FEBRUARY 23, 1987

# business insurance®

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**update**

## Two-thirds of IEA syndicates plan to seek rehabilitation

MIAMI—At least 10 of the 15 active syndicates on the Insurance Exchange of the Americas are planning to seek statutory rehabilitation, and the IEA has ceased writing any new or renewal business for an indefinite period.

Ten IEA syndicates say they will seek statutory rehabilitation because of the amount of potential losses they face on several rein-

*Continued on next page*

## BC/BS plan penalizes firms offering HMOs

**By DONNA DiBLASE**

PROVIDENCE, R.I.—Some Rhode Island employers are developing a serious case of "the blues" as they renew their group indemnity health care plans.

Blue Cross & Blue Shield of Rhode Island is assessing employers a prospective premium surcharge if they offer employees a health maintenance organization option in addition to conventional BC/BS indemnity coverage.

BC/BS of Rhode Island is the first group health insurer known to levy such a prospective surcharge, experts say.

Rhode Island

As a result of this "adverse selection factor"—based on a projection of how many "good risk" employees will opt for HMO coverage—BC/BS indemnity plan premium rates have increased significantly for some Rhode Island employers.

Consequently, the rating formula—which was approved by Rhode Island's Department of Business Regulation, the state agency that regulates insurance—is being criticized by employers as well as HMOs.

Some employers are even searching for new insurers for their group indemnity plans.

Adverse selection against an indemnity plan occurs when young, healthy employees—who typically utilize fewer health care services—opt for coverage through an HMO.

Often older employees, or those with health conditions that require more frequent use of health care services, will opt for indemnity coverage. This can drive up the cost to the indemnity plan because of increased frequency and severity of claims, benefit experts contend.

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# Funding tool proposed for retiree health costs

**By JERRY GEISEL**

WASHINGTON—Some employers would have a tax-effective tool for funding current retirees' health care costs under a new Reagan administration proposal.

The administration is asking Congress to allow employers to transfer excess assets from their overfunded defined benefit pension plans on a tax-free basis to finance health care benefits for current retirees.

In addition, as part of the most sweeping set of pension reform recommendations since the Employee Retirement Income Security Act of 1974, the administration is proposing that employers be allowed for any purpose to withdraw excess pension plan assets without terminating the plan, though these withdrawals would be taxed.

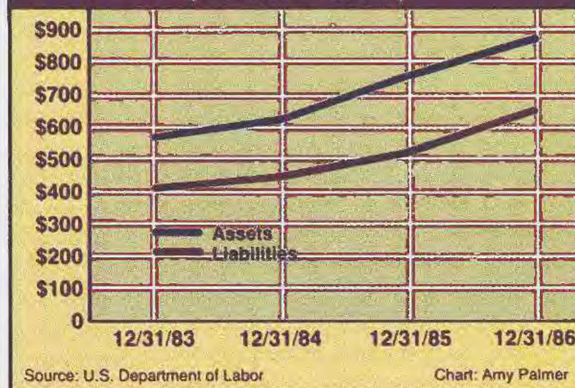
Under the retiree health care proposal, pension assets exceeding 125% of plan liabilities transferred to a special Voluntary Employee Beneficiary Assn. formed to fund current retirees' health care benefits would be exempt from federal excise or income taxes. And, assets in the VEBA would earn tax-free interest.

The recommendation, sent by the administration to Capitol Hill last week, follows years of employer complaints that the federal government—through cutbacks in the Medicare program—has increased the liabilities of employers' retiree health plans, but has refused to give them tax incentives to fund these benefits.

The liabilities of these plans, covering an estimated 6.9 million current retirees and dependents, now total $45 billion, the Labor Department says.

Under the administration proposal, employers could tap some of the $218 billion in surplus assets now held by defined benefit plans to fund health care liability for current retirees in a tax-effective manner.

Even though the proposal would not allow employers to prefund future retiree health care benefits for active



Source: U.S. Department of Labor — Chart: Amy Palmer

workers, benefit observers say employers would jump at this chance to fund benefits for current retirees.

"This will be a very popular funding method for employers," observed Frederick Rumack, director of taxes and legal services for Buck Consultants Inc. in New York.

"Employers have been anxious to utilize excess assets to provide (retiree health care plan) benefit security. But the tax code didn't permit it," Mr. Rumack said.

"I can think of several of our clients who would take advantage of this," said Lloyd Kaye, a managing director at William M. Mercer-Meidinger Inc. in New York. "Employers are looking for ways to make effective use of the excess pension funds."

The administration's pension package, which still

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# Florida judge enjoins ICA from writing

**By DOUGLAS McLEOD**

BOCA RATON, Fla.—The Florida Insurance Department is challenging the status of an insurer that claims to be authorized in all states and exempt from regulation under two alleged turn-of-the-century federal court decisions.

A Florida state judge recently enjoined the company, Insurance Corp. of America, from transacting insurance business in the state.

Also enjoined from transacting business in Florida on ICA's behalf were ICA President A.R. Johnson and ICA Vp Ernest Scalise.

The Florida department requested the injunctions, arguing that ICA solicited insurance business from three Miami-area organizations—including a health maintenance organization—without a license.

ICA—incorporated in West Virginia and operating from offices in Boca Raton, Fla.—is not related to a Houston-based insurer also named Insurance Corp. of America. The Houston-based insurer is licensed in Texas and specializes in medical malpractice risks.

Mr. Johnson, ICA's president, is also president of Boca Raton-based Dyna Span Corp. Dyna Span, which claims to operate as a purchasing group under the federal Risk Retention Act of 1981, has been hit with cease and desist orders by regulators in several states who charge that Dyna Span does not meet the requirements of the federal act (*BI*, May 26, 1986; March 3, 1986).

Peter M. Feaman, a Boca Raton lawyer who represents both Dyna Span and ICA, said there are no legal or business relationships between Dyna Span and ICA.

Mr. Johnson and other investors not associated with Dyna Span bought ICA last year, Mr. Feaman said.

According to court files, ICA was originally chartered in West Virginia in 1872 under the name Pocahontas Insurance Co. and adopted its present name in 1978. ICA was dissolved by a West Virginia state court in 1980 but was reinstated in 1983 after paying back taxes, court files say.

Meanwhile, West Virginia Insurance Commissioner Fred E. Wright has warned insurance buyers and agents to avoid dealing with ICA in Boca Raton. Though ICA is incorporated in West Virginia, it is not licensed as an insurer in the state "or in any other state, based on information to date," Mr. Wright said in a press release issued Jan. 28.

In addition, regulators in other states—including Alaska and Colorado—are investigating ICA's activities, insurance department officials in those states confirmed.

Documents show that ICA issued policies covered fishing vessels in Alaska through American Indian Insurance Group, an agency based in Denver.

The Florida department filed its complaint against ICA, Mr. Johnson and Mr. Scalise Jan. 21 in Palm Beach County Circuit Court.

Since June 1986, the complaint charges, the three defendants had been trying to sell home warranty coverage to members of the Gleneagles Condominium Assn. of Delray Beach, Fla., though ICA was not licensed to sell such coverage.

The warranty coverage was being sold using the name Warranty America, a registered trademark of ICA.

In a Dec. 23, 1986, letter to ICA, a Florida department examiner requested that ICA cease and desist from selling the warranties until it obtained a license.

The Insurance Department received a reply one week later from Dina MacLean, an executive assistant at ICA, saying that ICA had previously been licensed in Florida under the name Family Home Warranty and that its license was returned after it began operating as a purchasing group under the Risk Retention Act.

Family Home Warranty was a division of Dyna Span, according to Dyna Span promotional material.

The Florida department charged in its complaint that the Risk Retention Act does not authorize ICA to sell warranty coverage without being licensed by the Insurance De-

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**Property/casualty stocks trail gains on Wall Street Page 3**

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NEWSPAPER

## update

## Syndicates seek rehabilitation

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surance treaties. And late last week, the IEA was waiting to hear whether three other syndicates also would seek rehabilitation orders from the Leon County Circuit Court. The two remaining syndicates said they would not need to seek rehabilitation.

The thrust of the rehabilitation efforts will be to "work to achieve the commutation or recision of the treaties" that have produced the heavy losses, IEA President Nicholas Cross said.

If the effort succeeds, several of the syndicates seeking rehabilitation could be saved, said Bill Godwin, assistant director of company regulation at the Florida Insurance Department. If the effort fails, the exchange's future looks bleak, he acknowledged.

The IEA board voted last Wednesday to indefinitely cease underwriting. Earlier this month, the board had agreed to a Florida Insurance Department request to halt underwriting until March 1 because of mounting treaty reinsurance losses (*BI*, Feb. 16).

Exchange officials and the Insurance Department are investigating the participation of most of the 15 IEA syndicates on as many as a dozen reinsurance treaties that have produced heavy losses. The IEA has questioned whether managing general agents properly handled business connected with the treaties.

The 10 syndicates seeking rehabilitation include Hispano American Insurance Syndicate Ltd. and four managed by Daum Management Inc. Three of the Daum syndicates—Syndicate One Inc., Syndicate Two Inc. and Syndicate Three Inc.—had been ordered into rehabilitation earlier this month by the IEA. The Florida Insurance Department filed petitions for court-supervised rehabilitation of the fourth—Syndicate Four Inc.

Hispano American was placed into court-supervised rehabilitation earlier this month.

Mr. Cross would not release the names of all the syndicates seeking rehabilitation because all syndicate investors had not been informed of the action.

Mr. Godwin said last week that a decision was expected soon on whether the syndicates would be allowed to pay claims.

## House panel to probe MIC

WASHINGTON—The House Commerce, Consumer Protection and Competitiveness Subcommittee is investigating the collapse of Mission Insurance Co. and its effect on the insurance industry.

A Los Angeles Superior Court is expected to rule Tuesday on the California Insurance Department request to liquidate MIC and four subsidiaries (*BI*, Feb. 9).

"The possible impact of the Mission liquidation on the insurers who may have to contribute to guaranty funds in various states raises the specter of a possible domino effect through the industry," said subcommittee Chairman James Florio, D-N.J.

As part of the subcommittee's investigation, Rep. Florio has asked California Insurance Commissioner Roxani Gillespie to provide the subcommittee with:

- Conclusions the department has reached concerning the factors that contributed to MIC's collapse, including uncollectable reinsurance, cash-flow underwriting, unusually high claims and alleged illegal practices.
- The impact an MIC liquidation would have on policyholders, state guaranty funds and Mission creditors.
- The names of reinsurers that allegedly owe MIC funds and the amounts they owe.
- The names of ceding companies with claims against MIC, and the impact of MIC's alleged failure to pay claims.

## AMRECO suspends payments

LISLE, Ill.—American Mutual Reinsurance Co. has temporarily suspended claims payments while it prepares a commutation plan it hopes to present soon to claimants. The company stopped writing new and renewal business early in 1985.

"We hope to be able to resume some sort of payments at or before the middle of the year," said Roy J. Hammond, AMRECO's president, who was unable to provide details of the plan or the amount of outstanding claims.

Meanwhile, in Canada, the Ontario Superintendent of Insurance called for a hearing to determine whether underwriting should be limited at York Fire & Casualty Insurance Co. of Concord, Ontario, one of AMRECO's ceding companies.

However, York has challenged the superintendent's right to call such a hearing. That challenge was scheduled to be heard last last week.

In calling for the hearing, Superintendent John Weir was concerned that York's financial stability may be impaired if reinsurance payments are uncollectable from AMRECO.

## A&A's Bogardus to retire in '88

NEW YORK—John A. Bogardus Jr., 59, will step down as chief executive officer of Alexander & Alexander Services Inc. after the brokerage's May 21 shareholders' meeting.

Mr. Bogardus, who has been A&A's chief executive since November 1978, will remain chairman of the brokerage until May 1988, when he plans to retire. While the selection of a new CEO will occur at either the March or May board meetings, Mr. Bogardus has indicated the position likely will be assumed by Tinsley H. Irvin, A&A's president and chief operating officer.

## Oil tank coverage mandate

WASHINGTON—Owners of underground tanks used to store petroleum products will be required to have between $1 million and $6 million in coverage to pay cleanup costs and third-party liability claims under federal regulations to be proposed in April.

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# ABA backs softer version of tort reform proposals

By STEPHEN TARNOFF

NEW ORLEANS—The American Bar Assn. is supporting a watered-down version of a tort reform package recommended by a special ABA commission, but tort reform advocates say they still expect the ABA's position to propel more tort reform.

Some plaintiffs' attorneys, however, complain that the ABA's recommended reforms would take away plaintiffs' rights. They also say that the insurance industry's role in the liability insurance "crisis" should be studied before changes are made in the tort system.

The ABA recommendations—which are not radical departures from traditional tort law—in some cases were softened to gain passage in the ABA's House of Delegates, the association's policy-making arm.

At its midyear meeting last week, the 440-member ABA House of Delegates voted to approve 21 proposals, including recommendations that:

- Before punitive damages can be awarded, plaintiffs should prove by clear and convincing evidence that defendants acted with conscious disregard for their safety—a more stringent standard than currently required in some states.
- No caps be placed on damages for pain and suffering, but the ABA should consider studying whether juries should be guided on awarding such damages.
- Defendants should be held liable only for their equitable share of plaintiffs' non-economic loss, but only if their share of blame is "substantially disproportionate" to that of defendants unable to pay.

The recommendations were largely based on a report by the Action Commission to Improve the Tort Liability System, chaired by Robert McKay, former dean of and currently a professor at New York University Law School (*BI*, Jan. 19; Nov. 10, 1986).

In addition, the ABA's Litigation and Tort and Insurance Practice Sections also had developed recommendations on punitive damages.

Among the McKay Commission recommendations adopted by the House of Delegates as submitted calls for the ABA to establish a commission to study the insurance industry's influence on the tort system. The committee will be appointed shortly.

Spokesmen for buyers of insurance and insurers said last week that the recommendations will be a positive step in the drive to bring about tort reform.

"It is a positive development," said Franklin W. Nutter, president of the Alliance of American Insurers in Schaumburg, Ill.

"It is important impetus for tort reform" said Jon Harkavy, general counsel and director of governmental affairs for the Risk & Insurance Management Society Inc. in New York.

Given the diversity of interests among ABA members, the fact that they came out with something at all is important, he added.

The ABA has 330,000 members out of about 600,000 lawyers in the country.

Last week, Professor McKay said he was pleased with the results of the ABA House of Delegates' action on the Commission's work, despite the modifica-

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## Directory of captive managers

*Business Insurance* will publish its annual directory of captive management companies in the March 30 issue, which will contain a spotlight report on domestic and international captive domiciles and on captive insurance company trends.

There is no charge for captive management companies to be listed; however, to be included companies must request and return a questionnaire provided by *Business Insurance*.

The extended deadline for returning the completed questionnaires to *Business Insurance* is March 9.

If your company provides captive management services in the United States or abroad and you have not yet received a questionnaire, please request one immediately by writing Marilou Jones, Directory Editor, *Business Insurance*, 740 N. Rush St., Chicago, Ill. 60611; or by calling 312-649-5279.

Mail requests from outside the United States should be sent air mail.

# Future rate cuts to be less severe: Compton

By JUDY GREENWALD

PITTSBURGH—The next soft market will not be as severe as the one that triggered the current hard market, predicts Ronald E. Compton, president of New York-based American Re-Insurance Co.

Due to declining interest rates, insurers will not generate enough investment income to "paper over" their underwriting mistakes this time, said Mr. Compton, who spoke at the 6th annual seminar of the Pittsburgh chapter of the Risk & Insurance Management Society earlier this month.

Mr. Compton

The lesson taught by the recent hard market will "save us from ourselves," he said, noting that with lower investment income, poor underwriting will "stick out like a sore thumb," forcing insurers and reinsurers to do a better job.

The stock market also isn't as receptive to equity offerings by property/casualty companies as it was as recently as six months ago, he said. This also will discourage a return to epidemic price-cutting.

"We are in a very tough recovery," said Mr. Compton, who will become senior vp of Aetna Life & Casualty Co., American Re's parent, March 1. The current hard market will not soften for "at least another year to year and a half," he added.

Recovery—which Mr. Compton said began during 1984's fourth quarter—is slow because of the "suicidal" and "murderous" nature of the last down phase.

"We assassinated the morale of many of the best casualty and property underwriters in the business" during the last soft market, by preventing them from doing the job for which the industry had spent "hundreds of millions" of dollars training them, Mr. Compton said.

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## inside

Only time will tell whether the largest municipal group self-insurance program in Michigan proves to be financially sound, but concerns raised about the liability program serve as a warning today, not only to members of that program but also to members and managers of every self-insured group around the country, cautions this week's editorial. **PAGE 8**

California Gov. George Deukmejian, in an effort to trim $8 million from the state's budget, intends to restructure the California Division of Occupational Safety & Health, relinquishing most workplace safety enforcement responsibility to the federal government. **PAGE 10**

To stem the rise of health care costs, many employers are basing their cost-containment strategies on market competition, purchasing health care services on the same basis as a company would purchase other commodities, according to a Perspective article by Charles R. Stanfield, a benefit consultant with William M. Mercer-Meidinger Inc. For such a strategy to work, though, price and performance information must be obtained. **PAGE 21**

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# Insurer stocks trail Wall Street gains

By JUDY GREENWALD

NEW YORK—Investors in insurer stocks generally are finding themselves paddling in the quiet backwaters of Wall Street as the wave of the stock market rally continues to crest.

The overall market has dramatically outperformed the property/casualty insurer stocks recommended by securities analysts during the past six months. Even a group of insurer stocks picked out of a hat has outperformed a hypothetical portfolio made up of analysts' top picks.

Yet, despite this lagging performance, analysts remain confident in the long-term growth potential of insurer stocks, with American International Group Inc., General Reinsurance Corp. and Chubb Corp. remaining particular favorites.

Those three stocks—along with Fireman's Fund Corp., USF&G Corp., Ohio Casualty Corp., American General Corp. and CNA Financial Corp.—comprise the *Business Insurance* Model Portfolio, which *BI* established on July 25, 1986 with a hypothetical $10,000 investment (*BI*, Aug. 4, 1986). The stocks were selected based on the advice of stock analysts.

Since then, the value of shares held by the Model Portfolio has increased 1% from the original $9,943.89 invested in July. And, counting dividends and 5.75% interest on cash remaining from the original $10,000 stake, the total value of the portfolio stands at $10,212.64, or a 2.1% increase from the original $10,000 investment (see chart).

But this gain is overshadowed by the gain in the *BI* Random Portfolio, which was established at the same time as the Model Portfolio to help evaluate the analysts' recommendations.

***BI* Model Portfolio**

| Stock | No. of shares | July 25 purchase price | Total | Oct. 23 price | Total[1] | Percent change | Feb. 18 price | Total[1] | Percent change |
|---|---|---|---|---|---|---|---|---|---|
| Chubb | 37 | $72.13 | $2,668.63 | $69.63 | $2,590.56 | (2.9)% | $66.75 | $2,485.29 | (6.9)% |
| General Re | 33 | 61.88 | 2,041.88 | 57.75 | 1,913.01 | (6.3) | 61.88 | 2,050.13 | 0.4 |
| AIG | 30[2] | 134.25 | 2,013.75 | 128.25 | 1,925.40 | (4.4) | 71.88 | 2,158.13 | 7.2 |
| Fireman's Fund | 28 | 38.13 | 1,067.50 | 38.25 | 1,073.10 | 0.5 | 38.50 | 1,080.10 | 1.2 |
| USF&G | 15 | 40.00 | 600.00 | 38.38 | 584.33 | (2.6) | 46.75 | 709.95 | 18.3 |
| Ohio Casualty | 14[3] | 81.00 | 567.00 | 84.50 | 596.75 | 5.2 | 44.25 | 630.00 | 11.1 |
| American General | 13 | 41.63 | 541.13 | 39.00 | 510.64 | (5.6) | 41.50 | 543.14 | 0.4 |
| CNA | 8 | 55.50 | 444.00 | 55.88 | 447.00 | 0.7 | 62.25 | 498.00 | 12.2 |
| Cash | | | 56.11 | | 56.97 | 1.5 | | 57.91 | 3.2 |
| Total | | | 10,000.00 | | 9,697.76 | (3.0) | | 10,212.64 | 2.1 |
| S&P 500 | | | 240.22 | | 239.28 | (0.4) | | 285.42 | 18.8 |

[1] Includes dividend payments. [2] Shares after 2-1 split on Nov. 17. [3] Shares after 2-1 split on Jan. 23.

Chart: Amy Palmer

The value of the shares in the Random Portfolio—which includes shares of CIGNA Corp., CNA, Aetna Life & Casualty Co., Continental Corp. and The Home Group Inc.—has increased 6.4% to $10,270 on Feb. 18 from $9,652.50 on July 25. Dividends plus interest on leftover cash boosted the $10,000 stake to $10,703.44, a 7% increase (see chart, page 35).

The increase in both portfolios' value, however, pales compared with the stock market's overall gain. Between July 25 and Feb. 18, the Standard & Poor's 500 stock index increased 18.8% to 285.42 from 240.22, including a 5.79-point rise last Tuesday, the same day that the Dow Jones 30 Industrials jumped 54.14 points, its largest daily gain ever.

