43.75	3,653.5
Teledyne Inc (Argonaut)	NYSE	325.00	1.4	13.1	0.00	0.0	325.00	319.00	97.3
Transamerica Corp (Occidental)	NYSE	35.50	2.2	10.2	1.76	5.0	35.50	34.50	486.5
CONGLOMERATES/HOLDING COS.	AVERAGE			52.4		0.2			
Insurers									
Aetna Life & Cas Co	NYSE	60.38	5.0	10.5	2.64	4.4	60.38	57.75	2,346.3
American General Corp	NYSE	39.13	1.0	10.7	1.12	2.9	39.13	38.25	866.9
Amern Heritage Life Invt Co	NYSE	39.00	-0.3	14.0	1.32	3.4	39.13	39.00	1.3
American Indty Finl Corp	OTC	19.00	0.0	0.0	1.12	5.9	19.00	18.50	5.6
American Intl Group Inc	NYSE	62.88	6.6	18.0	0.25	0.4	62.88	58.75	1,478.7
Aneco Reins Ltd	OTC	2.13	0.0	0.0	0.00	0.0	2.13	2.13	9.0
Avemco Corp	NYSE	29.63	5.8	14.5	0.50	1.7	29.63	28.00	26.5
Business Mens Assurn Co Amer	OTC	26.38	0.5	0.0	1.10	4.2	26.38	26.25	70.0
Chubb Corp	NYSE	64.50	4.7	25.9	1.56	2.4	64.50	61.50	548.2
Combined Intl Corp	NYSE	55.25	0.7	10.3	2.24	4.1	55.25	54.50	156.4
Continental Corp	NYSE	48.88	5.7	232.7	2.60	5.3	48.88	45.88	568.4
Crown Life Ins Co	OTC	360.00	0.0	12.4	6.40	1.8	360.00	360.00	0.4
Durham Corp	OTC	40.50	-1.5	12.4	1.36	3.4	41.00	40.50	8.7
Farmers Group Inc	OTC	42.50	-4.9	14.2	1.00	2.4	42.50	40.75	443.5
Fairmont Finl Inc	AMEX	14.63	-7.9	11.7	0.00	0.0	15.63	14.63*	150.3
Fireman Fd Corp	NYSE	36.13	6.3	0.0	0.30	0.8	36.13	33.75	629.2
Fremont Gen Corp	OTC	16.25	-4.4	0.0	0.48	3.0	16.50	16.13*	168.7
Great West Life Assurn Co	OTC	740.00	0.0	15.2	18.00	2.4	740.00	740.00	0.0
Home Group Inc	AMEX	20.88	15.2	33.7	0.00	0.0	20.88	18.13	752.8
Hanover Ins Co	OTC	61.50	0.4	13.1	0.56	0.9	61.50	61.00	28.3
Hartford Steam Boiler Insptn	OTC	50.25	5.8	12.8	1.60	3.2	50.25	47.75	191.5
Kans City Life Ins	OTC	27.50	1.9	11.5	0.87	3.2	27.50	27.00	5.3
Kemper Corp	OTC	25.25	2.0	10.1	0.60	2.4	25.25	24.75	862.6
Liberty Corp S C	NYSE	38.00	2.7	12.8	0.72	1.9	38.00	37.25	10.9
Lincoln Natl Corp Ind	NYSE	50.13	1.8	11.5	2.16	4.3	50.13	48.38	393.2
Mission Ins Group Inc	PAC	1.88	0.0	0.0	0.00	0.0	4.38	1.75	11.9
Monumental Corp	OTC	55.63	0.0	16.8	0.00	0.0	0.00	0.00	0.0
Nac Re Corp	OTC	26.50	-1.9	0.0	0.00	0.0	26.88	25.50*	24.7
Nobel Ins Ltd	OTC	15.00	0.0	11.3	0.37	2.5	15.00	14.75	12.4
Northwestern Natl Life Ins	OTC	31.50	0.8	10.5	0.86	2.7	31.50	31.50	65.0
Ohio Cas Corp	OTC	78.25	0.3	14.7	3.00	3.8	78.75	78.00	86.7
Old Rep Intl Corp	OTC	29.63	-0.8	11.5	0.78	2.6	29.75	29.13*	301.9
Orion Cap Corp	NYSE	28.00	0.0	0.0	0.76	2.7	28.00	27.75	22.4
Protective Corp	OTC	18.75	-2.6	10.4	0.70	3.7	18.75	18.25*	151.1
Provident Life & Acc Ins Co	OTC	25.25	2.0	9.6	0.84	3.3	25.25	24.50	248.8
St Paul Cos Inc	OTC	40.75	7.2	12.5	1.50	3.7	40.75	39.00	574.7
SAFECO Corp	OTC	56.25	2.7	12.3	1.70	3.0	56.25	56.00	271.3
Seibels Bruce Group Inc	OTC	15.25	1.7	0.0	0.80	5.2	15.25	14.75	132.1
Selective Ins Group Inc	OTC	22.50	1.1	44.1	0.92	4.1	22.50	21.75	28.5
Statesman Group Inc	OTC	5.00	-2.4	0.0	0.05	1.0	5.13	5.00	22.6
Tokio Marine & Fire Ins Co	OTC	519.00	5.3	58.4	1.66	0.3	530.00	489.00	4.3
Torchmark Corp	NYSE	28.63	0.4	10.9	0.80	2.8	28.63	28.25	166.3
Travelers Corp	NYSE	45.88	0.8	11.0	2.16	4.7	45.88	44.25	1,482.5
Trenwick Group Inc	OTC	17.00	4.6	130.8	0.00	0.0	17.00	15.75	21.7
United Fire & Cas Co	OTC	27.50	-1.8	12.9	0.80	2.9	27.50	27.25	7.7
United States Fid & Gty Co	NYSE	39.13	2.0	45.0	2.32	5.9	39.13	36.75*	2,110.2
Uslife Corp	NYSE	47.38	0.5	12.3	1.20	2.5	47.63	47.38	116.8
Washington Natl Corp	NYSE	32.13	0.8	14.6	1.08	3.4	32.13	31.38	29.1
Zenith Natl Ins Corp	OTC	22.50	-1.1	27.1	0.80	3.6	22.75	22.50	376.2
INSURANCE COMPANIES	AVERAGE			16.5		2.2			

System design: Altman Information Systems

BI Insurance Index



Insurance industry stocks surged as the *Business Insurance* stock index rose 7.6 points to close at 486.3 on Dec. 3, up from 478.7 on Nov. 25. Thirty-five issues gained during the period, 14 stocks posted losses and 12 closed unchanged. The largest increases were reported by: The Home Group Inc., up 15.2%; W.R. Berkley Corp., up 10.1%; General Re Corp., up 8.2%; The St. Paul Cos. Inc., up 7.2%; and American International Group Inc., up 6.5%. The largest declines were posted by Fairmont Financial Corp., down 7.9%; Fremont General Corp., down 4.4%; Frank B. Hall & Co. Inc., down 3.8%; Protective Life Corp., down 2.6%; and Statesman Group Inc., down 2.4%. The *BI* index rose 1.6% during the period, or less than the major stock market averages.



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