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# McCarran-Ferguson hearings begin

By JERRY GEISEL

WASHINGTON—Small business organizations, Reagan administration officials and state legal officers are urging Congress to repeal the antitrust provisions of the McCarran-Ferguson Act.

At the first of what will be many congressional hearings on the McCarran-Ferguson Act—the 1945 federal law that leaves primary regulation of the insurance industry to the states and gives insurers a limited exemption from federal antitrust law—a representative of the National Federation of Independent Business said there is no "continuing justification" for the exemption.

"Our members want to see a level playing field for all companies, including those in the business of insurance. We believe the antitrust exemption hinders competition," said John Motley, director of federal legislation for the 500,000-member NFIB, before the Senate Judiciary Committee.

"Having a level playing field where the insurance sector lives under the same rules of the economic game as every other industry is essential to resolving the insurance crisis for the long term," Mr. Motley said.

Federal Trade Commission Chairman Daniel Oliver described the McCarran-Ferguson Act as anti-consumer, contending that it protects industry price-fixing and gives insurers the freedom to limit policy forms and to divide customers and territories among themselves.

Mr. Oliver labeled as "bogus" industry contentions that the repeal of McCarran-Ferguson's antitrust provisions will hurt policyholders.

"The evidence from other industries that have been deregulated and exposed to application of the antitrust laws demonstrates that consumers benefit from competition," he said, citing the increased choices available to consumers since antitrust laws have been applied to health care providers.

In addition, Mr. Oliver said insurers still would be free to pool data to make actuarial projections, noting that antitrust law does not place an obstacle on the pooling of loss data.

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# Insurers refuse oil rig claim

By STACY SHAPIRO

LONDON—U.S. and European insurers are refusing to pay a $62.2 million claim for a storm-damaged oil rig in the Beaufort Sea, raising the possibility that broker Sedgwick Group P.L.C. and its errors and omissions insurers may wind up paying the loss.

Esso Resources Canada Ltd. of Calgary, Alberta, and 12 other oil and gas exploration companies are suing 20 insurers and brokers Sedgwick Tomenson Inc. in Calgary and Sedgwick Offshore Resources Ltd. of London in a Canadian court to recover as much as $62.2 million in losses, including extra expenses.

The insurers, led by Commonwealth Insurance Co. of Vancouver, British Columbia, refuse to pay the claim, contending the risk was misrepresented either by the oil companies or the Sedgwick units when coverage was renewed.

Specifically, the insurers—which include Canadian, U.S., Lloyd's of London and Scandinavian underwriters—say they were not informed about what type of man-made island served as a base for the rig in the Beaufort Sea in the Arctic Ocean. The island was made in shallow water off the northern coast of Alaska and the Yukon Territory.

Further, the insurers claim that the policy did not cover extra expenses.

Esso and the other plaintiffs maintain that if the court finds that the risks were misrepresented to the insurers, then Sedgwick Tomenson and Sedgwick Offshore Resources should pay the claim.

The Sedgwick units deny the risks were misrepresented to the underwriters, but Sedgwick Group has notified its errors and omissions underwriters of the claim.

Lawyers in the case, who were in London last week taking depositions, said the dispute could be settled.

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# Oklahoma comp insurers plot future

By CAROL M. CAIN

OKLAHOMA CITY—Insurers say they will continue to write workers compensation coverage in Oklahoma, despite the sting of a recently affirmed state Supreme Court decision that nullifies an average 25.9% rate hike approved in 1985 and orders premium refunds.

However, insurers say they soon will submit another rate filing seeking an increase that likely will exceed the 41.9% hike originally requested in early 1985.

In addition, a new insurance rating bill that would supercede the Supreme Court's July 25 decision is expected to be introduced in the Oklahoma Legislature soon.

Meanwhile, two other bills have been filed in the Oklahoma Senate: one to convert the competitive state fund into an exclusive state fund, thereby banning commercial insurers from the work comp market, and another measure that would allow the state fund to write reinsurance for workers compensation self-insurers and write professional liability insurance.

In its July 25 ruling, the state Supreme Court not only overturned the 25.9% rate hike, which took effect Nov. 1, 1985, but also ordered that insurers refund any excess premiums paid by employers based on the rate hike (*BI*, Aug. 4, 1986).

The court said that insurers failed to provide sufficient information to justify the rate increase. It also said before rate increases are approved in the future, insurers will have to prove that current rates are unreasonably low and that those low rate levels would endanger insurers' solvency or restrict competition.

The National Council on Compensation Insurance, which represents workers compensation insurers in Oklahoma, asked the high court to reconsider its July

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# DeAlessandro joins Commercial Credit

By STEVE TARAVELLA and JUDY GREENWALD

NEW YORK—Joseph P. DeAlessandro, a 19-year veteran executive of American International Group Inc., is now with a group of much smaller insurers to lead them into new lines of business.

Mr. DeAlessandro, who had been president of AIG affiliate National Union Fire Insurance Co. of Pittsburgh, Pa., is the second top-AIG official to leave the company since Jan. 1. Last month, American Home Assurance Co. President Dennis Busti resigned to become president of Columbia Insurance Co., a unit of Berkshire Hathaway Corp. (*BI*, Feb. 2).

As chairman and chief executive officer of New York-based Commercial Credit Insurance Services, a unit of Baltimore-based Commercial Credit Co., Mr. DeAlessandro will head operations at Gulf Insurance Co., a property/casualty underwriter based in Irving, Texas, and American Credit Indemnity Co., a credit insurance company based in Baltimore, as well as their subsidiaries.

Commercial Credit Co., a former affiliate of Control Data Corp., is headed by Chairman and Chief Executive Officer Sanford I. Weill, former president of American Express Co. and former chairman and chief executive officer of Fireman's Fund Insurance Cos.

Control Data put the company up for sale in 1985, but retracted the offer early last year and, in October, spun the company off to the public. Commercial Credit's stock is now traded on the New York Stock Exchange.

Mr. DeAlessandro, who joined Commercial Credit last week, says he plans to lead the two insurance units into new lines of business they have not previously written, like professional liability insurance and directors and officers liability insurance, a line in which Mr. DeAlessandro is regarded as an industry expert.

Mr. DeAlessandro

Within a week of Mr. DeAlessandro's departure from AIG, two National Union vps also resigned to accept positions at Commercial Credit.

Norman Butzow has been named senior vp in charge of reinsurance and management information systems at Commercial Credit, while Raymond Donovan has been named senior vp in charge of administration at the company.

Gulf, which reported net written premiums of $254.1 million and direct written premiums of $127.7 million in 1985 has written a variety of commercial and personal lines coverage, including auto liability and physical damage, workers compensation and homeowners coverage. Its 1985 combined ratio was 131%.

For the six months ended June 30, Gulf posted $95.7 million in net premiums written, a pretax loss of $1.8 million and an aftertax net loss of $300,000. The company reported a 119.3% combined ratio.

The stock prospectus issued last October by Commerical Credit notes that "a recent review by Gulf management suggests that it may be necessary to make an addition to the reserves, which could have an aftertax cost of up to approximately $9 million."

*Continued on next page*

## DeAlessandro leaves AIG

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A Commercial Credit spokeswoman noted that Gulf's reserves were boosted by an additional $27.8 million in the fourth quarter of 1986.

American Credit, which reported net written premiums of $39.6 million and direct written premiums of $48.7 million in 1985 has written credit insurance exclusively.

Its 1985 combined ratio was 94%.

American Credit Indemnity wrote $19 million in net premiums for the first half of 1986, and reported a combined ratio of 107.1% for that period.

By contrast, National Union in 1985 reported net written premiums of $806.9 million and direct written premiums of $3.1 billion.

Besides expanding the types of business the two insurers write, Mr. DeAlessandro says he also plans to make the insurers a market for large brokers. Currently, agents produce most of the companies' business.

The two insurers will bring much-needed capacity to the market, Mr. DeAlessandro said, adding that he is confident that "all of our operations are going to grow."

Gulf reported a policyholders surplus of $89.1 million at year-end 1985, while American Credit reported a surplus of $57.2 million.

Mr. DeAlessandro, who will also serve as senior vp of Commercial Credit Corp., says he is "very delighted" to take advantage of what he terms "a fantastic new opportunity."

Mr. DeAlessandro left AIG Jan. 30 after almost 20 years with the company. Besides his post at National Union, he was also an executive vp at American Home and a vp with the parent company.

Mr. DeAlessandro dismissed rumors that his exit was prompted by personal differences with AIG President Maurice R. Greenberg, and says Mr. Greenberg was unhappy to see him leave.

"I respect, admire, and think most highly of Mr. Greenberg or I wouldn't have been with him for 19 years," says Mr. DeAlessandro, 56.

"Everyone has a need to see what they're happy doing. I'm happy creating; I'm a creative person," he said.

Mr. DeAlessandro said his departure was friendly and without animosity.

Thomas R. Tizzo, executive vp-domestic general brokerage at AIG, will assume Mr. DeAlessandro's responsibilities until a permanent replacement is named, said an AIG spokeswoman.

The spokeswoman would not comment on the number of insurance company executives that have recently left AIG. ■


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## ABA tort reform proposals

*Continued from page 2*

tions made to win the support of certain attorney groups.

"Essentially, our report was adopted," he said. "I think it is a good package." However, he admitted that in several instances, largely because of objections from the plaintiffs' bar, there was a "softening" of the language to get the proposals passed.

Some plaintiffs' attorneys still object to the ABA's recommendations.

"The report is fatally flawed because it did not entertain the underlying issue," which is the insurance industry's role in the tort "crisis," said Ray Ferrero Jr., with the Fort Lauderdale, Fla., firm of Ferrero, Middlebrooks, Strickland & Fischer.

Mr. Ferrero also objected to the ABA's recommendations to tighten the standards for awarding punitive damages, and to the ABA's treatment of joint and several liability.

One area where the ABA House recommendations differ significantly from the McKay commission is punitive damages.

Prior to the vote in the House, members of the McKay commission and the Litigation and TIPS sections negotiated which recommendations would go before the House. The result was statements that punitive damages have a place in appropriate cases and should not be abolished, but that their scope should be narrowed.

Like the McKay Commission, the House recommended that plaintiffs be required to demonstrate by "clear and convincing" evidence rather than the lesser standard of by "a preponderance of the evidence" that defendants are liable for punitive damages.

The House also approved a recommendation that plaintiffs must demonstrate that defendants engaged in a "conscious or deliberate disregard with respect to the plaintiff."

It also approved the McKay Commission recommendations that appropriate pretrial procedures be used to eliminate frivolous claims and that evidence, such as the net worth of a defendant, relevant to the question of punitive damages be introduced only after the defendant's liability for compensatory damages and the amount of those damages are determined.

In addition, the ABA recommendations also provide that punitive damage awards should be subjected to court scrutiny and that trial courts should reduce punitive damage judgments when justified.

The House also recommends that safeguards be adopted to prevent defendants from being subjected to multiple punitive damage awards arising from a single wrongful act that are "excessive in the aggregate." But the House stopped short of recommending that such multiple damage awards be prohibited in the case of mass torts, as has been proposed by some defendants.

And, the House failed to adopt a provision approved by the McKay Commission that recommended that a portion of a punitive damages award be allocated to public purposes.

The ABA House approved a version saying that in certain punitive damage cases, a court could be authorized to give part of the award to the public after determining what is a reasonable portion to compensate the plaintiff and his attorney.

But the approved version also states: "The novelty of such proposals and the absence of any adequately tested programs for implementing require further study before an informed judgment can be made as to whether, or to what extent, such proposals will work in practice. We urge such studies."

On the doctrine of pain and suffering awards, the House of Delegates also endorsed McKay Commission proposals that no ceilings be placed on the size of pain and suffering awards but that trial and appellate courts should more aggressively use their power to reduce excessive verdicts or to increase awards if they are too low.

However, the ABA deleted a recommendation that options should be explored to provide more guidance to juries on the appropriate range of damages to be awarded for pain and suffering in a particular case. Instead, it recommended that options be explored "by appropriate ABA entities whether additional guidance can and should be given to the jury."

On the issue of joint and several liability, the House approved the McKay Commission proposal in its entirety, recommending that the doctrine be modified so defendants whose responsibility is "substantially disproportionate" to the liability of the entire loss be liable only for their share of the plaintiff's non-economic damages.

"A defendant's responsibility should be regarded as 'substantially disproportionate' when it is significantly less than any of the other defendants; for example, when one of two defendants is determined to be less than 25% responsible for the plaintiff's injury," the commission explained in its report. This recommendation does not apply to economic damages.

The House of Delegates also agreed with the McKay Commission on certain aspects of attorneys' fees, including calling for fee arrangements to be set forth in a written agreement identifying the basis on which the fee is calculated and that a contingent fee information form be given to each plaintiff before a contingency fee agreement is signed.

However, the House watered down another McKay Commission recommendation on contingent fees. The House approved a recommendation that courts should "discourage" the practice of taking a percentage fee out of the gross amount of any judgment or settlement.

The McKay Commission recommended that this practice be "prohibited" and that contingent fees be based only on the net amount recovered after litigation expenses such as expert witness fees and deposition costs.

The House also adopted a modified version of a recommendation by the McKay Commission that would require that fee arrangements with each party be submitted to the court in private whenever a judgment is entered in a tort case. Under the McKay recommendation, the court would have the authority to disallow a portion of the fee if it is excessive.

Instead, the House modifications provide that fee arrangements may be submitted to the court or other approved public body for disallowance of excessive fees "upon complaint of persons who retained counsel or are required to pay counsel fees"

In addition, the House recommended that discipline of lawyers should continue to be the responsibility of the highest judicial authority in each state rather than controlled by a state body, as the McKay Commission had recommended.

The delegates also approved a recommendation that one or more tort award commissions be established to review tort awards during the preceding year, publish information on trends, and suggest guidelines for future trial court reference.

Recommendations for streamlining litigation through methods of discouraging frivolous claims and unnecessary delays, plus limiting secret and coercive agreements between defendants' and plaintiffs' attorneys also were approved. ■

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# Antitrust

*Continued from page 3*

"The problem arises when insurers go beyond collecting and aggregating loss data, and collectively determine rates or coverages to be offered," according to Mr. Oliver.

While stressing that the Reagan administration favors state regulation of the industry, Charles Rule, an assistant U.S. attorney general, said insurers "have no special characteristics" that should bar them from full competition.

While hedging on whether a repeal of the antitrust provisions of the 42-year-old statute is appropriate now, Mr. Rule said there would be no justification for an antitrust exemption if the insurance industry sought such an exemption today.

But, Mr. Rule questioned whether the existence of the McCarran-Ferguson Act has played a role in the liability insurance crisis, adding that the crisis probably is more due to an expansion of the legal system.

He noted, for example, that even if insurers in a state all followed rates set by industry-supported rating organizations, it would be difficult for those insurers to prevent new companies from entering the market and offering a lower price to consumers.

**The mass cancellation of medical malpractice coverage in West Virginia 'exemplifies to my mind and to most of the citizens of West Virginia why the McCarran-Ferguson antitrust exemption should be scrapped,' says Mr. Brown.**

However, state legal officers testified that if insurers had been subject to antitrust law, they would not have withdrawn en masse from certain markets.

"If there had not been a McCarran-Ferguson Act, I doubt if there would have been a mass withdrawal of insurers from the West Virginia medical malpractice market" last year, said West Virginia Attorney General Charles Brown (*BI*, April 28, 1985; June 2, 1985).

Mr. Brown said the "combined, coordinated, simultaneous" mass cancellation of medical malpractice coverage in the state "exemplifies to my mind and to most of the citizens of West Virginia why the McCarran-Ferguson antitrust exemption should be scrapped."

Massachusetts Attorney General James Shannon, who spoke on behalf of the National Assn. of Attorneys General, said the industry has the best of both worlds: immunity from federal antitrust law and weak state regulation.

"I can't believe this is what Congress had in mind in 1945" when it passed the McCarran-Ferguson Act, Mr. Shannon said.

Other state officials urged the committee to pass legislation to give the federal government authority to collect extensive financial information from insurers. Such information would include—on a line by line basis—premium volume, claims paid, reserves and investment income.

Without access to such information, states cannot decide what is the real cause of the high cost and shortage of liability insurance, said Jeffrey Teitz, chairman of the Rhode Island House Judiciary Committee.

While state officials favored repeal of the antitrust provisions of the McCarran-Ferguson Act, some Senate Judiciary Committee members said they either had no position or were opposed.

For example, committee Chairman Sen. Joseph Biden, D-Del., said he had an "open mind" on changes to McCarran-Ferguson, while ranking minority member Sen.

Strom Thurmond, R-S.C., said: "The McCarran-Ferguson Act should not be disturbed. . .repeal of the act will not solve the insurance crisis."

However, Sen. Howard Metzenbaum, D-Ohio, a longtime critic of the insurance industry who is leading the effort to repeal the antitrust exemption, said businesses have been hurt by allowing insurers to rely on industry rating bureaus.

"Small businesses face enormous and often unjustified rate increases, in part, because of the industry's system of relying on jointly recommended premiums," he said.

"The property/casualty industry does not set rates by free competition. Instead, insurance companies rely on an elaborate, nationwide system of recommended rates, rates recommended by an organization totally controlled by the industry. This practice would be illegal in any other industry," Sen. Metzenbaum said.

But even Sen. Metzenbaum said he wanted to retain state regulation of the insurance industry. The only change he advocates is simply subjecting insurers to the full scope of antitrust law.

Sen. Paul Simon, D-Ill., likened repeal of the antitrust provisions of the McCarran-Ferguson Act to a train traveling down a track at full speed: Insurers have the choice of either being run down by the train or hopping abroad and working with legislators to reach a reasonable compromise.

While insurance industry and state insurance department officials generally oppose any changes in the McCarran-Ferguson Act, Delaware Insurance Commissioner David N. Levinson recommended that Congress give the National Assn. of Insurance Commissioners new regulatory powers.

Mr. Levinson said the Judiciary Committee should consider legislation to give the NAIC the authority and resources to solve such problems as interstate insurance fraud, monopolistic behavior and solvency oversight.

But Sen. Howell Heflin, D-Ala., questioned if there was a precedent for such a congressional delegation of authority, while Sen. Metzenbaum described the NAIC as an organization that has had difficulty separating itself from the insurance industry. ■


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## opinions

# In the public's interest

ONLY TIME WILL TELL whether the largest municipal group self-insurance program in Michigan proves to be financially sound, but concerns raised about the liability program are a warning today not only to members of that program but also to members and managers of every self-insured group around the country.

As we reported last week, the Michigan Municipal Risk Management Authority is either a godsend or a gamble for its 252 members, depending on whether MMRMA can support its assumption of risk and whether MMRMA is reserving enough money to cover future claims against its members.

By conventional commercial insurance company standards, MMRMA is self-funding too much liability risk and its estimated combined ratio appears to be unrealistically low. The president of MMRMA's management company contends that it's unfair to apply conventional commercial insurance company standards to the financial structure of MMRMA, which differs from a commercial insurer. If that's true, then some other standard should be offered by MMRMA to help its members judge its financial stability.

Financial stability is critical to members of every self-insurance pool. For example, if MMRMA should ever run out of money to pay claims within the self-insured portion of its reinsurance program, the individual municipality with the claim will be left to foot the bill—out of general revenues, a tax hike or perhaps even a bond issue.

While financial stability must be of paramount importance to MMRMA members and to every self-insurance pool member and manager, our nine-month investigation of allegations about MMRMA also revealed two related issues that should concern all members of self-insurance pools: the degree of members' own understanding and analysis of a pool's operation and the extent of the pool manager's disclosure of information about the pool's operation. Only with complete understanding of all the facts can a member of a self-insurance pool make an informed decision about the pool's financial stability and whether to join it.

Based on our investigation of MMRMA, it's obvious that at least some pool members don't fully understand the pool's operation and finances. They have accepted at face value that they have $10 million in coverage at a lower price than that being charged by commercial insurers for lower limits. However, MMRMA self-insures about 47% of the $10 million limit after members' retentions. Given the extent of self-insurance, it is conceivable, though arguably unlikely, that large losses could at some point exhaust MMRMA funds set aside to cover the self-insured portion of the reinsurance program. And, unlike a licensed insurer, MMRMA is not covered by the state guaranty fund.

Pool members and pool managers must share responsibility for ensuring that members understand their program. Pool members should ask the right questions, and if they don't know enough to ask the right questions, they should engage an expert who does. Furthermore, pool managers have an obligation to fully and clearly explain the financial operation of the pool to potential members.

We can sympathize with MMRMA officials who grew weary of answering unfounded criticism leveled at their pool, particularly by competing insurance agents with axes to grind because they were losing accounts to MMRMA. But, we believe MMRMA should not have responded to the criticism by clamping down the lid on information about its reinsurers and circulating inaccurate lists of reinsurers in order to track down leaks. This trench mentality only breeds more suspicions. The best weapon against unfair and unfounded allegations is publicly provided proof to the contrary.

And, while some pool members may not express an interest in, say, the details about the amount or scope of commercial reinsurance coverage—trusting this analysis to their pool manager—the information nonetheless should be provided to every member of a pool. This is especially important when public entities are buying coverage from a self-funded pool. Even if the county clerk or city treasurer is not expert enough or not interested enough to analyze the financial stability of the program, insurance-savvy citizens whose tax dollars are at stake have a right to the information.

A public entity's commercial insurer and its financial status can be determined from public records. The financial status of a public entity pool and its operations should be open to public scrutiny.

In the case of MMRMA, despite disclosure by the pool manager to its members, some members aren't fully aware of the growing amount of risk assumed by the pool and don't understand the possible results. Furthermore, some conditions of reinsurance contracts were not disclosed and some questions remain about the scope of coverage.

In addition, self-insurance pool managers who have a financial interest in another company that might eventually benefit from the operation of the pool should practice full disclosure. We believe this is good business practice for both public entity pools and the private entity pools that are being formed under the Risk Retention Act.

In the case of MMRMA, a Bermuda-based company owned by managers and advisers to the program served as a retrocessionaire on a portion of the MMRMA reinsurance program and the retrocession was not fully disclosed to all MMRMA members. There is nothing illegal or necessarily improper about this, but non-disclosure creates at least an appearance of possible impropriety.

Currently, municipal self-insurance pools generally are unregulated, except for monoline workers compensation self-insurance pools. However, there already is a movement in Michigan to impose more regulation on MMRMA and the Michigan Municipal League, which also sponsors a pooling program, *Business Insurance* learned last week.

The chairman of the Michigan House Insurance Committee, Rep. Mary C. Brown, D-Kalamazoo, has drafted a bill that would: bring pools under the oversight of the insurance commissioner; require minimum capitalization as provided in the insurance code; impose some uniformity of financial reporting; and require actuarial certification of loss reserves. Additional details of the bill, expected to be introduced soon, were not available.

Given the extreme difficulties many municipalities face in finding affordable commercial liability insurance, we would not welcome regulations that hamper the formation and operation of municipal self-insurance pools—in Michigan or in any state. We therefore reserve judgment on the provisions of the bill until we see the specifics, except for the actuarial certification of loss reserves. We share concern with pool members and managers that onerous regulation could put the pools out of business, but we cannot imagine a valid reason to oppose actuarial certification of loss reserves.

As the world's oldest insurance marketplace, Lloyd's of London, has learned, self-regulation will be permitted by government regulators only so long as it benefits all concerned. Raise suspicions that the self-regulation may be inadequate to protect the interests of policyholders or investors, and government intervention is sure to follow.


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# Governor proposes massive cuts at Cal/OSHA

**By STEVE TARAVELLA**

LOS ANGELES—To shave about $8 million from the state's budget, Gov. George Deukmejian intends to dissolve most of California's workplace safety agency and shift those responsibilities to the federal workplace safety agency.

The governor proposes restructuring Cal/OSHA—the California Division of Occupational Safety & Health—to regulate only public employees.

The proposal has met with opposition from organized labor, the state's Assembly speaker and the federal Occupational Safety & Health Administration, while employers' reactions are mixed.

Labor unions in the state claim that if Cal/OSHA is restructured as proposed, it will lead to more workplace accidents and, as a result, employers' workers compensation premiums will balloon.

In a statement released Feb. 10, California Assembly Speaker Willie Brown pledged that the state Legislature would not pass laws that would destroy Cal/OSHA. Mr. Brown called eliminating the agency "really stupid."

"It would be humorous, were it not so potentially damaging and dangerous for the workplace," he observed.

While the Legislature must approve the governor's budget, he has a line-item veto ability.

Joining the voices of opposition is the federal safety agency.

"We'd very much prefer that California remain a state-plan state," said an OSHA spokesman in Washington. "But by July 1, we must be prepared to assume jurisdiction and promote a smooth transition."

July 1 is the first day of California's 1987/1988 fiscal year.

Employers appear divided on the issue. Some large companies with multistate operations prefer to deal with one uniform set of regulations for their various divisions, while some smaller companies prefer local access and communication to a federal bureaucracy.

California is one of 23 U.S. states and territories that currently operate workplace safety agencies independent of and superceding the federal OSHA, as allowed by the Federal Occupational Safety & Health Act of 1971.

California, which has operated Cal/OSHA since 1973, would not be the first state to return control to the federal government.

Three states—Illinois, New York and Wisconsin—were forced to relinquish safety enforcement re-

It is this type of system—one that regulates safety for public employees only but would offer only safety advice and consultation to working conditions for public employees, such as highway construction workers and firefighters, the federal agency says.

sponsibility to federal OSHA in 1973 when state legislatures did not approve the new role they had assumed. Under the 1971 act, states were allowed to regulate workplace safety immediately, but their legislatures were required to approve those agencies within two years. Colorado withdrew in 1980.

Connecticut withdrew all but regulation of public sector employees in 1978, and New York reinstated regulation of public sector workplaces in 1982. These states are the only two that only regulate private sector employers—that Gov. Deukmejian wants California to adopt.

Doing so would eliminate about 366 jobs and save the state $8 million in the first year and perhaps more in future years, according to a summary of the governor's 1987/1988 budget proposal.

Eliminating all but the public sector enforcement sections would cut $22.2 million from the approximately $33.5 million budgeted for Cal/OSHA in 1987/1988: $8 million from state funds and $14.2 million from the federal government, the governor hopes.

To press Gov. Deukmejian to change his mind, labor unions and others claim the $8 million savings would cause more job accidents and higher workers compensation insurance premiums.

"If he takes a look at the facts, we can prevail," observed Richard Holober, legislative representative for the California Labor Federation in San Francisco.

Most parties recognize that Cal/OSHA is far more strict than its federal counterpart, because Cal/OSHA's standards had to be at least as rigorous as OSHA's before the state agency could be formed, according to the 1971 act.

Mr. Holober cites numerous differences between the agencies, among them the regulation of chemical exposure: Cal/OSHA's permissible exposure levels on about 100 toxic chemicals are more strict than the federal OSHA's requirements, and the state agency also enforces minimum exposure levels on about 170 other substances that the federal agency does not.

Employers appear divided over the issue.

For example, although Lucky Stores Inc., a multistate grocery chain, has not had difficulties with Cal/OSHA, eliminating it would give Lucky one fewer state agency to deal with, said Clay Creasey, Lucky's financial services manager in Dublin, Calif.

Many multistate companies already have adopted safety standards based on the most strict regulations of the states in which they operate.

For example, Hills Brothers Coffee Inc. applies Cal/OSHA standards to its operations in Arizona, Louisiana, New Jersey and Virginia, as well as in California.

"If you can meet California's (standards), you can meet them all," noted Risk Manager Constance Roberts in San Francisco.

If the governor's proposal is approved, Hills Brothers would not lower its current safety standards, she said. Instead, the company likely would model its workplace safety programs after the laws of New Jersey, the second most rigorous of the states in which the company operates, she explained.

But some California employers, such as those in the construction industry, would prefer to see the federal agency take control of workplace safety regulation in the state, said John Upshaw, a former risk manager who now operates Employer Services Group, a consultant, in Pleasant Hills, Calif.

"There are enough motivations in the marketplace to make a contractor sit up and do the right thing by his workers rather than have a selective enforcement agency running around handing out tickets and large fines," he said.

Other California business voices, like the Merchants & Manufacturers Assn., have not yet taken a position on the proposal. ■

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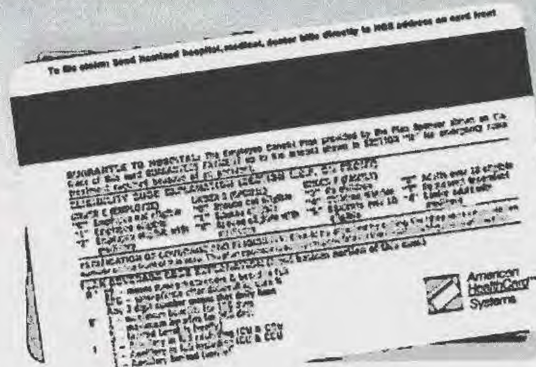

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**products & services**

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Excess aircraft liability insurance with limits of up to $100 million is available through Stewart Smith Holdings Inc. for non-scheduled commercial or private/corporate aircraft operators with fixed or rotor-wing aircraft with capacities of fewer than 25 passengers.

Stewart Smith can quote and bind excess aircraft liability above a minimum underlying limit of $5 million combined single limit or $1 million per passenger seat, whichever is greater, according to Michael Iacovelli, vp-aviation for the New York-based surplus lines broker.

The excess aircraft liability coverage is written by Lloyd's of London underwriters, Mr. Iacovelli said.

Worldwide coverage also is available, he said; however, to be qualified, operators must be domiciled within the 48 contiguous United States.

Rates for the coverage are negotiable, according to Mr. Iacovelli.

For more information about the excess aircraft liability coverage, contact Stewart Smith's aviation staff at 123 William St., New York, N.Y. 10038; 212-964-2929, or at 1 S. Wacker Drive, Chicago, Ill. 60606; 312-236-733.

## Work comp video

A new videotape explaining the hows and whys of the Texas Workers Compensation Assigned Risk Pool is available to employers and agents from the Insurance Information Institute.

"A Workable Solution: An Introduction to the Texas Workers Compensation Assigned Risk Pool" describes how the TWCARP is organized and funded, why some businesses are rejected in the voluntary workers compensation insurance market and what services the pool offers to help employers prevent future losses.

The TWCARP was created in 1953 by the Texas Legislature to provide a source of workers compensation insurance for employers that cannot obtain the coverage in the commercial marketplace.

The videotape is available on loan without charge in VHS and ¾-inch videotape format from the Insurance Information Institute, 800 Brazos, Suite 4220, Austin, Texas 78701; 512-476-7025.

## Commercial umbrella

CNA Insurance Cos. is marketing a new Commercial Catastrophe Umbrella Third-Party Liability Policy with a $1 million aggregate limit.

"This is an additional high-limit protection that steps in where primary commercial liability insurance leaves off, providing continuous coverage that makes good business sense today," said Philip L. Engel, CNA's vp of marketing.

CNA's Commercial Umbrella policy provides coverage for liability, such as bodily injury, property damage, advertising or personal injury and fire damage legal liability. The simplified policy language states what is covered, Mr. Engel explained.

The coverage attaches at various levels.

Designed to accommodate changes brought about by the Insurance Services Office's new commercial general liability forms, CNA's new commercial umbrella provides coverage on either a claims-made or occurrence basis, depending on the primary coverage.

Extended reporting period options are available for coverage written on a claims-made basis, regardless of whether the policyholder or CNA cancels or nonrenews the policy, according to Mr. Engel.

In addition to comprehensive commercial umbrella coverage, CNA offers personal umbrella liability supplements for named policyholders. Coverage limits under the supplement equals those of the personal umbrella liability policies

*Continued on next page*


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*Continued from previous page*
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For convenience, the supplements are attached to and billed as part of the commercial liability policy.

Adaptable to a portfolio approach, CNA's commercial umbrella policy can be added to any one of CNA's business insurance packages—Encompass II Business Account Program, Encompass II Commercial Account Program and Tailored Commercial Program.

CNA's commercial catastrophe Umbrella Third Party Liability Policy will be underwritten by six of the CNA companies, including Continental Casualty Co. in Chicago and American Casualty Co. of Reading, Pa.

For more information, contact your local CNA Insurance Cos. agent.

## Legal services

The Signature Group is offering its prepaid legal services plan to employers as an employee benefit program.

The plan, which provides affordable, quality, legal counsel, also has been offered to the general public, said Nancie E. Poulos, general manager.

A $6.75 monthly fee entitles members to services including: unlimited advice and consultations by telephone and mail; legal letters and phone calls on the client's behalf to resolve matters, if necessary; initial face-to-face consultations; review of documents up to six pages in length; a simple will; a toll-free phone number for customer service comments; and a 24-hour in-house bail bond service.

In addition, the plan provides a fixed rate for services such as name changes, residential real estate closings, uncontested divorces and adoptions.

The plan also guarantees a maximum hourly fee of $50 for other legal services.

The year-old plan is available in 20 states so far.

For more information, contact Nancie E. Poulos at the Signature Group, 200 N. Martingale Road, Schaumburg, Ill. 60173-2096; 312-490-7245.

## CGL manual

A new reference manual comparing the old comprehensive general liability forms and the new commercial general liability forms is available from Griffin Communications Inc.

"The Old and New CGL Forms: A Practical Comparison" provides a word-by-word comparison of the 1973 Insurance Services Office's CGL form and broad-form CGL endorsement with the 1986 ISO-CGL claims-made and occurrence forms.

All of the forms are reproduced in their entirety in this new, illustrated publication, the publisher says.

Following the reproduced policy forms are analyses on how sections of the 1986 forms compare with those of the 1973 CGL policy form and the broad-form CGL endorsement.

References are provided to direct readers to those sections of the 1986 CGL claims-made and occurrence forms where the comparable or new wording being discussed can be found.

The publication also discusses the coverage peculiar to the claims-made version of the 1986 ISO CGL forms, including retroactive dates, extended reporting periods, claims and occurrence information and laser endorsements.

Copies of the manual are $50 each, including shipping and handling. California residents must also pay 6% sales tax.

For more information, or to order a copy of "The Old and New CGL Forms: A Practical Comparison," write Griffin Communications Inc., 1420 Bristol St. N., Suite 220, Newport Beach, Calif. 92660.

## Digest of PPOs

The National Assn. of Employers on Health Care Alternatives has published its second annual edition of the "Blue Book Digest of PPOs."

The state-by-state directory lists 462 preferred provider organizations in 43 states, the District of Columbia and Puerto Rico.

The digest includes information such as the sponsorship of the PPO, the number of hospitals and physicians contracting with the PPO and the date the PPO began operating.

The digest is available for $54.50 from the National Assn. of Employers on Health Care Alternatives, 104 Crandon Blvd., Suite 304, Key Biscayne, Fla. 33149; 305-361-2810. ■


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BI 22387

# USX finalizes employee benefit changes

**benefit beat**

USX Corp. is finalizing employee benefit changes made in the new four-year contract recently ratified by the United Steelworkers of America.

The new contract, which was ratified by almost a 5-1 margin, includes benefit cost-containment provisions and an optional universal life insurance program (*BI*, Feb. 9; Jan. 26).

Under the new contract, union employees will receive dental care coverage through a prepaid dental plan, Dental Network U.S.A., a Blue Shield of Pennsylvania affiliate. The coverage is effective May 1.

Under the new dental plan, employees will not contribute to the monthly premium. The only costs employees must pay will be varying deductibles for certain prosthodontic services, like dentures and crowns, said George Hanserling, director of employee benefits for Pittsburgh-based USX.

The annual maximum dental benefit also will increase to $1,400 from $1,000.

Under the previous dental plan, underwritten by the Equitable Life Assurance Society of the United States, employees did not contribute to the monthly premium or pay annual deductibles. However, they paid 15% of expenses for most restorative services and 50% of prosthodontic services.

In addition, a new hospital utilization review program will go into effect for USX unionized employees on July 1, said Mr. Hanserling. The final selection of a program vendor is expected to be completed soon.

The program will include pre-admission review, pre-admission testing, a second-surgical opinion program and an outpatient surgery program, he said.

Currently, union employees do not share in hospitalization costs. However, if employees do not have non-emergency hospital admissions reviewed, they will pay a penalty of $300, Mr. Hanserling said.

"The reason we are implementing the cost-containment program is to try to diminish the high costs and over-utilization under the hospital coverage," Mr. Hanserling explained.

Employees do share in health care costs under the company's major medical plan. USX self-insures the plan and contracts for administration services with various local Blue Cross/Blue Shield plans.

Under the new contract, annual deductibles for major medical coverage increased to $150 for individual coverage, up from $75, and to $300 for family coverage, up from $150, he said. The lifetime maximum under the plan also increased to $100,000 from $50,000.

Employees also pay 20% of all expenses under the major medical plan. "Since this is a low-cost plan that covers many things like prescriptions and office visits, there is no cap on employees' out of pocket costs," Mr. Hanserling said.

In addition to changes in health care benefits, unionized employees will be offered an optional universal life insurance program beginning May 1.

"We discussed the possibility of adding a 401(k) savings plan, but instead decided to offer a universal life insurance plan," Mr. Hanserling said.

Under the program, employees will have the option of purchasing universal life insurance coverage through payroll deduction. The coverage offers employees not only life insurance benefits, but also will allow employees to save for retirement with tax-deferred interest on savings.

Final details of the plan, including selection of an underwriter, are now being worked out.

USX will continue to provide union employees group term life insurance coverage, underwritten by Equitable. Benefits vary according to a schedule based on the worker's salary, years with the company and other factors.

Other benefit changes in the new USX contract, as reported, include a new profit-sharing plan, increased pension benefits and special early retirement benefits.

## Legal benefits

Chicago-based Navistar International Corp. is offering its union employees a company-sponsored legal assistance plan.

Some 7,000 active employees and 16,000 retirees represented by the United Auto Workers Union are eligible to participate in the plan, which is administered by Kansas City, Mo.-based Hyatt Legal Services, said a Navistar spokesman.

Employees do not share in the cost of most services covered under the plan, which include legal advice on consumer and financial matters; wills; adoptions; divorce; real estate transactions; and tenant problems.

However, the plan requires the employee to pay for some services, such as the cost of filing court papers in divorce cases, said a spokeswoman for Hyatt.

And, the plan covers only legal advice—and not legal action by the attorney—on some services, such as handling traffic offenses, child custody cases and debt collection actions.

The majority of Navistar's UAW-represented employees are located in Springfield, Ohio; Indianapolis; and Chicago, he said.

## HMO regulations

The Florida Insurance Department has formed a task force to study issues concerning the quality of care delivered through health maintenance organizations.

The task force will evaluate existing HMO regulatory authority by the Insurance Department and the state's Department of Health and Rehabilitative Services and suggest new approaches, said Peter Levin, Dean of the College of Public Health at the University of South Florida and chairman of the task force.

Currently, the Insurance Department requires all HMOs to file annual financial reports. HMOs also are required to maintain a surplus of at least $100,000 or 5% of the HMO's total liabilities.

HRS has the authority to examine HMOs' medical records to monitor quality of care.

Along with evaluating the regulatory authority in Florida, the task force will examine current HMO laws in other states. "We will compile a summary of state-of-the-art provisions in various states in order to identify and clarify specific roles of public and private groups responsible for prepaid plans," Mr. Levin explained.

"The task force will provide an overall analysis for managing quality of care. In the whole HMO movement thus far state insurance departments have been comfortable with having just financial and solvency information. What the insurance departments don't understand is that there is a definite relationship between financial solvency and how care is organized and delivered. We're going to try to link solvency and quality in our new regulations," he continued.

The task force will include representatives from the Insurance Department, HRS and the University of South Florida.

HMOs in the state are "supportive and are aware of the difficulty involved in this project," he said.

Public hearings on the quality of care issue will be conducted in Miami and Tampa, he added.

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*Benefit beat keeps insurance and employee benefit managers informed on what other companies are doing and of current developments in the employee benefit field. We'd like to know if you've made any changes in your employee benefit plans. Write Donna DiBlase, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611; 312-649-5393.*

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# Lang assumes new post at Kohler Co.

## comings & goings: buyers

**Harold C. Lang**, 56, has been named director of risk management at Kohler Co. in Kohler, Wis. In this newly created position, Mr. Lang will supervise Kohler's risk management and insurance activities for the company and its subsidiaries. Kohler, which created the position due to recent expansion of the company and its insurance program, manufactures plumbing fixtures and fittings, generators, air-cooled engines and specialty products. Mr. Lang reports to Eugene P. Siefert, vp and treasurer. Prior to this appointment, Mr. Lang was director-insurance and risk management at Leaseway Transportation Corp. in Cleveland. While at Leaseway, Mr. Lang was named *Business Insurance*'s 1985 Risk Manager of the Year (*BI*, April 15, 1985). Prior to that he served as risk manager at Bunker-Ramo Corp. in Chicago. Mr. Lang received a bachelor of science degree in industrial management from St. Peter's College in Jersey City, N.J. He is a member of the American Society of Safety Engineers, holds the Professional Safety Engineer designation and is a deputy member of the Risk & Insurance Management Society.

Mr. Lang

* * *

**Erick L. Johnson**, 32, has been promoted to vp for risk management at Del E. Webb Corp. in Phoenix, Ariz. In this position Mr. Johnson will oversee corporate insurance programs, including self-insured workers compensation and property/casualty programs, as well as loss prevention. He reports to Philip J. Dixon, executive vp and chief financial officer. Mr. Johnson, who joined Webb in 1983 as director of corporate claims, previously served as the company's director of risk management. Prior to joining Webb, which is a diversified company involved in the management and development of real estate, retirement communities and leisure facilities, he was assistant manager for loss prevention services in Greyhound Corp.'s insurance department. Mr. Johnson holds a bachelor of arts degree in public administration and a master of business administration degree in finance from the University of Arizona in Tempe. Mr. Johnson is a director of the Arizona Central Chapter of the Risk & Insurance Management Society and holds the Associate in Risk Management designation. He is working toward his Chartered Property & Casualty Underwriter designation.

* * *

**John J. Bayeux**, 31, has been named vp and risk manager at L.F. Rothschild, Unterberg, Towbin Inc. in New York. As its first full-time risk manager, he will oversee the securities firm's risk control efforts and asset conservation activities. He reports to Douglas M. Libby, managing director and general counsel. Previously, Mr. Bayeux was senior risk analyst at PepsiCo Inc. in Purchase, N.Y. He also held risk management positions with Revlon Inc. in New York and Foster Wheeler Corp. in Livingston, N.J. He received a bachelor of arts degree in history and a master of business administration degree from Seton Hall University in South Orange, N.J. In addition, he holds the Associate in Risk Management designation and is a deputy member of the Risk & Insurance Management Society.

* * *

**Charles S. Kolodkin**, 30, has been named director of risk management at Harris Methodist Health Services in Fort Worth, Texas. In this position he will oversee property/casualty and medical malpractice insurance programs as well as loss control for Harris Methodist, which operates a chain of hospitals and nursing homes throughout Texas. He replaces **Bob Schwevel**, who left Harris Methodist to join HealthCare International Inc. in Austin, Texas. Mr. Kolodkin reports to Jack Roper, vp-finance. Prior to joining Harris Methodist, he was an account executive with Corroon & Black of Texas. He received a bachelor of arts degree from Miami University of Ohio in Oxford, and a master of business administration degree from the University of Georgia at Athens. Mr. Kolodkin is a deputy member of the Risk & Insurance Management Society and holds the Chartered Property & Casualty Underwriter designation.

* * *

**Ernest J. Maddox**, 48, has been named assistant treasurer-corporate risk manager at Alexander & Alexander Services Inc. in New York. In this newly created position, he will be responsible for the administration of risk management and insurance programs for A&A and its operating units. He reports to James B. Lockhart, vp and treasurer. Previously, Mr. Maddox was corporate risk manager for Pitney Bowes Inc. in Stamford, Conn., and prior to that served in the same capacity for Citizens Utilities Inc., also in Stamford. He received a bachelor of arts degree in economics and political science from Queen's College in New York and a doctor of law degree from Pace University Law School in New York. Mr. Maddox is a former director and chairman of the education committee of the Fairfield/Westchester Chapter of the Risk & Insurance Management Society. In addition, he is a member of the American Bar Assn. and the New York State Bar Assn.

* * *

**John R. Watts**, 25, has been named corporate risk analyst at American Honda Motor Co. Inc. in Los Angeles. In this newly created position, he will be responsible for the company's property insurance, fleet safety and loss prevention programs. He reports to Lawrence Nemirow, corporate risk manager. Prior to this appointment, Mr. Watts served as safety engineer at McDonnell Douglas Helicopter Co. in Culver City, Calif. Prior to that he was coordinator of owner-controlled insurance programs at General Motors Corp. in Lansing, Mich. Mr. Watts received a bachelor of science degree in safety management from Indiana State University in Terre Haute. Mr. Watts is a member of the American Society of Safety Engineers.

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


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# Surety underwriters eye private sector

By JUDY GREENWALD

PITTSBURGH—The surety business, reeling from large losses, is expanding further into the private sector, says Lloyd Provost, president of the Surety Assn. of America.

The surety business suffered a 135% combined ratio in 1985, and all indications are the 1986 combined ratio probably approached, and conceivably surpassed, the 1985 figure, said Mr. Provost during a session on surety bonding at the sixth annual seminar sponsored by the Pittsburgh Chapter of the Risk & Insurance Management Society.

The slump in public construction—which declined to 17% of all U.S. construction in 1984 from 34% in 1976—also is contributing to the surety industry's financial problems, Mr. Provost said.

**In cases in which the self-insurer defaults, the desire to see an injured worker receive benefits has led to an 'awful lot of innovative court decisions' that hurt the surety business, says Lloyd Provost of the Surety Assn. of America.**

Public construction requires surety bonds to guarantee construction contracts. If the contractor fails to perform as specified, the bonding company either oversees completion of the task or indemnifies the entity for which the work is being done up to the limit of the bond.

In response, the surety industry is trying to expand its business into the private sector, Mr. Provost said, with surety bonds acting as a guarantee that contractors can do the job promised. "We have met with some success," he said.

Surety insurers, however, are concerned about writing bonds for workers compensation self-insurers, he said.

Because of the long-tail nature of the claims, "a claim can come 50 years down the pike," he said. And, surety companies must agree to pay out the claims over time, rather than in one lump sum.

In addition, in cases in which the self-insurer defaults, the desire to see an injured worker receive benefits has led to an "awful lot of innovative court decisions" that hurt the surety business, he said.

Surety companies also are concerned about the stability of the companies they insure, according to Mr. Provost. At one time, he noted, it could safely be predicted a Fortune 500 company would "stick around." But business trends such as leveraged buyouts, poison pills—moves by target companies to make acquisition undesirable—and "greenmail" can place some companies in jeopardy.

As a result of the surety industry's financial problems, some companies have left the business, according to Mr. Provost. And those that remain are doing so on "different terms," he said.

Almost all contract bonds, for example, have been re-underwritten, required financial information is being upgraded and "underwriters are once again paying attention to documents," he explained. And, reinsurers are adding their own restrictions.

To speed the surety industry's financial recovery, Michael P. Tilton, managing director at broker Marsh & McLennan Inc. in New York, suggested that surety companies become more innovative.

Mr. Tilton advocated using surety bonds as a substitute for directors and officers liability insurance and suggested that commissions for producers of surety business be revamped. Typically, he said, they have earned high commissions.

Also during the session, Timothy Kenneally, executive vp of Fred S. James & Co. Inc. in New York, discussed the pros and cons of regulators' efforts to segregate the financial guarantee insurance business from other lines of insurance.

Some regulators contend that financial guarantee insurance should be written only by monoline financial guarantee insurers, which also should not be covered by state guaranty funds. They do not want to risk that multiline insurers could go broke writing financial guarantee products and ultimately cost state guaranty funds property/casualty claims.

However, the large amounts of capital required to establish monoline insurers may not be the most effective and economic use of capital, Mr. Kenneally said.

He also said there is room in the financial guarantee business for both insurers and banks, as long as the business is properly underwritten. ■

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## Future markets

*Continued from page 2*

These underwriters' values were prostituted and, in turn, they became cynical, he said. At the same time, training programs were shut down.

As a result, "we have thinned out the expertise of this industry to a frightening level," Mr. Compton said.

While American Re had a good year in 1986, he said, "We could not grow our facultative business as fast as we would have liked to grow it" because of a shortage of adequate personnel.

Another problem affecting the industry is the fact that its price cutting during the soft market eroded clients' confidence, Mr. Compton said.

In addition, reserves during the last down cycle were inadequate, which generally have been corrected, but surplus also must be rebuilt to satisfy demand for insurance, he said.

Another indicator that the hard market will endure is Mission Insurance Co.'s insolvency, according to Mr. Compton. Even the staunchest, most conservative iconoclast "has to know that's bad news" he said.

The California Insurance Department earlier this month asked a state court to liquidate Mission, which was insolvent by $448.1 million as of Sept. 30, 1986 (*BI*, Feb. 9).

Licensed insurers will be assessed through guaranty funds to cover claims against Mission policies written on an admitted basis while insurers that ceded business to Mission probably will recover less than their full claims.

During the last soft market, a "tremendous amount" of the funds that filtered into the market came from Europe. Funds also came from big U.S. industrial companies, which did a poor job of managing them and, as a result, many are no longer involved in insurance.

These newcomers to the market had been attracted to the insurance industry by the 30% to 40% returns on equity insurers were making in the late 1970s, Mr. Compton pointed out.

"They really believed, these people, they were underwriting the lines," he said.

But, someone who acts out of ignorance, said Mr. Compton, often is more dangerous than someone who's aware he's doing wrong, but does it anyway.

During the soft market, a new reinsurer was being created in the United States every two weeks for five years, he said.

At the same time that capacity was being created, the tort system was "going nuts," said Mr. Compton, criticizing the concept of joint and several liability, which he said he could not morally justify. So far, he said, those who are attempting to reform the system have not yet made a "significant dent."

Mr. Compton also blamed the tight market on the industry's reliance on the premium-to-surplus ratio, which does not reflect either the risks being insured or their pricing.

For example, he said, a company could maintain the same 3-to-1 ratio of $500 million in premium and a $1.5 billion surplus by writing 1,500 risks for $1 million each or it could double its prices and halve its exposure by writing only 750 risks.

In late 1984 and 1985, reinsurers began to raise prices, and that meant they could write fewer risks. American Re, for instance, dropped its excess and surplus lines and directors and officers liability coverage and went through its surety bond portfolio "like Sherman to the sea."

"We had no choice, anyway," said Mr. Compton, noting that one client company canceled insurance on almost all the churches in South Carolina.

At the same time, London "got tired" of the situation and decided it wanted a "more sensible system in which to play." This led to sunset clauses and other tightening of coverages.

During 1985, he said, 67 companies "abandoned" the reinsurance business. Not all of them were insolvencies, though, said Mr. Compton. Many decided "it just wasn't worth it."

The tight market also tarnished reinsurers' image and made them "the targets of outrage." For the first time, reinsurers are undergoing intense scrutiny. Until now, he said, the reinsurance business was regarded as mysterious, because few people paid attention to it, he said.

**Attempts to reform the tort system have not yet made a 'significant dent,' Mr. Compton says.**

"We just sort of rolled along."

Now, the reinsurance business has become popular with legislatures, investigating committees and attorneys general, among others, said Mr. Compton, who wistfully added he only wishes they would make the distinction between "Temporary Re and American Re."

He said the insurance industry must help the public understand the cyclical nature of its business. The Insurance Information Institute is now making an effort to polish the industry's image.

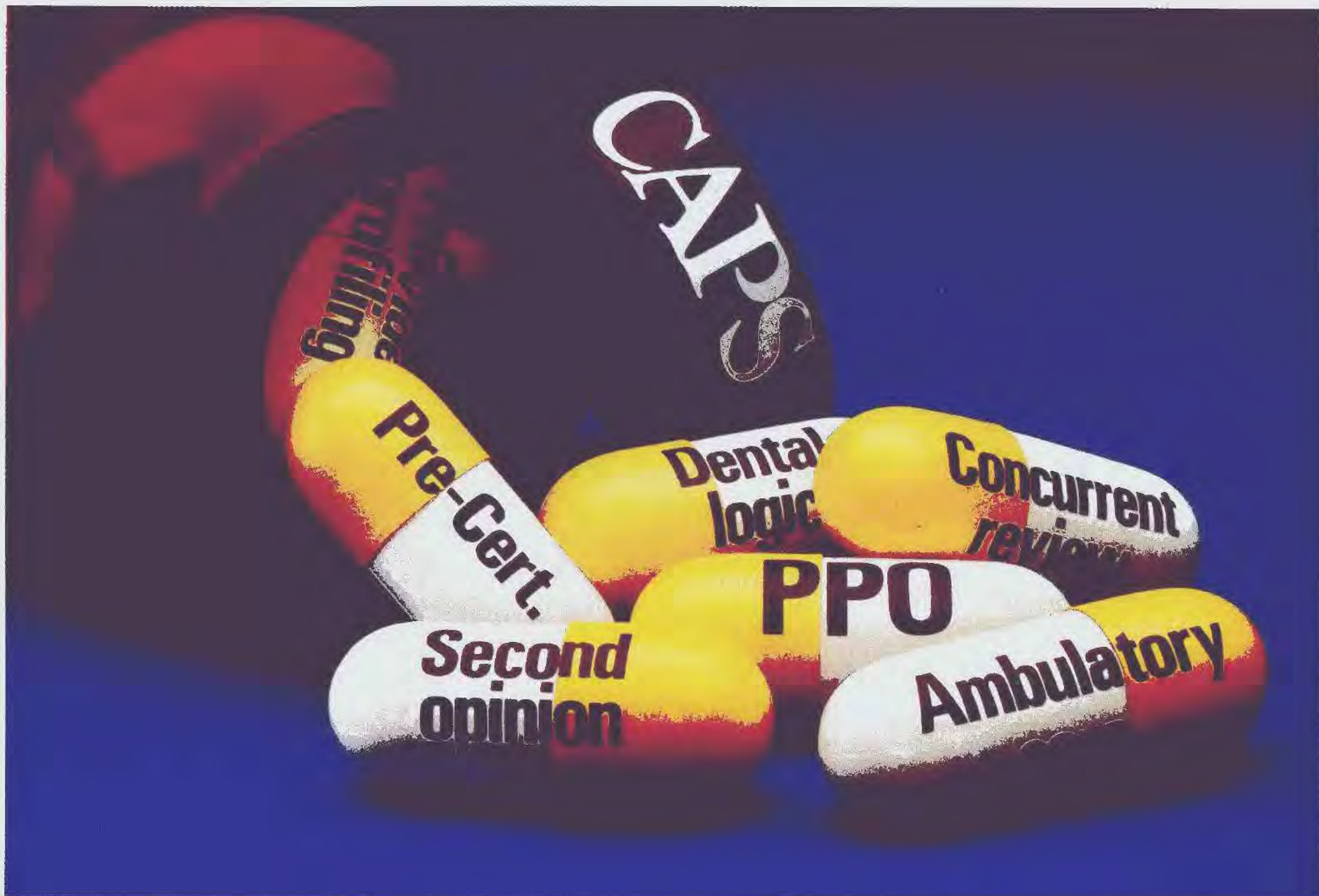
Responsible companies have done a "superb job" of building up their reserves, said Mr. Compton. Some problems remain, he said, but "it's very spotty."

And the new players in the market to date have "chosen excellent talent to manage," their investments, he observed.

One of the lessons the industry should have learned, he said, is that "market share is an irrelevant concept in a cyclical business."

The next time some "yahoo" with a post office box in the Cayman Islands offers a deal at a cut-rate price, risk managers that buy it should remember that they are contributing to the problem just as much as the underwriter who "shuts off the water" when the market hardens three years later, he told the RIMS chapter. "We are all involved in this."

This business must absolutely be regulated for solvency first, and pricing should be a secondary consideration only, Mr. Compton explained. ■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# Good underwriters are necessity: Bolinder

By JUDY GREENWALD

PITTSBURGH—If insurers learned a lesson from the last property/casualty insurance cycle, it is to take care when dealing with their underwriting staffs, an insurance company executive says.

"We've really turned a lot of our underwriters into processing clerks," said William H. Bolinder, president and chief operating officer of Zurich-American Insurance Group in Schaumburg, Ill. He added that he is not sure whether these employees can again make the transition to underwriter.

Mr. Bolinder made his remarks as a member of a panel that discussed "What Have We Learned" at a Feb. 10 seminar sponsored by the Pittsburgh Chapter of the Risk & Insurance Management Society.

Other members of the panel included James W. McMahon, vp of CIGNA Corp.'s claim and management division in Philadelphia, and Thomas V. Hallett, chairman and chief executive officer of Adjustco in Tarrytown, N.Y., a claims management and risk management consulting unit of Frank B. Hall & Co. Inc.

Mr. Bolinder said the industry also learned that it must pay attention to other types of employees, including claims administrators, actuaries and loss-control personnel.

"You need the best and you need time and care to develop them," he said, adding that the industry should have also learned the importance of finding and developing good, young talent.

He said the insurance industry can be compared to Sisyphus, the Greek mythological figure who showed disrespect toward Zeus and was condemned to an eternal punishment of pushing a heavy rock up a hill. Just as he would get it almost to the top, it would roll down again, forcing him to start over.

"A lot of us are cleaning the dust off our shoulders" from rolling the rock up the hill, he said, referring to the cyclical nature of the business.

"People don't like us very much," he said, noting that many observers regard the property/casualty industry as a cartel that manipulates market conditions to its best advantage. These observers, however, also have come to consider insurance a commodity, failing to recognize the distinctions between policies issued by different companies.

This perception is the result of cash-flow underwriting, where premiums are set in anticipation of earning investment income rather than on the risk to be underwritten, Mr. Bolinder suggested, adding that he hopes that industry has learned the importance of evaluating exposures. According to Mr. Bolinder, among other things the industry and buyers should have learned from the last underwriting cycle are that:

- Services should be provided based on need, not on price.
- "Cheap reinsurance is worth the price you pay for it."
- Insurance buyers know how to shop the market.
- The insurers that do the best are the companies that "stick to basics."
- "The insurance business needs top management teams who understand the insurance business."

"More importantly," concluded Mr. Bolinder, "I hope we've learned enough to put our lessons into action."

CIGNA's Mr. McMahon said insurance company claims departments once reminded him of a quip by award-winning sportswriter Red Smith, who declared that sports was the "toy department" of newspapers.

**Claims departments are 'not fun anymore. The fun and simplicity have been replaced by complexity, and now it's a deadly serious business,' says James W. McMahon, vp of CIGNA Corp.'s claim and management division.**

Claims departments once were "pretty simple and straightforward," said Mr. McMahon. However, "It's not fun anymore. The fun and simplicity have been replaced by complexity, and now it's a deadly serious business."

For instance, product liability claims are the "most bedeviling of all the areas we have to deal with," he said, explaining that many product liability claims do not even cite a specific disease or injury that was allegedly caused by the product in question.

Mr. McMahon also noted the rise in disputes between policyholders and insurers over the terms of insurance coverage and the damage it can cause to both parties.

Coverage litigation is a phenomenon "that has threatened to devour us all," he said, stating he is not sure what can be done to stop the increase in coverage disputes.

"Litigation won't solve anything," he said. "You're going to have to work for innovative solutions to these problems."

It is in insurers' and policyholders' interest to find a common purpose in minimizing plaintiffs' claims," Mr. McMahon said. Insurers and buyers need to make more of an effort to cooperate with one another and avoid situations where "the plaintiff is off setting fire to the barn" while the insurer and the policyholder are locked in a dispute.

"Someone may hurl a thunderbolt from Mount Olympus to help all of us. But until then, there's a lot of hard work that has to be done," said Mr. McMahon, concluding with the warning: "It's only going to get tougher."

Adjustco's Mr. Hallett noted that "we are all practicing 20-20 hindsight" in analyzing the competitive commercial insurance market.

But at the same time, if industry observers think they know what the next three years will bring, "we probably played too many games without a helmet," Mr. Hallett noted

Among the things learned from the last cycle, he continued, are that:

- "Underwriters should be treated as underwriters."
- As "responsible players," the insurance industry should have realized that plaintiffs' attorneys were an "awesome adversary" and "we should have matched power

*Continued on next page*


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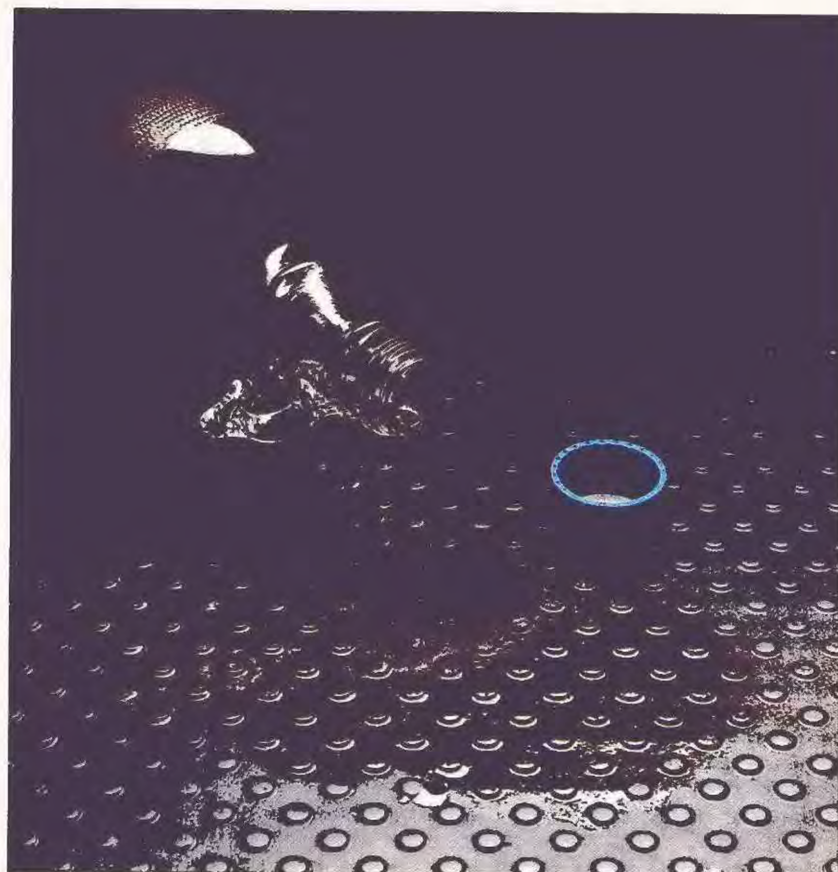

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Continued from previous page
with power."

- The industry would have been better off focusing its legislative efforts on the state rather than the federal level.
- The industry would have been better off pushing a short list of tort reforms, focusing on what it considered important, rather than on an long, unwieldy list.
- Buyers should oppose diminution of liability insurance limits by defense costs.
- Buyers should remain adamant in their demand for congruent coverages.
- Insurance brokers' important role as market makers should be recognized.
- Professionalism should be a primary concern in the future "because the challenges will be bountiful."

But Mr. Hallett, responding to a question from the audience, noted that it may take a long time for buyers and insurers to repair damage to long-term relationships that was caused when the market hardened recently.

"You don't do it quickly, obviously," Mr. Hallett said. "I think we're starting almost back at scratch with a lot of these relationships, unfortunately."

Mr. Bolinder added, "I think we really stepped on it this time, and it's going to take a long time to repair."

Also participating on the panel was attorney Peter J. Kalis, with the Pittsburgh firm of Kirkpatrick & Lockhart, who specializes in defending manufacturers in cases involving toxic tort and environmental law. ■

# D&O competition may resume: Broker

**By JUDY GREENWALD**

PITTSBURGH—Competition may return to the directors and officers liability insurance market this year, thanks in part to increasing availability of D&O coverage through offshore facilities, says Peter J. McKenzie, vp at J&H Intermediaries Ltd. in Bermuda.

"Twelve months ago, we were in the middle of a very serious D&O crisis," Mr. McKenzie said during a panel discussion on D&O insurance at a seminar conducted by the Pittsburgh Chapter of the Risk & Insurance Management Society.

Today, however, with the continuing development of offshore facilities, there is "something we never had before, and that's options," he said.

Offshore captives that write excess D&O coverage, according to Mr. McKenzie, include: A.C.E. Insurance Co. Ltd. and X.L. Insurance Co. Ltd., established to write coverage for all types of companies; Corporate Officers & Directors Assurance Co., developed for Fortune 500 companies; and Directors & Officers Liability Insurance Ltd., which was developed for utilities (*BI*, Oct. 20, 1986).

Furthermore, competition for D&O business may emerge later this year, Mr. McKenzie said, "and not necessarily competition between the offshore and the onshore facilities." The competition may be among the offshore facilities alone, he said.

U.S. corporations have been eager to contribute capital to these facilities so they can write D&O coverage, he noted, but added "maybe we have reached a saturation point."

Mr. McKenzie pointed out the property/casualty insurance industry never has experienced market conditions as tight as they have been over the past several years.

"I think it's gong to be a very interesting 12 months to see how things develop."

Other speakers at the session on D&O insurance included Michael Miller, manager-executive protection in Chubb Corp.'s Pittsburgh office, and Stephen Sills, senior vp of Executive Risk Inc. in Simsbury, Conn., which writes on behalf of Aetna Life & Casualty Co.

Meanwhile, two risk managers speaking at a session on excess insurance held at the Pittsburgh RIMS seminar disagreed over whether the new alternative insurance market will disappear once commercial insurers begin offering increased capacity.

Richard T. Shillinger, corporate risk manager at Pittsburgh-based Aluminum Co. of America, said offshore alternative facilities have been a boon to his company during the hard market.

ALCOA has been active in both A.C.E. and Tortuga Casualty Co., a Cayman-based excess liability insurer that was organized for captive management clients of The Reiss Organization.

The company plans to continue to purchase coverage from these companies even after the market becomes more competitive because of the stability they provide, he said.

"I think the alternative is chaos," Mr. Shillinger said.

However, another risk manager said he does not believe these alternatives facilities will be around once the market changes, even though his company is participating in both A.C.E. and X.L.

"I don't know where we'll be three years from now," said John R. Thomas, assistant treasurer at PPG Industries Inc. in Pittsburgh, who moderated the session.

"If the market does come raging back, I would expect A.C.E. and X.L. to fold their tents and everyone go home," Mr. Thomas said.

Mr. Shillinger responded that the companies that now purchase coverage for these facilities "are in it for the long haul." ■


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# HEALTHY COMPETITION

By Charles R. Stanfield

EMPLOYERS' ATTEMPTS to gain better control of their health care costs is nothing new. However, the methods they are beginning to use and the effect those strategies will have on the health care market are revolutionary.

Many employers still are adding incentives and limitations to their traditional indemnity benefit plans (see related story).

Such actions are evolving into multifaceted management programs intended to stem some of the overuse of services inherent with the fee-for-service, patchwork method of delivering and reimbursing for health care.

Many of these actions might be characterized as repairs to the current laissez-faire health care system. For example, inpatient precertification and utilization management programs use third-party advisers to "reform" physicians whose practice styles are determined to be out of conformance with prevailing physician practices.

While these repairs are underway, other employers are reaching another stage in health care cost management: They're focusing on competition as a specific strategy.

This is characterized by their recognition of the additional savings that might be achieved by channeling plan members to providers who already have been practicing cost-efficient, conservative health care. Such selective purchasing arrangements can produce immediate savings, plus prompt market-driven discipline in the local health care marketplace by shifting customers away from inefficient providers.

But, there is concern that over-emphasis on cost efficiency and aggressive price competition may adversely impact quality and satisfaction. The challenge for employee benefit managers is to stimulate competition on the basis of performance as well as price.

The emerging objectives of progressive employers are:

- To encourage the restructuring of the current fee-for-service, patchwork method of delivering and reimbursing for health care by stimulating competition among providers based on price *and* performance.
- To offer alternative plans that are determined by the employer to deliver health care in a more efficient manner and limit—or not offer—less efficient plans.
- To allow employees to make choices, to promote the involvement of employees in smarter shopping and to encourage employees to lead healthier lifestyles.

The evolving selection criteria and performance requirements applied by major purchasers will have a reciprocal effect on suppliers of health care services.

The focus of the health care marketplace will be shaped by the willingness of purchasers and by the responsiveness of the suppliers. Based on an increasingly performance-driven environment, the success of health care organizations will be increasingly tied to their ability to identify and utilize measures of their performance relative to local competitors.

Such increased involvement of benefit managers has broadened their function beyond the historic role of arranging financial protection, with specifics delegated to third-party bill payers. Their new role is being redefined as a purchaser of cost-effective health care services that are intended to promote a healthy and productive workforce.

As purchasing agents, benefit managers are recognizing that health care involves the concept of winners and losers (as is true in other competitive markets) and that they must decide *not* to buy from producers who are identified as giving less value.

Given these new objectives, it is natural for benefit managers to also adopt the principles used by their employers to purchase other costly material goods. This entails developing contractual arrangements based on specific measurable performance results.

The perceived task is one of inducing marketplace discipline at a local level, since health care is a localized type of service.

Briefly, in a functioning competitive marketplace, customers are rewarded for seeking out the more efficient and better-quality suppliers—those that deliver more value for the client's money. Inefficient and substandard quality suppliers subsequently lose customers.

For marketplace discipline to work in a sustainable manner, price *and* performance information must be available, and customers must have enough financial incentives to shop around for better value.

There is an obvious difficulty in applying these two conditions to local health care marketplaces. Both providers and customers have historically viewed economics and pricing of services as incidental to the physician-patient relationship.

However, the attitudes of the American public are changing as they are confronted with advertising for brand-name health care "products." Also at work in reshaping attitudes is the public's new sensitivity to cost due to recently increased employee contributions for coverage, higher deductibles and larger employee copayments.

Thus, the public is coming to view health care as a definable product and appropriate matter to be scrutinized like other major purchases.

As new types of alternative health care delivery organizations mature, like HMOs now are doing, standards evolve by which management and purchasers can assess the relative performance levels.

These often include measures relating to finance, resource utilization and allocation, productivity and quality. Competition in health care today prompts a need to focus attention on all these measures. While these measures have not yet reached the degree of standardization in other industries, they are nonetheless important for health care organizations which are now in the competitive marketplace.

Fundamental to employers' commitment to HMOs and preferred provider organizations is their expectation that subsequent marketplace discipline will reorient health care organizations and providers to operate with business-type imperatives—that competition will restructure and better control the delivery system. This is a new sense of accountability that employers have only recently sought.

While there has been a greater flow of data to employers on specific providers' efficiency, the release of measures on health care quality and appropriateness has been sparse and sporadic. New assessment methods include third-party auditing of medical charts to determine the performance level of HMOs and utilization review programs. Another is the expansion of diagnosis-related group information to include severity of illness and intensity of services.

Another alternative method of evaluating product value is to comprehensively measure the consumer perspective.

Using marketing research techniques, consumers can be surveyed in local marketplaces about their experience with various health care products, such as HMOs, PPO networks, hospitals and dental clinics.

Such a multiple HMO evaluation process has proven effective.

Using a standardized survey of more than 75 questions, a rather complete evaluation is generated with comparative ratings for categories such as convenience and access to services, administration and procedures, quality of physician care and overall recommendations.

This evaluation process can pinpoint potential problem areas like the delivery of care for mental illness or for emergency situations.

Quality of physician care is measured using more than 30 questions. These questions include how well physicians communicated; how well they practiced with a genuine interest in their patients; how well they gathered relevant medical histories; how well they tailored treatments to the patient's needs; and how well achieved good results.

The survey questions in all the rating categories function well to uncover variances in performance among the different physician groups and HMOs.

This evaluation process shows that such marketing research techniques provide a practical approach to monitoring (and potential for more effectively managing) the delivery of health care. While such consumer viewpoints are not the last word on quality and performance, they are an important means to evaluate complex services like health care.

Another distinction of this process is that it reveals actual results being achieved and not just traits, abilities and operational characteristics.

Applying a survey technique in a standardized manner makes possible facility-to-facility, year-to-year and city-to-city comparisons. Other purposes include:

- Building a commonality of purpose between employers and employees regarding health care cost management focused on involving employees in smarter shopping and leading healthier lifestyles.
- Monitoring year-to-year changes in the quality and quantity of services that may be impacted by wider and intensified use of utilization controls, new methods of paying providers (like diagnostic-related groups and per-capital charges) and more aggressive price competition. Such initiatives may be stymied in their infancy if they

*Continued on next page*

## Cost control variety

EMPLOYERS ARE taking a wide variety of measures to control health care costs, a recent study shows.

According to a recent Mercer-Meidinger Employer Attitude Survey of chief executive officers:

- 80% encourage the use of ambulatory surgery facilities.
- 76% shift some health care costs to employees.
- 62% implement utilization review programs.
- 60% sponsor wellness/disease prevention programs.
- 58% have established hospital preadmission testing programs.
- 57% encourage the use of health maintenance organizations or other alternative delivery programs.
- 55% negotiate rates with providers.
- 50% have joined coalitions of other employers to work together on cost management.
- 45% have reduced health care coverage.

*Charles R. Stanfield is a group benefits consultant with William M. Mercer-Meidinger Inc. in Brookfield, Wis.*

# Facts are key to handling political risk

By Laurence S. Clootz

**speaking out**

THE MULTINATIONAL corporation is surrounded by many uncertainties.

These companies must cope with trade barriers, labor problems, aging factories, foreign exchange problems and technological advancements as well as the risks and political pressures inherent in dealing with many different cultures.

Most companies that operate on an international scale have risk managers and risk management departments to guide them in their search for safety in an uncertain world. These risk managers not only purchase insurance and manage self-insurance programs for their corporations, but also actively attempt to reduce the property/casualty risks their companies face.

However, there is often one area that risk managers have a rough time handling, not because of intent, but because of the difficulty of obtaining reliable guidance and information on which to make decisions on a timely basis. This area is political risk.

Risk managers can go to the commercial insurance market and purchase political risk insurance for some risks, but this coverage does not cover all the special risks that multinational corporations face operating on a global scale.

In addition, in many nations, multinationals must purchase insurance from resident domestic insurance companies, which creates new political risk exposures for the buyer—namely the stability of the insurance company.

Some of the problems that corporations operating abroad experience include:

- A bank operating in a troubled nation has large investments in that country and wants commercial insurance coverage in case of nationalization of the properties involved. What's the likelihood of nationalization?
- A factory is located in an area that has just changed governments. The new government is not yet in full control and potential problems loom. What is happening? Who is in control? What factions will win? What is the real danger to the factory output, the workers and the property involved? What should the factory owner do? Where can it turn for information?
- A multinational company's captive insurer has purchased extensive reinsurance from reinsurers in a nation that is now undergoing an economic downturn. The reinsurers seem stable enough for the time being, but can they be relied upon to pay claims in the future? What can the ceding company do? What happens if the nation's laws require that coverage continue to be purchased from local insurers in order to do business in the country? What is the possibility that a mew government, to cope with currency problems, will order local insurers to stop paying claims?

Of course, the answers to these questions will differ from company to company and from country to country. However, all of these questions have one similarity: the need for information and timely action.

A company cannot take any action unless it has information on which to base a decision, and that decision is not reliable unless an adequate interpretation of the facts is at hand. And, even with all of that, what good is the information and the interpretation if they come too late for effective action to be taken?

It has always been, in my mind, a strong concern for a multinational company to use only solvent, stable insurers and—in cases of captive insurance companies—reinsurers. Today, one must check the solvency of each insurer and reinsurer very carefully, no matter where the underwriter is domiciled. The buyer must check whether the insurer is willing—and will be in the future—to perform its obligations as they arise: paying claims; returning premiums; allocating proper reserves for incurred-but-not-reported losses; charging proper premium rates; purchasing adequate and secure reinsurance; rapidly transferring currency; and maintaining a stable staff and a solid portfolio of business.

In conducting their investigations, some multinational risk managers are now visiting the insurers they use on their turfs and are not letting decisions be made by agents and brokers. More corporations are looking into the solvency of their insurers and reinsurers not only by checking financial statements, but by subscribing to various solvency reporting services.

These more progressive companies consider that it is better to "sweat in peace than to bleed in war"—it is better to work to preclude problems than to fight them because vital decisions have been left up to others that do not have the same concerns and interests as the companies themselves. If one chooses to let others make vital decisions, one must not expect perfect performance.

The sticky problem with operating overseas is that much of the data available is not "hard" data, but rather "soft," non-numerical data.

For instance, companies must decide what to do in the face of economic and political uncertainties. For the most part, it is business as usual—unless turmoil in a foreign country affects the operation of a plant, the availability of natural resources or the ability of an insurer to pay claims.

Still, all can go well until a new government takes control and nationalizes the company's operations—with no payment forthcoming. All is in order until the state insurance institute is closed, with no claims payments probable in the near future. What happens when the company is advised that its claims will be paid in an unsatisfactory currency at an unsatisfactory rate, thus reducing the amount the company will collect from a local insurer? How uncertain will life be for the corporation if extensive operations are, in reality, controlled by political figures in an unstable political environment?

Many companies would consider the preceding scenarios to be quite unlikely and would not give too much thought to strategies to negate such actions. However, these examples do show a need for timely information and interpretation of the facts so that companies can make the proper decisions and have a chance to benefit from them.

Coping with the muddled world of political risks is beyond the resources of some of the most sophisticated companies. Most businesses are equipped to handle their manufacturing, delivery, accounting and design problems, but few have trained personnel on staff to report on, interpret and advise the company on political risk problems. This is a specialty area for groups of highly trained personnel—academicians and others—who often spend their entire careers studying a single nation.

To do the job effectively, these specialists must monitor the nation or region daily and be able to interpret events that are not even evident to others.

Companies with large overseas operations may need the services of a consultant that is fully staffed with experts that can act as the client's political risk department on a 24-hours-per-day basis. One missed event or incorrect interpretation can cost a company millions—perhaps billions—of dollars.

These experts must know what your company does and what are your company's specific concerns and expectations. It is also valuable that the experts know what types of operations and relationships the company maintains in each country so they can assess the impact of events that could go unnoticed to the uninformed observer.

A company's risk management staff cannot rely on reports in magazines and newspapers or on broadcast programs or even on personal visits by company personnel to foreign nations, unless that person is an expert in the affairs of that nation. And even if there is an expert on the risk management staff, that person needs rapid and reliable access to others to monitor and interpret events when they occur.

Managing a corporation's political risks is fraught with uncertainty. All events are important in assessing the stability and reliability of operating in a particular foreign nation.

International operations are not for those that have limited resources and little knowledge of the nations in which the operate.

However, with the proper information, and the expertise necessary to interpret that information, the company's chances of success in managing political risk are very much increased.

*Laurence S. Clootz is president of Reinsurance Intermediary Corp. in Overland Park, Kan.*

# Promoting healthy competition in health care

*Continued from previous page*

become generally perceived as producing a negative impact on people's personal health.

- Providing a vital element for employers negotiating prices with HMOs by contrasting various price differentials with performance differentials.
- Creating a comprehensive diagnostic tool that providers may access for setting business-type performance goals, building consumer loyalty and achieving product superiority. The process can identify weaknesses, establish realistic performance levels being attained by other providers/suppliers and serve as a benchmark to measure progress or change.

**Consumers' perceived value is especially important for managing *services*, which. . . are not outwardly differentiated from one vendor to the next as much as many *products* are.**

In a more general way, this also serves employers' evolving sense of fiduciary responsibility for preselecting which HMOs will be offered to employees.

Awareness of consumers' perceived value is especially important for managing *services*, which by nature are not outwardly differentiated from one vendor to the next as much as many *products* are.

The emerging axiom is that the success of many employer health care initiatives will be dependent upon how the relevant public perceives specific providers' performance in delivering first-class services.

Performance measures, like those described above, represent a powerful new tool for both purchasers and providers.

With such tools, marketplace discipline can be seen as not just the rhetorical preference of business leaders but as a practical strategy workable in many cities.

## info

• An introductory brochure on **alternative dispute resolution** methods has been published by the American Arbitration Assn. The descriptive brochure defines arbitration, mediation, the minitrial and other alternatives in easy-to-understand language. It lists the steps in arbitration and mediation processes as practiced under AAA rules and contains examples of standard arbitration and mediation clauses. It also discusses the types of cases suitable for alternative dispute resolution. The 18-page brochure is available for $1 prepaid from Betty Berry, American Arbitration Assn., 140 W. 51st St., New York, N.Y. 10020-1203.

• The Greater Los Angeles Chapter of the National Safety Council's Film Library has added hundreds of new **safety-related films and videos** emphasizing, among other topics, safety and health issues. Many titles are also available in Spanish. For a free film catalogue, write to the Film Library, Greater Los Angeles Chapter, National Safety Council, 616 Westmoreland Ave.,. Los Angeles, Calif. 90005.

• Two new books from Commerce Clearing House Inc. address the effect of recent federal legislation on certain employee benefits. **"CCH Guide to Employee Benefits Under 1986 Tax Reform"** explains major changes to rules governing pensions and employee benefits. Included in its analysis are changes made to rules governing pension plan qualifications, new penalties and restrictions imposed to ensure that amounts that are tax deferred are actually used for retirement and not as tax shelters, and new rules limiting tax incentives to benefits that are provided on a non-discriminatory basis. In addition, the guide contains full texts of the Internal Revenue Code and Employee Retirement Income Security Act sections as added, amended or repealed by the act. Single copies of the 512-page book are $12. **"New 1986 Mandatory Retirement and Maximum Income Age Benefit Rules"** is the title of CCH's 64-page explanation of the new maximum age employee benefits rules and the laws as added or amended. These new rules—affecting employers, labor unions, employment agencies, and employee benefit plan administrators—are contained in 1986 amendments to the Age Discrimination in Employment Act, ERISA and the Internal Revenue Code. A table of court cases referred to in the explanations and a topical index are also included. Single copies are available for $6. For a copy of this book or the guide to the new tax law send payment to Cash Item Department, Commerce Clearing House Inc., 4025 W. Peterson Ave., Chicago, Ill. 60646.

• Corporate Contingency Services is offering a new brochure on **disaster recovery planning.** The brochure describes the planning assistance that is provided by CCS, which includes development of data processing and corporate contingency plans, the audit of existing contingency plans and the maintenance of contingency plans. Also included are descriptions of some recent disasters that befell companies without contingency plans. For a free copy of the brochure contact Corporate Contingency Services, P.O. Box 805, New Hudson, Mich. 48165; 800-426-4620; 313-486-2090 in Michigan.

• "Health Benefit Management System: the Foundation for Effective Plan Management and Cost Control" is a new six-page brochure brochure from Genelco Inc. that describes the company's **comprehensive health claims administration and reporting software system.** For a free copy write to Larry M. Amundsen, Genelco Inc., 1600 S. Brentwood Blvd., Suite 500, St. Louis, Mo. 63144. Or Call 800-325-3018; 800-392-3488 in Missouri.

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## update

**RIMS PREVIEW**
*Issue Date*: March 23
*Ad Closing*: March 10

The editors of *Business Insurance* are preparing a pre-conference report on the upcoming RIMS Conference in Las Vegas, Nevada. We'll provide last minute updates on the Conference agenda, exhibits and events, including info on the host city.

business insurance


# DATA BASE: IRI

**Our Total Information System, which contains 1.5 billion bytes** of information, helps us analyze losses, plot loss trends and prepare loss prevention and control programs for our insureds. The loss information portion of this system codes the cause of loss 75 different ways, ranging from fire, windstorm or explosion to freezing, smoke or volcanic action. Also, it accumulates loss data on more than 500 occupancy classes from airplane plants to wholesale groceries, from hospitals to oil refineries, from aboveground storage tanks to X-ray rooms. All of this information is of value to producers, insureds, and IRI. We want to know *how* and *why* things happened, *where* they happened, and *what* we can do to prevent their recurrence. In property markets, the lessons of the past direct future activities.

**Back in 1982, This Kind of Loss Analysis** contributed greatly to the development of OVERVIEW, IRI's total management program for loss prevention and control. During this period, IRI examined 1,169 losses, which totaled $172 million. We concluded that 97.9% of these losses were related in some manner to management failure in several areas including smoking regulations, maintenance, pre-emergency planning, and housekeeping. Without adequate data and without computers to help us massage it, we may have taken several years to develop a program such as OVERVIEW, which has been implemented in thousands of facilities across this country and around the world. Although it is difficult to measure how many OVERVIEW-oriented properties have *not* suffered a loss, we know that OVERVIEW works in helping to prevent single human error incidents from becoming multiple human error losses.

**Industrial Risk Insurers is also Applying OVERVIEW** to the control of loss as related to natural hazards such as tornadoes, hurricanes, floods, earthquakes, and arctic freeze. (Arctic freeze is a phenomenon which has inflicted hundreds of millions of dollars of loss on business and industry throughout the world during the past few years.) That's why special sections in the Pre-Emergency Planning portion of OVERVIEW deal with getting prepared for hurricanes, floods, and arctic freeze. When IRI loss prevention consultants meet with insureds, agents and brokers, these subjects are discussed in detail.

**OVERVIEW Enables Companies and Corporations to Manage** their loss prevention and control programs in much the same way as they manage manufacturing, or construction activities. For example, since facility process changes are planned and budgeted, it makes sense to plan and budget the loss protection hardware necessary to respond to these changes. Or, when a new building is planned and budgeted, so are the extinguishing systems and loss prevention programs necessary to keep it functioning. It's all in OVERVIEW. Just ask your servicing IRI loss prevention consultant for assistance, or contact Mrs. P. A. Sasso, IRI, 85 Woodland Street, Hartford, CT 06102, area code (203) 520-7412 and request a complimentary copy of the OVERVIEW brochure.

Industrial Risk Insurers

**66,000 properties insured worldwide**

# Sullivan Payne hires CIGNA's Patterson

## coming & goings: industry

**Guy Patterson** has joined the Philadelphia office of reinsurance intermediary Sullivan Payne Co. as senior vp.

Mr. Patterson had been president of the reinsurance and services divisions at CIGNA Corp. and senior vp of CIGNA's property/casualty group.

In addition to his experience at CIGNA and affiliate Insurance Co. of America, Mr. Patterson was formerly a director at Terra Nova Insurance Co. Ltd. in London.

**Other reinsurance industry changes:**

**Harrison de Koning Rose** appointed senior vp of The Home Reinsurance Co. in New York. Mr. Rose, who joined The Home in 1986, previously was senior vp-ceded reinsurance.

**James W. Heslin Jr.** promoted to vp at General Reinsurance Corp. in Stamford, Conn. Also, General Re promoted **Richard C. Shaw** to second vp in its New York office.

**Arthur W. Wright** joined National Reinsurance Corp. in Stamford, Conn. as vp-casualty facultative operations. He replaces **Carl Zuanelli**, who was promoted to manager-corporate retrocessions.

**Patrick E. Gentile** joined the treaty department of Skandia America Group as vp. Mr. Gentile previously was second vp with North Star Reinsurance Corp. In addition, **Eugene W. Slattery** and **Ronald J. Yarashefski** appointed vps at Skandia America. Mr. Slattery has been a member of the treaty underwriting department since 1977. Mr. Yarashefski joined the company in 1978.

## Agents/brokers

**Albert J. Pelham** named chairman of Hilb, Rogal & Hamilton Co. of Jackson Inc. in Jackson, Mich. Mr. Pelham has served as president of the company since 1969. Replacing Mr. Pelham as president is **James F. Mortell**, who had been executive vp.

**Edward J. Bolger** promoted to president of Jardine Emett & Chandler Santa Clara Inc. from his previous position as head of the office. Mr. Bolger joined Jardine in 1982.

At Jardine Emett & Chandler Hawaii Inc., **Malcolm R. Louis** promoted to president from vp/manager. Mr. Louis joined the company in 1984.

Mr. Gillam

Johnson & Higgins Vp **Anthony Gillam** named supervisor of the firm's international actuarial and benefit consulting unit for the Eastern region. Mr. Gillam joined the company in 1974.

**William W. Werther** promoted to vp-insurance risk management group for Lawrence United Corp. in Rochester, N.Y. Previously, Mr. Werther was a placement specialist. He joined the company 10 years ago in sales and underwriting capacities.

**Arthur M. Ostrow** joined Amalgamated Programs as senior vp-property/casualty operations. Mr. Ostrow previously was with B.R.I Coverage Corp. for 17 years.

At Marsh & McLennan Inc. in San Francisco: **Peter Garvey** and **Dan Nicholas** appointed managing directors. Mr. Garvey joined M&M in 1980 and had been a senior vp. Mr. Nicholas joined M&M in 1981.

Mr. McGehee

Also at M&M, **H. Smith McGehee** named managing director in charge of the St. Louis office. Mr. McGehee was senior vp at Lawton-Byrne-Bruner when that company merged with M&M in January 1987.

**Robert E. Cronin** promoted to senior vp at the Tampa office of M&M. He had been a vp.

Mr. Gray

**William L. Gray II** and **Robert M. Jenkins Sr.** named principals of Noel, Greaves & Strother in Dallas.

Mr. Jenkins

**Thomas A. Watson** promoted to assistant regional director of the Pacific Northwest Region of Corroon & Black Corp. Mr. Watson, also a senior vp, was most recently assistant manager of Alaska operations. He joined the company in 1976.

Also at C&B, **Wayne W. Brown** promoted to president of Alaska operations from chief executive officer. Mr. Brown joined C&B in 1974. In addition, **Gerald E. Borstad** promoted to chief operating officer from office administrator. Mr. Borstad joined C&B in 1976.

Mr. Pullan

**Robert E. Pullan** appointed executive vp of Kelter-Thorner Inc. in Southfield, Mich. Previously a senior vp, Mr. Pullan joined the company in 1981.

**Carla Damrill** promoted to senior vp at Frank B. Hall & Co. of California-Orange County in Costa Mesa, Calif. Ms. Damrill joined Frank B. Hall & Co. of California-Los Angeles in 1974.

Also at Hall, **Louis F. Locante** promoted to vp of Frank B. Hall & Co. of Pennsylvania.

## Insurers

**Jack R. Hughes** appointed senior vp-ceded reinsurance at The Home Insurance Co. in New York. Previously he was senior vp-ceded reinsurance for property-casualty operations at CIGNA Corp.

**James L. Weidner** promoted to senior vp of The Home's 14-state Western Region, based in Glendale, Calif. Mr. Weidner joined the company in 1983. He most recently was vp and general manager of the company's Brea, Calif., field office.

**Bradford W. Rich** designated senior vp of Crum & Forster Corp.

*Continued on next page*


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Hello, MetLife Showcase. Let's see a Menu.

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Number Three Please.

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| At age | Monthly |
|---|---|
| 62 | 487 |
| 65 | 523 |

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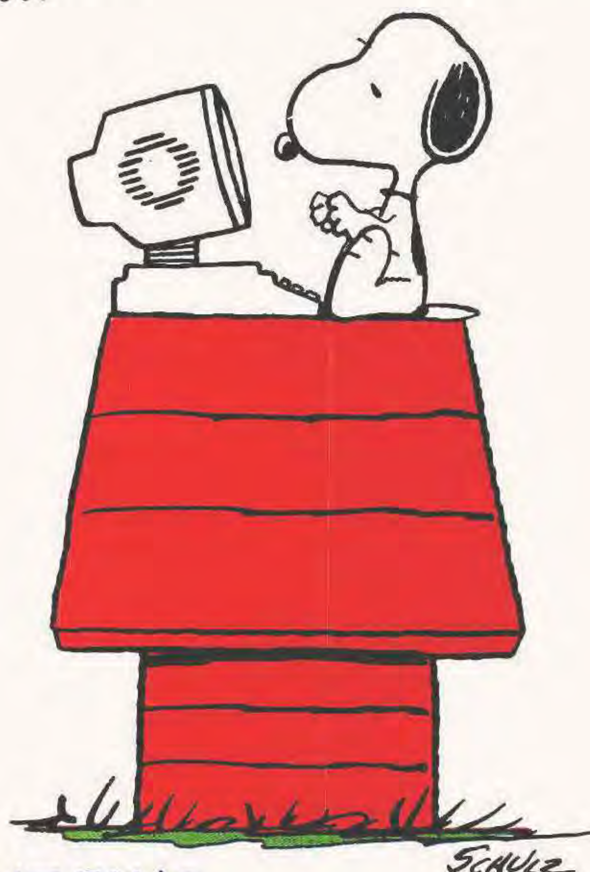


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*Continued from previous page*
in Morristown, N.J. Mr. Rich joins C&F from Guardian Royal Exchange, where he was president and chief executive officer of several subsidiaries.

**Jeffrey J. Park** promoted to executive vp from senior vp at Crum & Forster Corp., responsible for actuarial planning.

**David N. Hafling** promoted to vp-actuary from second vp-actuary of American States Insurance Co.'s property/casualty units in Indianapolis. Mr. Hafling joined the company in 1972.

## Excess/surplus

**D. Richard Meyer** promoted to vp at Equity Insurance Managers Inc. in Lexington, Ky.

At Atwater McMillian Inc., a subsidiary of The St. Paul Cos. Inc., **George Tsui** named senior vp-specialty risk division and **Joe Schumi** named vp-actuary. Mr. Tsui joined St. Paul in 1982 and was named vp in 1984. Mr. Schumi joined St. Paul in 1973 and was named actuarial officer in 1982.

## Other suppliers

**Michael L. Stoll** appointed senior vp at Ambel Consultative Services Inc. Mr. Stoll previously was with Frank B. Hall & Co, Employers Insurance of Wausau, James S. Kemper & Co. and British American Insurance Co.

**Tim E. Donney** appointed president of Hull & Cargo Surveyors Inc., a subsidiary of Marine Office of America Corp., which is a unit of Continental Corp. Based in New York, Mr. Donney succeeds **William F. Warm** who retired. Mr. Donney joined the company in 1975 and most recently had been executive vp of national business operations in New Orleans.

**George E. Bell III** elected a partner at employee benefit consultant Kwasha Lipton in Fort Lee, N.J.

Also at Kwasha Lipton, **Richard B. Cornwell**, **Peter W. Rutherford** and **John S. Westervelt** named principals. Prior to joining Kwasha Lipton in 1977, Mr. Cornwell worked for the Insurance Services Office. Mr. Rutherford has been with the company since 1979, and Mr. Westervelt joined the company in 1976.

**Charles H. Cox** named president at consultant Aldrich & Cox Inc. in Buffalo, N.Y. He succeeds his father, **Herbert Cox**, who has been elected chairman of the board. Herbert Cox co-founded the company in 1951 and served as president since 1963. Charles Cox joined the company in 1974 and has been vp since 1982.

Also at Aldrich & Cox, **James B. Hood Jr.** named executive vp and secretary of the company. Mr. Hood, who joined the firm in 1975, had been a vp since 1982.

**James M. Berry** joined Seattle-based consultant Milliman & Robertson Inc. as a consulting actuary. In addition, **Gregg P. Richter** joined the Omaha, Neb., office of M&R as a consulting actuary. Prior to joining M&R, Mr. Richter was director of actuarial and benefits consulting services at Touche Ross & Co.

**Allen Bennett** named vp and director of Summit Loss Control Services Inc., a unit of Summit Consulting Inc. Based in a Lakeland, Fla., the Summit Consulting is a third-party administrator.

**William E. Thomas** joined Robert Hughes Associates Inc. as corporate vp. Prior to joining the Dallas-based consultant Mr. Thomas was president of American Agency Profit Systems Inc., a managing general insurance agency.

**Steve A. Martin** appointed president of Hayes & Associates, a human resources consulting unit of Booke & Co. in Winston-Salem, N.C. Prior to his appointment, Mr. Martin had owned a consulting practice in Winston-Salem since 1981.

**Dave Wilson** named president and chief executive officer of St. Paul, Minn.-based CC Systems Corp., a TPA affiliate of Blue Cross and Blue Shield of Minnesota. Prior to this appointment, Mr. Wilson served as president of CC Systems of Minnesota. ■


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**london**

# London architects establish insurer

By CAROLYN ALDRED

LONDON—A group of Britain's largest architectural firms is establishing a mutual insurance company to write architects professional liability insurance on a claims-made basis.

At least 26 firms have committed to join Wren Insurance Assn. Ltd., according to Robert Seward, a partner at Tindall, Riley & Co., the mutual's manager.

Wren, which will write coverage for primarily large architectural firms, will offer professional liability insurance limits of up to 5 million pounds ($7.6 million) per claim.

Member firms may retain a portion of their risk, but are encouraged not to self-insure an amount equal to more than 2% of their annual fees, said Mr. Seward.

The total revenues of Wren's 26 founder members and two additional members expected to join will be about 130 million pounds ($197.6 million) in 1987, said Mr. Seward. "The premium income from the original 26 members will be at least 6 million pounds ($9.1 million) in the first year of the mutual's operation," he added.

Wren already has lined up reinsurance support, Mr. Seward noted. London underwriters are writing excess-of—loss reinsurance that attaches at 3 million pounds per claim, while the mutual has purchased an aggregate reinsurance treaty with reinsurers outside of the London market that will cover an individual firm's aggregate claims that exceed 3 million pounds in a policy year, Mr. Seward said.

The mutual's financial backing will be established by members' first year premium payments, said Mr. Seward.

"Premiums for the first year will be broadly in line with what our members are paying at the moment. Over a period of years we expect. . .cheaper premiums, but we didn't want to launch the mutual by offering cut-price premiums," he said.

The mutual will also provide claims and risk management consulting services for members, he added.

## Tax changes for insurance companies

British insurers fear that tax law changes contained in the U.S. Tax Reform Act of 1986 could prompt the government to introduce similar tax reforms in the United Kingdom.

British insurers are worried that property/casualty insurers will be forced to discount loss reserves, as U.S. insurers now must do under provisions in the new tax law.

The discounting of loss reserves has been the subject of a two-year debate between the British insurance industry and the government's Inland Revenue, with insurers arguing that the proposals have been introduced merely to increase tax revenues.

The Assn. of British Insurers rejects the suggestion that the discounting of loss reserves produces more accurate reserves and is concerned that companies should not be required to anticipate investment income on reserves for tax purposes.

Although several British insurance companies have begun to discount reserves and release revised financial statements to shareholders, the vast majority still do not discount their reserves.

"The U.S. Tax Reform Act last year has set a precedent for including such measures in legislation," said Keith Loney, the ABI's manager for taxation and accountancy. "The Inland Revenue could ask treasury ministers to include a provision in the finance bill," which is the tax bill to be introduced in Parliament by Prime Minister Margaret Thatcher's government later this year.

However, Mr. Loney believes it is too late—and too close to a national government election—for such a provision to be included in this year's finance bill.

Alternatively the Inland Revenue could choose to test the issue in the courts, according to Mr. Loney.

"The Inland Revenue could pick a vulnerable company, such as one with particularly long-tail business, and take it to court in a test case. In such a case, the ABI would finance the insurer's defense through to the House of Lords," Britain's highest appellate court, he said.

Meanwhile the ABI has published a statement of recommended practice on accounting for all British insurance and reinsurance companies, except Lloyd's of London syndicates.

The statement, which deals with accounting for premiums, expenses, claims and incurred-but-not-reported losses, "should lead to greater consistency in accounting practice between insurance companies," says the association.

In 1988, the ABI will review how member companies have followed the recommendations included in the statement.

On the question of loss reserve discounting, the statement says "the choice of whether or not to discount is for the enterprise to decide."

## Aftershocks of Mission's collapse

The collapse of Mission Insurance Co. could have a domino effect on the U.S. insurance industry, according to Donald Greene, senior insurance partner for the New York law firm of LeBoeuf, Lamb, Leiby & MacRae, Lloyd's of London's U.S. counsel.

Massive insolvencies of U.S. property/casualty insurers could continue unabated, Mr. Greene warned at a seminar earlier this month organized by the Insurance Institute of London.

"We have seen dozens of corporate insurance companies become insolvent in the last two years, but what is more ominous is we are now seeing professional reinsurers, such as the Mission, going down," said Mr. Greene.

The California Insurance Department has requested that MIC and four subsidiaries be liquidated. A California Superior Court in Los Angeles will hold a hearing Feb. 24 on the request (*BI*, Feb. 9).

"Mission's liabilities exceed $600 million and much of this is owed to

*Continued on next page*

# Cost Care to launch new California PPO

## markets

The Exclusive Provider Healthcare Network, a new preferred provider organization, soon will be available to self-insured employers, third-party administrators and insurers in Southern California.

The new PPO is sponsored by Cost Care Inc., a Huntington Beach-based health care cost management firm. It will begin operating on April 1.

"The Exclusive Provider Network will include 300 primary care physicians and 700 specialists," said Sharon Reichle, director of the project.

"We chose specialists that already have referral systems set up with the primary care physicians we selected for the network."

To use the network, employees select a primary care physician from Cost Care's list of providers. This physician then directs the employee to specialists or medical facilities that have contracted with the network. The PPO also includes utilization review, said Ms. Reichle.

For more information, contact Sharon Reichle, at Cost Care, 17011 Beach Blvd., Huntington Beach, Calif. 92647; 800-762-3029; 800-922-8403 in California.

### Work comp software

Pacific Technical Services is a new software manufacturer offering risk and benefit managers computer programs for claims administration.

The company, which opened Jan. 30, initially will offer a workers compensation software package for use on personal computers. That program, to be released in April, can be used by as many as 64 persons simultaneously, and can be used by employers with up to 750,000 employees, says Craig A. Zivolich, the company's president and founder.

The company expects to offer software with general liability, group health and long-term disability claims administration capabilities in the future, says Mr. Zivolich, who was previously vp at National Risk Management Inc., a software firm in San Ramon, Calif.

For more information, contact Mr. Zivolich at Pacific Technical Services, 2974 Montevideo Drive, San Ramon, Calif. 94583; 415-895-0832.

### BICL membership

Bankers Insurance Co. Ltd., the Bermuda mutual that has inspired numerous buyer-led insurance ventures among financial institutions, has lowered its membership criteria.

BICL, which had been considering applications only from commercial banks with assets of $2.75 billion or more, recently opened its doors to banks with assets of only $2 billion or more, according to Edith S. Lichota, senior vp-risk management for Irving Trust Co. in New York and a BICL architect.

However, these financial institutions must agree to have their premiums rated as if they were banks with assets of $3 billion, she says. Premiums are based on number of employees, number of foreign branches, return on equity and other factors.

BICL's shift in its minimum size requirement means that about 52 additional U.S. banks are now eligible for membership in the mutual, according to the American Bankers Assn.

The mutual also has adopted a provision enabling commercial insurance brokers to receive a commission upon arranging BICL coverage for a bank, Ms. Lichota points out.

For more information about BICL, contact Anna Summers at International Risk Management (Bermuda) Ltd., P.O. Box 660, Hamilton, Bermuda, HMCX; 809-295-0713.

### New wholesaler

Vermont's former deputy commissioner of insurance has left that post to head a new wholesale brokerage.

Donald A. Kifer, 42, is now heading the new Excess Insurance Underwriters of Vermont Inc. after working with the Vermont Insurance Department for six years.

Excess Insurance Underwriters in Montpelier, Vt., is a newly formed subsidiary of EIU Holdings.

It will place coverage or write it itself through MGA contracts for hard-to-insure commercial auto insurance and long-haul trucking risks, as well as some commercial general liability and property insurance risks, Mr. Kifer says.

It will initially concentrate on Vermont risks, but may later expand into New York state, he says.

Retail brokers may reach the new company at 26 State St., Montpelier, Vt. 05602; 802-229-4223; 800-356-6653 in Vermont.

### Travelers PPO

Travelers Preferred, the Travelers Corp. preferred provider organization, is being introduced in seven new markets.

The PPO now is available in Baltimore; Denver; Grand Rapids, Mich.; St. Louis; Seattle; Tampa, Fla.; and Tulsa, Okla.

The PPO in each market will include a broad network of hospitals and physicians, the Patient Advocate utilization review program and the Taking Care Program of health promotion and medical self-care.

While employees have freedom to choose health care providers, they incur lower out-of-pocket expenses if they use preferred providers.

For more information, contact John Troy, President, Travelers Health Network, 1 Tower Square, Hartford, Conn. 06183; 203-277-4271.

### Mergers/acquisitions

San Francisco-based broker **ABI Management Inc.** and its subsidiary, **American Business Insurance Agency of Illinois** in Schaumburg, Ill., have acquired the **Elmhurst Insurance Agency Ltd.** of Elmhurst, Ill. Elmhurst Agency will be merged into ABIA's operations in Schaumburg. The Elmhurst agency specializes in restaurants, bowling centers and manufacturing plants.

**KL&K Associates Inc.**, a Portland, Ore.-based independent agency, has merged with **Post & Associates Insurance** in Boise, Idaho. Post & Associates specializes in construction and industrial coverages, as well as surety bonds. KL&K Associates handles all lines of insurance and bonding.

**Marsh & McLennan Inc.** has acquired **Fenchurch Insurance Brokers Pty. Ltd.** The Australian subsidiary of London-based Fenchurch Insurance Holdings Ltd. has offices in Perth, Melbourne, Sydney and Adelaide. These operations will be merged with Marsh & McLennan's Australian subsidiary, Marsh & McLennan Pty. Ltd.

**Partners National Health Plans** has reached an agreement in principle with Nashville, Tenn.-based **Physician Health Plan Ltd.** to acquire up to 50% of **Healthmaster**, a health maintenance organization. Healthmaster is an independent practice association model HMO that serves about 14,000 members through a network of 15 hospitals and 750 physicians. Partners is a joint venture of Aetna Life & Casualty Co. and VHA Enterprises Inc., the equity arm of Voluntary Hospitals of America Inc.

**Stewart Smith Holdings Inc.**, an underwriting management unit of Lloyd's of London broker Stewart Wrightson Group, has acquired two surplus lines brokers: **Major Surplus Holdings** and **S.L. Alexander Inc.** New York-based Major Surplus Holdings will maintain operations at its headquarters, as well as a branch office in Cedar Knolls, N.J. The firm had a 1986 premium volume of about $80 million. The Los Angeles operations of S.L. Alexander will be merged with Stewart Smith West in Los Angeles. The Sacramento and Prescott, Calif. offices will become branch offices of Stewart Smith West. S.L. Alexander reported a 1986 premium volume of about $35 million.

### New offices

**Advanced Risk Management Techniques Inc.**, a risk management and employee benefits consulting firm headquartered in Laguna Hills, Calif., has opened a new office in Salt Lake City. It is located at 5295 South 320 West, Suite 540, Salt Lake City, Utah 84107; 801-268-8324. ■


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## london

*Continued from previous page*

other insurers who are on tertiary credit status. Many of the claimants are small companies with fragile surpluses and the impact on them could be devastating. I suspect we will have other insurers and perhaps reinsurers becoming insolvent as a result," said Mr. Greene, whose firm represented more than 50 MIC ceding insurers during negotiations on various rehabilitation proposals for the company.

Mr. Greene also warned insurers not to believe that the tide has turned in the liability insurance market. "The liability crisis isn't over by a long shot—the worst is yet to come," he predicted.

Mr. Greene argued that the tort reforms enacted by various states are not enough to combat the problems facing the insurance industry, and that the outlook for long-term tort reform looks bleak.

"I no longer believe that our (legal) system can be successfully amended. The only way to change it is to abandon it and give the population something that they like better," he said. "I am now convinced that some form of no-fault, scheduled benefit and damages is something we desperately need in the U.S."

He described the present tort system—whose main aim, he said, is to pay plaintiffs' attorneys huge contingency fees—as obscene and called on the insurance industry to provide some type of system that ensures that those claimants who need money receive it. ■


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## around the states

# California day-care rates justifiable, regulator says

SAN FRANCISCO—The state Insurance Department says rate hikes and curtailed capacity for day-care center liability insurance during the past two years were justified because insurers were suffering huge losses.

However, Insurance Commissioner Roxani M. Gillespie says insurers must be careful when raising rates and limiting coverage for day-care providers.

"The insurance companies must be sensitive to the concerns of child care providers. The midterm policy cancellations and sudden drastic premium increases we've seen in the last few years are not a responsible way of doing business," she said.

In addition, "Child-care providers must realize that insurance companies cannot write unprofitable coverage," Ms. Gillespie said.

The department maintained that, although higher prices and restricted capacity have hurt many day-care providers, it has done all it can to help and that a legislative—not a regulatory—solution is needed.

The department is now proposing legislation that would require day-care liability insurers to report rate increases of more than 25%.

In addition, the department also recommended:

- The creation of no-fault insurance to cover children's injuries on the premises of child care facilities and in the vehicles used by these organizations.
- Mandating that all insurance company data regarding day-care liability experience be reported to a licensed rating organization.
- Asking personal lines insurers to voluntarily provide liability insurance for day-care providers with six or fewer children. If this cannot be done on a voluntary basis, the department said, personal lines insurers should be required to provide this coverage though the enactment of a statutory joint underwriting association.
- That pooling of risks be permitted, as in workers compensation safety groups, to strengthen the premium base for this line of coverage and encourage loss control programs.
- The insurance industry be required to work with the day-care industry to establish mutually agreeable guidelines for licensing child-care centers and establishing children-to-teacher ratios.

The department drafted these proposals and conclusions after analyzing testimony and loss data collected from several major property/casualty insurers during a joint investigative hearing held by the department and a state legislative task force committee in Los Angeles last summer.

Ms. Gillespie pointed out that in 1985, the Department of Insurance worked with 21 insurance companies to set up Cal-Care, a voluntary market assistance program to provide additional capacity for the day-care liability insurance. Despite this program, however, day-care providers testified last summer that affordability of coverage remained a problem.

The commissioner said that only a legislative proposal could make child care liability insurance both available and affordable.

## Labor commissioner

MINNEAPOLIS, Minn.—Ray Bohn, 37, is Minnesota's new commissioner of labor, replacing Steve Keefe, who has become chairman of the state Metropolitan Council at the request of Gov. Rudy Perpich.

Mr. Bohn had been director of Minnesota's Public Service Department. He previously served as Gov. Perpich's special assistant.

Mr. Keefe, who had served eight years in the Minnesota Senate, was a major author of the state's 1983 workers compensation reform legislation. During his tenure at the Department of Labor & Industry, he implemented provisions of the new law. ■


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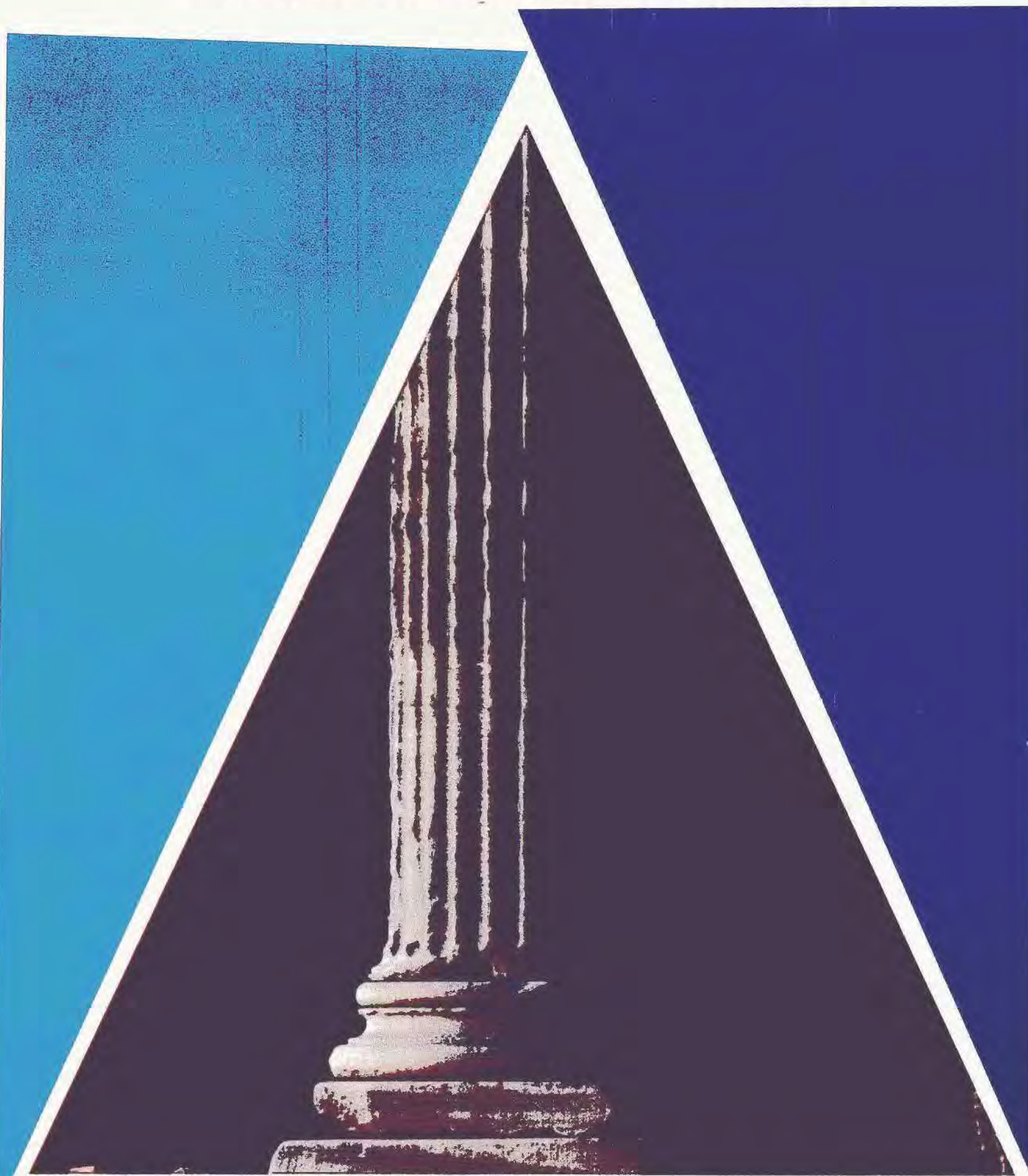

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# Oklahoma rates

*Continued from page 3*

decision, but the court denied the NCCI's petition earlier this month (*BI*, Feb. 16).

Insurers last week were meeting with the state attorney general's office and the Oklahoma State Board for Property and Casualty Rates to develop a method for refunding excess premiums paid by employers. While the exact amount has not been calculated, the NCCI estimates excess premiums total less than $50 million.

The refund plan is not expected to be finalized until next month at the earliest.

However, many of the state's largest workers compensation insurers believe that since they were writing the coverage in question on a consent-to-rate basis they do not owe a refund to employers. Consent-to-rate agreements allow an insurer to negotiate with a policyholder a premium higher or lower than the approved manual rate.

Among the insurers that wrote all work comp coverage on a consent-to-rate basis following the rate hike are Mid-Continent Casualty Co. in Tulsa and Employers Casualty Co. in Oklahoma City. Other insurers, like Liberty Mutual Insurance Co. in Boston and Travelers Insurance Cos. in Hartford, Conn., wrote only a portion of their business on a consent-to-rate basis.

Since consent-to-rate agreements are not mentioned in the Supreme Court decision, coverage written under such agreements will not be affected by the ruling or be subject to the refund if the policies met all existing regulations, said J. Angela Ables, an Oklahoma City attorney who represented the State Board of Property and Casualty Rates in the Supreme Court appeal and is now local counsel for the National Assn. of Independent Insurers.

"Right now we are using consent-to-rate; but we haven't always," said John W. Purkis, a vp with Liberty Mutual, adding that the insurer will have to issue some refunds.

Hartford also will have to make some refunds, said Ralph Schunk, Hartford's underwriter director.

Meanwhile, the NCCI's law committee last week decided not to seek review of the Oklahoma ruling with the U.S. Supreme Court at this time, but instead decided to make another rate filing. However, a U.S. Supreme Court review still could be requested.

"We would not take a federal appeal at this time," said Michael Camilleri, senior vp and general counsel for the NCCI. Instead, the NCCI will file a new request for higher rates within 30 to 60 days, he said.

"There's no way. . .we can meet all the tests" set out in the Supreme Court decision for a rate increase, Mr. Camilleri conceded. "It's physically impractical. We would have to show that every insurer is almost insolvent before (the Rating Board) could approve a filing."

The rate increase request is expected to be as high or higher than the average 41.9% increase proposed in 1985, which was whittled down to the 25.9% average increase approved by the rate board.

"The experience doesn't appear to have changed in Oklahoma," Mr. Camilleri said, explaining the need for higher rates.

The latest NCCI figures show work comp rates in Oklahoma to be about 45% inadequate, said Richard I. Fein, an NCCI executive vp.

Mid-Continent Casualty also is considering making an independent rate filing, said President Perry Inhofe Jr., who added that the insurer would probably seek a rate increase exceeding the 25.9% hike denied by the Supreme Court.

Such a filing would appear to go against the grain of the Supreme Court's ruling, which is being interpreted to mean that an insurer can only secure a rate hike if it borders on insolvency.

"We are not insolvent," Mr. Inhofe said, adding that "we want to give it a try and see if the board will overlook" that Mid-Continent is solvent.

Meanwhile, Mr. Inhofe and other insurers are now discussing a new rating law with state legislators, while Gov. Henry Bellmon has recommended that the Legislature consider reworking Oklahoma's entire work comp system.

Current problems would be eased if the Legislature adopted a new rating law that expressly said that insurers do not have to border on insolvency before workers compensation rates can be increased, Mr. Inhofe said.

Such action is seen as imperative by insurers to preserve the commercial workers compensation insurance market in Oklahoma.

"If I were a CEO of a large insurer and wrote only 1% of the volume in Oklahoma, I'm not sure I would put up with the Supreme Court ruling," Mr. Inhofe said. "We have to have the large national insurance companies in Oklahoma. . . .We need the capacity of all companies in Oklahoma now."

The state Senate, however, is considering two other bills that could change the complexion of the state's work comp market:

- S.B. 25, introduced by Sen. Gene Stipe, D-McAlester, which calls for Oklahoma's competitive state fund to be converted to an exclusive state fund, thereby banning commercial insurers from writing work comp coverage in the state.

Sen. Stipe said he introduced the measure because of fears that commercial insurers will pull out of the state.

- S.B. 23, introduced by Sen. Stratton Taylor, D-Claremore, which calls for the state fund to write reinsurance for employers in Oklahoma that self-fund their work comp risks as well as professional liability insurance for all companies.

"The theory behind it is that a lot of statements have been made that insurance will be unavailable or unaffordable for certain professions or that self-insurers can't get reinsurance," Sen. Taylor said.

No hearings have been set yet on the measure.

Chances for passage for either measure appear slim right now, according to Oklahoma sources, but may pick up momentum depending on whether filings for higher work comp rates are approved by the Rating Board.

In the House, some members say they may introduce a competitive rating bill, which would require insurers to make individual rate filings, rather than rely on a rating organization like the NCCI.

Insurers and employers in Oklahoma generally have opposed competitive rating, but are studying the concept in light of the Supreme Court ruling.

"We have referred the idea to a committee," said Julius Kubier, vp of the industrial division for the Oklahoma Chamber of Commerce & Associated Industries.

Only 10 other states have competitive rating laws, all of which took effect in the early 1980s: Arkansas, Georgia, Illinois, Kentucky, Maine, Michigan, Minnesota, Oregon, Rhode Island and Vermont.

Workers comp experts around the country believe that a move toward competitive rating may be a solution in Oklahoma, but such a move probably will not be the start of a new trend elsewhere, though two separate open rating bills are pending in Maryland.

"Traditionally, competitive rating" is proposed to cut rates, said Donald T. DeCarlo, special counsel for the American Insurance Assn. "But this is not what we're talking about in Oklahoma," where rates are "too low" already. And, even with an open rating law, regulators have the authority to challenge an insurer's rates, he said.

But insurers believe that the Oklahoma Supreme Court decision may prevent them from obtaining a rate increase under the current rating law, and therefore they say they may be better off under a competitive rating system.

"We never have been in favor of open rating, but we might be in favor of it (as an alternative) to where we are today," said Mid-Continent's Mr. Inhofe. ■


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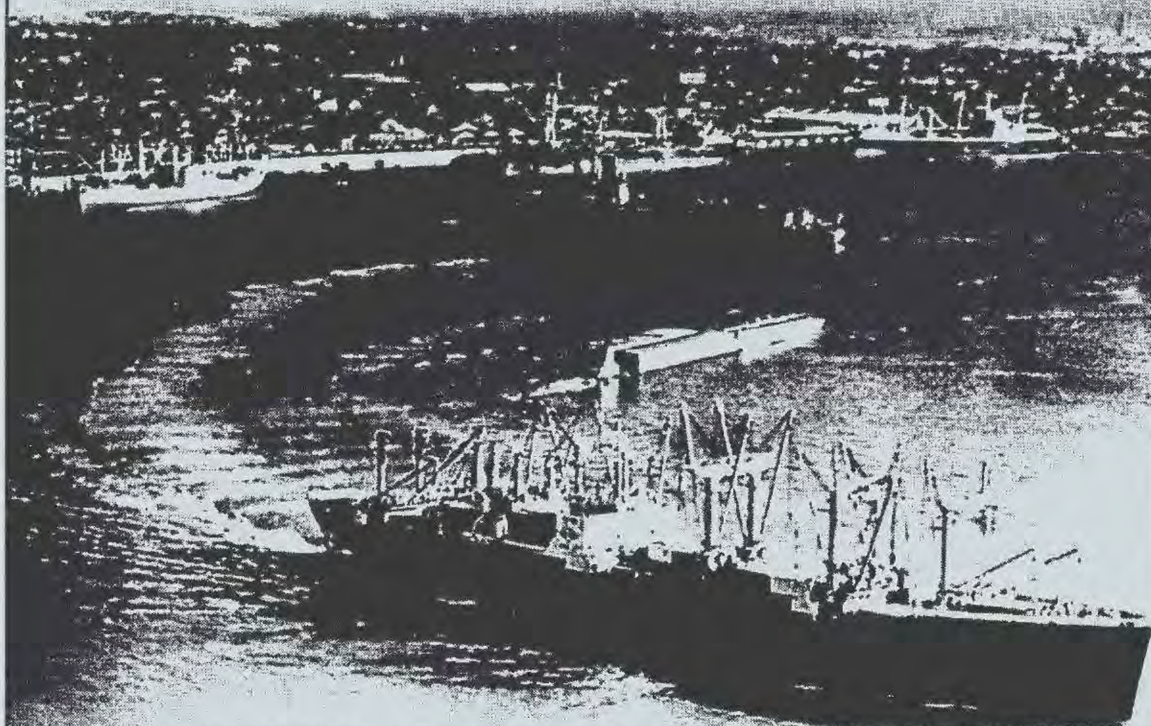

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# Oil drilling loss

Continued from page 3

John Harries, general counsel for Esso Resources, which is managing the litigation for the oil companies, says he hopes the case will be settled before the trial, which is scheduled for 1988.

"If anyone gives me a check, I will take it," Mr. Harries said "But, nobody has paid so far."

Nevertheless, the disputed losses could be reduced to as low as $40 million, following new reports from Esso's adjusters, Mr. Harries admitted. "The losses could now range from $40 million to $62.2 million," he said.

Esso is a subsidiary of Imperial Oil Ltd. of Toronto, which is 70% owned by New York-based Exxon Corp.

The losses were caused by a three-day storm in the Beaufort Sea between Sept. 16 and 18, 1985. The storm severely damaged the oil companies' $30 million rig and other equipment for a total of $34.3 million in damage.

Esso and the oil companies also claim $27.9 million in extra expenses, according to the suit, filed in June 1986 in the Court of Queen's Bench in Calgary.

While not specified in the suit, the extra expenses presumably include cleanup costs and the cost of redrilling the well.

Esso and the oil companies charge the losses are covered under a property and extra-expense policy covering their operations in the Beaufort Sea.

The policy in dispute, Policy No. SA-056T, was led by Commonwealth, which retained the first 15% of the risk, according to court papers.

Commonwealth, a subsidiary of The Home Insurance Co. since 1983, also served as a fronting insurer for another 52% of the coverage. It ceded 32% of the risk to European companies, including Lloyd's underwriters, and 20% to Ancon Insurance Co. S.A., Exxon's Bermuda-based captive.

The coverage was placed through Commonwealth's managing general agent, Reandex Home International Ltd.

Another 15% of the coverage was written by The Home Insurance Co.; 5% by CIGNA Insurance Co. of Canada; 5% by the All American Marine Slip; 5% by Arkwright-Boston Insurance Co.; and 3% by The Reinsurance Corp. of New York.

Sedgwick's Canadian unit first placed the coverage April 1, 1984—prior to the merger of the units with Candian broker Tomenson Saunders Whitehead—and renewed the coverage a year later with the help of the London offices of Sedgwick Offshore Resources, according to court papers. However, Sedgwick Offshore never dealt with any of the plaintiffs, Sedgwick contends.

The coverage dispute revolves around the kind of man-made island on which the oil companies' Rig 7 was sitting when the three-day storm hit the Beaufort Sea, according to court documents.

The rig and the man-made island are a part of extensive drilling operations in the Beaufort Sea by Esso and the other oil companies. Esso is the managing operator of the project.

Rig 7 stood on a "sacrificial beach" island, which washed away during the three-day storm. The island was made by the oil companies by dredging up gravel from the seabed and piling it offshore to create an island that was 2,000 feet in diameter on the seabed and 300 feet in diameter for the 15 feet of the island that was above sea level.

A sacrificial beach island is used when drilling offshore in relatively shallow water, Mr. Harries explained. The island is designed to let the waves gradually erode it so that the island will eventually disappear. The theory is that drilling will be completed by the time the man-made island is washed away.

To slow down erosion as sea waters wash over some man-made islands, Esso has designed a giant steel ring, known as a caisson, that acts as a breakwater around some islands. A caisson-retained island is expected to last longer than a sacrificial beach island.

The island on which Rig 7 was located when it was damaged was not protected by a caisson.

Esso and the oil companies claim that the disputed insurance policy covers property on and extra expenses related to all of their artificial islands, including sacrificial beach islands and caisson-retained islands.

The plaintiffs say "the insurers agreed to indemnify the plaintiffs with respect to destruction of or damage to property of every kind of description owned, leased or rented by the plaintiffs or for which the plaintiffs were legally liable or for which the plaintiffs had assumed responsibility or agreed to insure, as well as for any extra business expenses caused by destruction of or damage to property."

But, the insurers have "wrongfully neglected or refused" to pay claims from the 1985 storm, the lawsuit says.

The insurers have told Esso and the oil companies that some or all of the rest of their Beaufort Sea operations are not insured under the policy, the plaintiffs noted. As a result, Esso and the companies have "been forced" to buy contingent insurance coverage to insure their continuing Beaufort Sea operations at a cost of $60,000, court papers say.

Esso and the oil companies want the Canadian court to declare that the policy is valid and order the insurers to pay them as much as $62.2 million in losses, the $60,000 in additional insurance costs and unspecified damages and costs.

However, the insurers contend in court papers they do not have to pay the claim because they were told by Sedgwick's Canadian units in letters before the original policy was placed in 1984 that all offshore operations in the Beaufort Sea would be on caisson-retained islands, not on sacrificial beach islands.

"At no time prior to the issuance of the policy were these defendants advised that

Continued on next page

# BC/BS of Rhode Island

Continued from page 1

To determine indemnity plan premiums, BC/BS of Rhode Island estimates what percentage of an employer's employees will opt for HMO coverage. This is based on previous claims and enrollment experience, said Ron Battista, senior vp of the Rhode Island BC/BS plan.

With this percentage in mind, BC/BS of Rhode Island then evaluates the claims experience of the group of employees that would opt for the indemnity plan.

Then, the insurer estimates the next year's cost of the indemnity plan, based on the possible claims experience of the employees that would be left in that plan, compared with the claims experience of the employees opting for HMO coverage.

Mr. Battista said the resulting three-tiered rating structure works as follows:

- The "reference" rate is the premium increase the employer would receive if all employees remained in the indemnity plan. This includes a normal rate increase based on the prior year's claims experience and other inflation factors.
- Employers that offer the indemnity coverage and HMOs would receive a premium increase based on the estimated percentage of employees opting for HMO coverage.
- However, the employer can receive a lower increase if it offers the BC/BS "HealthMate" plan in addition to HMOs and traditional coverage.

HealthMate is an experience-rated preferred provider plan that offers more coverage than the indemnity plan, Mr. Battista said. BC/BS of Rhode Island introduced HealthMate in July, and it now covers about 12,000 people.

Employers that offer HMOs and traditional BC/BS indemnity coverage but do not offer HealthMate would receive the highest premium increase under the formula.

"For example, say the employer's indemnity rate increases to $100. If the employer offers HMOs and indemnity coverage, plus HealthMate, the rate will increase to $115. But, if the employer offers HMOs and the indemnity plan, but decides not to offer HealthMate, the premium would increase to $125," Mr. Battista explained.

"The tricky part of this is predicting which coverage employees will choose. It is possible that we could overestimate the percentage opting for HMO coverage and the employer would perceive this as even more of a penalty," he said.

"We are in the process now of filing an adjustment with the insurance regulator that would say, 'If we missed the mark by say, 10%, we will go back and adjust the rate accordingly,' " he explained.

Before BC/BS of Rhode Island began using this "adverse selection" premium formula, the insurer had for a time retroactively adjusted premium increases after an employer's open enrollment was completed.

Previously, BC/BS of Rhode Island gave employers a chart showing how their indemnity premium would increase if more than 5% of the employer's workforce chose HMO coverage. The premium would increase as the percentage of employees opting for HMOs increased, with the increase applied when the enrollment results were known.

But, this retrospective adjustment was withdrawn.

For example, B.A. Ballou Co. Inc., an East Providence-based employer, originally was quoted an increase under the previous formula.

However, the company's premium did not increase as a result of this, "because we didn't lose more than 5% to HMOs," explained Robert Richer, personnel director of the jewelry manufacturer.

"The Blues originally came up with an adverse selection factor to penalize a company for a loss of Blues subscribers to HMOs. The increase was applied retroactively, once the percent of loss was determined after the enrollment. They built the factor in and were going to charge a piggyback premium," he said.

Ballou's premium still increased 34%, "which was fairly moderate, but a lot more than the general inflation rate," Mr. Richer said.

The company has 430 employees, about 30 of whom receive health coverage through HMOs.

While "the intent (of retroactively adjusting premiums) was good on our part, we disbanded that method," and switched to prospectively estimating the percentage of employees opting for HMOs, Mr. Battista of BC/BS of Rhode Island explained.

According to the Health Insurance Assn. of America—a health insurer trade group—and the Group Health Assn. of America—the trade group for prepaid health plans—no other health insurer is using a prospective adverse selection factor in determining indemnity premiums.

"Some people view this (adverse selection factor) as a penalty rate," admitted Mr. Battista.

"We know the employers can't say no to our federally qualified competition. But, you can't argue with the actuarial facts," he continued. Without the prospective surcharge, or if rates were based only on the previous year's experience, BC/BS of Rhode Island would always be trying to recover from past adverse loss experience, he contended.

However, "there is absolutely no documentation or actuarial justification for the Blues' adverse selection factor premium formula," argued Blair R. Suellentrop, chief executive officer of Ocean State Physicians Health Plan Inc., a Warwick-based HMO with 86,000 enrollees.

"This is actually anti-competitive in our eyes. The Blues already have 85% of the commercial market," Mr. Suellentrop said.

BC/BS of Rhode Island currently covers about 700,000 people in Rhode Island, said a plan spokesman.

"Blue Cross & Blue Shield did actuarial studies that satisfied this department," said Nancy Mayer, chief legal counsel for Rhode Island's Department of Business Regulation. "We had an independent actuary examine this."

Mr. Battista noted that the BC/BS adverse selection problem is compounded because "in Rhode Island, the HMOs typically offer more benefits than Blue Cross & Blue Shield, but they utilize a pre-existing condition clause. Adverse selection itself is a problem, but the use of pre-existing condition clauses is what's exacerbating the problem," he argued.

These pre-existing condition clauses could encourage some employees with certain health conditions, who would not be fully covered by an HMO, to opt for the indemnity plan. "While most are prohibited from using such a clause, they call it a copayment," Mr. Battista said.

For example, Ocean State Physicians Health Plan uses a pre-existing condition copayment.

"This applies to a new enrollee who has a condition that has been diagnosed and that requires surgery within the first 12 months of coverage. The enrollee would have to pay 25% of his or her hospital costs associated with surgery up to a maximum of $1,000," explained Mr. Suellentrop.

"This type of copayment is absolutely necessary to prevent adverse selection against our HMO. We have sold HMO coverage to only one group in our history without a pre-existing condition copayment and we lost over $1.1 million on that group alone," he noted.

The other two HMOs in the state—Providence-based Rhode Island Group Health Assn. Inc. and the Blues' HMO Rhode Island—do not require copayments or utilize pre-existing condition clauses.

The BC/BS "adverse selection factor" creates significant problems for employers, some experts say.

For example, because the three HMOs operating in the state—including HMO Rhode Island—are federally qualified and can therefore mandate employers to offer HMO coverage to employees, "this puts the employer between a rock and a hard place," said Robert Kelly, a consultant in the Boston office of The Wyatt Co.

"The implication of this is that HMOs increase the total cost of your benefit plan," he said.

Indeed, as a result of the formula, some Rhode Island employers have received large premium increases from the Blues.

"We received a 48% increase, and we cannot justify anything more than a 35% increase based on our claims experience," said Joseph Cembrola, vp and manager of compensation and benefits at Fleet National Banks in Providence. The indemnity coverage was renewed on Jan. 1.

More than 2,000 of the company's 2,800 employees are covered by BC/BS of Rhode Island, he said. The remainder receive coverage through HMOs.

"The Blues went back and looked at the people who dropped Blue Cross coverage and assumed that they went to HMOs," he said. "The Blues looked at those employees' past claims experience and figured that they had good experience or that they used little benefits.

"Blue Cross wanted us to offer HealthMate, but we didn't think it was competitively priced, compared with other HMO products," Mr. Cembrola explained.

Brown University in Providence received a premium increase of 27% when it renewed its BC/BS coverage on Nov. 1, said Margaret Ives, assistant vp of personnel.

However, "the reasons for the increase are very complex," she said. "Many employers in the state received rate increases of 40% or more and they are angry. I'm angry too, but there are many factors influencing the cost of health insurance now. This is a scene of high change right now."

The university also offers HMO coverage through Ocean State Physicians Health Plan and Rhode Island Group Health Assn. Those premiums increased 13.5% and 11.5%, respectively, she said.

The Providence Journal-Bulletin, a newspaper in Providence, was quoted "a huge increase this year (Jan. 1). We're now negotiating the increase with Blue Cross & Blue Shield," said a spokeswoman, who would not comment further.

Some experts say the new premium formula is an effort by BC/BS of Rhode Island to rebuild its reserves and to prepare for its loss of tax-exempt status this year.

"They've had some reserve problems, and this is also the first time the Blues have had to pay federal tax," said Ms. Ives of Brown University.

"They have to rebuild their statutory reserves, and the only way to do that is through the policyholders," said Wyatt's Mr. Kelly.

"We are required by law to keep enough money in reserve to pay at least half a month's worth of claims," said a spokesman for BC/BS of Rhode Island.

"Periodically, there are cycles where we go below this and we have to take action to rebuild reserves," he added.

But, regardless of the reasons for the huge increases, some employers now are looking for new health insurers for their group indemnity plans.

"From a public relations point of view, this has been a disaster for Blue Cross & Blue Shield of Rhode Island," said Wyatt's Mr. Kelly. "For the first time in my memory, Rhode Island employers have asked us to find new insurers for them."

"We are exploring other alternatives at this time," said Mr. Cembrola of Fleet National Banks.

Some experts say that competition in the Rhode Island market will become even more intense.

"Rhode Island is a trembling market right now," Mr. Battista of BC/BS of Rhode Island observed. "There already are three HMOs, and another three to six HMOs are in the licensing process."

Ms. Mayer of the Department of Business Regulation agreed that, while Rhode Island is a small market, "now there are several more HMOs being licensed." ■

# Oil drilling loss

*Continued from previous page*

the plaintiffs would use or intended to use sacrificial beach islands in connection with offshore drilling," said Commonwealth and Reandex in court papers.

"The failure by the plaintiffs or their agent, the defendant Sedgwick Tomenson, to disclose the intention to use sacrificial beach islands in connection with offshore drilling was a failure to disclose material circumstances that were known or ought to have been known by the plaintiffs, or, in the alternative, their agents, defendant Sedgwick Tomenson."

The insurers claim that if sacrificial beach islands were intended to be used but were not disclosed to the insurers, then the plaintiffs and Sedgwick "misrepresented the circumstances material to the risk," court papers say.

Furthermore, the insurers "specifically deny that the plaintiffs are entitled to extra-expense coverage."

Esso and the oil companies claim, however, that all information about the Beaufort Sea operations was available to brokers Sedgwick Tomenson and Sedgwick Offshore to show to underwriters.

If the court determines that the claims are not covered under the policy, the plaintiffs argue that Sedgwick Tomenson and Sedgwick Offshore should pay the losses plus damages for "breach of contract or negligence. . .in failing to obtain and maintain complete insurance coverage on the Beaufort Operations in accordance with their obligations and representations to the plaintiffs."

The Sedgwick companies contend in court papers that the disputed policy "constitutes a binding contract of insurance."

Sedgwick Tomenson and Sedgwick Offshore claim that they did not make any material misrepresentation nor fail to disclose any material circumstance in respect of the risk.

**Sedgwick contends the disputed policy 'constitutes a binding contract of insurance.'**

In addition, Sedgwick claims that the installation of Rig 7 on the island did not constitute a material change to the risk and that the insurers' surveyor knew about the planned installation.

But if the installation of the rig on the island was a material change to the risk, the brokers note the installation was completed in September 1985, at least one month earlier than the brokers had been told the rig would be installed. "Any duty on (Sedgwick) to give notice to the defendant insurers of the alleged material change to the risk therefore did not arise prior to the loss, or in the alternative was not breached. . . ," the brokers claim in court papers.

The Sedgwick companies also say they have not breached any duty owed to the plaintiffs and therefore are not responsible for paying any losses the plaintiffs may not recover from insurers.

The brokers claim they fully disclosed the nature of the risk to the insurers, including the plaintiffs' use of "artificial islands" for offshore drilling in the Beaufort Sea.

"The use by Esso of artificial islands, including sacrificial beach islands, in the Beaufort Sea was well known in the industry," the Sedgwick companies say in court papers. "It was known or must be presumed to have been known by the underwriters to whom Sedgwick Canada presented the risk, all of whom purport to be experts in the insuring of property used in oil and gas drilling programs."

The Sedgwick companies also say that they gave insurers no information during the original placing or at renewal that would have "restricted the nature of the intended coverage, excluded the use of sacrificial beach islands, or confined future offshore drilling operations to caisson-retained islands.

Although the brokers admit that they wrote that "Rig 7 will work on caisson" in information given to the underwriters at the time of the original placing, "this statement was not material," the Sedgwick units argue in court papers.

The brokers also claim that the underwriters knew the plaintiffs were conducting drilling operations on artificial islands, including sacrificial beach islands, because they had been notified and had paid other claims on the original and the renewed policies.

Sedgwick Group has notified its errors and omissions underwriters of the claim against the two Sedgwick units.

Sedgwick Secretary George Hilton refused to comment on the lawsuit, although he did confirm that a list of possible E&O claims was given to Sedgwick's E&O insurers when the policy was renewed Jan. 1.

Sedgwick's E&O policy, which was renewed Jan. 1, was placed by Lloyd's broker Willis Faber P.L.C. The coverage was led by Lloyd's of London underwriters, and Sedgwick's Bermuda captive participated in the coverage, Mr. Hilton confirmed.

In 1986, Sedgwick paid 20 million pounds ($29.7 million at the applicable exchange rate) in premiums for its E&O insurance, compared with 7 million pounds ($10.1 million) in 1985, Mr. Hilton confirmed. Sedgwick will pay about the same this year for its E&O coverage as it did in 1986, said Mr. Hilton, who would not disclose the limits of the coverage, nor the amount retained by its captive.

In 1984, Sedgwick's E&O underwriters paid the bulk of $100 million in claims against an Australian electric utility Southern Electricity Commission of Victoria for bush fires losses.

SECV's liability insurers refused to pay the claims because facts were not disclosed and/or were misrepresented when the liability coverage for the utility was placed in 1982. The coverage was placed by two Sedgwick units, Sedgwick Ltd. and Sedgwick International Ltd. (*BI*, Jan. 30, 1984).

The two Sedgwick units and the underwriters paid about $75 million of the more than $100 million in claims in a settlement that ended an eight-week trial (*BI*, March 26, 1984).

Besides Esso, the other plaintiffs in the current case are Petro-Canada Inc.; Home Oil Co. Ltd.; Canalands Resources Corp.; AT&S Exploration Ltd.; Lochiel Exploration Ltd.; Oakwood Petroleums Ltd.; Albeta Energy Co. Ltd.; Mow Valley Industries Ltd.; Trillium Exploration Corp.; Westcoast Petroleum Ltd.; Beau Canada Exploration Ltd.; and MLC Oil & Gas Ltd.

Besides the Sedgwick units and Commonwealth, defendants include are The Home; CIGNA of Canada; Marine Office of America Corp., which is carrying on business as All American Marine Slip; Continental Insurance Co.; The Fidelity & Casualty Co. of New York; Fireman's Fund Insurance Co. of Newark, New Jersey; Switzerland General Insurance Co. Ltd.; Arkwright-Boston; Reinsurance Corp. of New York; Reandex; Ancon; Skadeforsikringsselsdapet Vesta A/S; Storebrand Norden Reinsurance Co. Ltd.; Excess Insurance Co. Ltd.; Pearl Assurance P.L.C.; Scottish Lion Insurance Co. Ltd.; London & Hull Maritime Insurance Co. Ltd.; English & Scottish Maritime Insurance Co. Ltd.; and Lloyd's underwriters. ■


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# ICA ruling

*Continued from page 1*

partment.

ICA's lawyer, Mr. Feaman—who described Ms. MacLean's letter as "inartfully written" —said that ICA is not operating under the Risk Retention Act. Family Home Warranty, formerly a division of Dyna Span, is now a division of ICA operating under the name Warranty America, Mr. Feaman said.

He added that Warranty America ceased operating as a purchasing group when it became an ICA subsidiary.

The Florida department's complaint also alleged that on Dec. 23, 1986, ICA offered a premium quote for insurance covering Braman World Car Center, a Miami car rental agency and auto dealership.

The complaint also charges that on Jan. 1, ICA sold a specific excess reinsurance policy to Finlay Medical Center, a Miami HMO, to cover plan members against the HMO's insolvency.

ICA was not authorized to conduct either of these transactions in Florida, the complaint charged.

ICA admitted in its answer to the complaint that it was selling insurance in Florida without a license, but it contended that it is empowered to do so under two rulings it claims were issued by a judge in a federal court in Delaware in 1911 and 1914, according to Mr. Feaman. In addition to its answer, ICA filed a counterclaim seeking a declaratory judgment of its status under two rulings.

The 1911 decision allegedly was issued in connection with two cases: *Pocahontas Insurance & Trust Co. vs. Pocahontas Insurance Co.* and *Pocahontas Insurance Co. vs. Insurance Corp. of America and First Corp. Insurance Group.*

In this decision, Ben Green, identified as a "substitute judge," ruled that Pocahontas Insurance & Trust, Pocahontas Insurance Co., ICA and First Corp. each have 71 separate insurance company divisions, each of which is authorized and approved to do business in all states and the District of Columbia.

Exhibits attached to the ruling list the 71 subsidiaries of each of the four corporations and list deposits made by the old ICA with each state as of May 1, 1911.

The court ruling says that these deposits—including $124,517 deposited in Florida as of May 1, 1911—are to remain with the states "to serve as security for all the corporations and each division which shall share and share alike."

The ruling also lists eight additional corporations that are separate from the four already listed. These eight corporations are World Insurance Co., West Virginia Life Insurance Co., United Pocahontas Insurance Co., American Insurance Co., West Virginia Multiline Insurance Co., United American Insurance Co., American Insurance Group and Pocahontas Insurance Group.

None of these companies appears in either the property/casualty or life/health editions of Best's Insurance Reports. American Insurance Co. is not related to a Fireman's Fund Insurance Co. unit of the same name. United American Insurance Co. is unrelated to a life insurer of the same name based in Dallas, while World Insurance Co. is unrelated to a life insurer of the same name based in Omaha, Neb.

The 1914 decision was issued in a case titled *Pocahontas Insurance & Trust, Pocahontas Insurance Co., ICA and First Corp. vs. J.S. Darst, Insurance Commissioner for West Virginia.*

In the 1914 decision, the same "substitute judge" ruled that the four corporations, their 71 divisions and the eight other insurers are " 'Grandfathered Insurance Corporations' and are not in any way subject to regulation by any insurance department, commissioner or any other official of any state, territory or by the District of Columbia."

The ruling—which later adds that all of these companies and their divisions are also exempt from federal regulation—does not explain under what law or regulation the insurers are being "grandfathered."

Mr. Feaman contends that these decisions allow ICA to operate in any state free from regulation and that the decisions supercede state law and the 1945 McCarran-Ferguson Act, which affirmed state control over insurance regulation.

Mr. Feaman added that the sale of ICA last year included "most or all" of the 71 divisions listed in the court decision.

The Florida department, however, contends that the McCarran-Ferguson Act and Florida insurance laws prevail, according to Susan Stafford, a lawyer with the Florida department.

Ms. Stafford said she argued in court that ICA had not properly authenticated the two federal decisions, adding that she is uncertain where the rulings came from.

(Mr. Feaman noted that the judge hearing the case overruled Ms. Stafford's objection allowing the decisions to be entered as evidence.)

Neither decision contains a case number or citation and, in a search of federal and state cases going back to 1910, Ms. Stafford said she was unable to find any reference to any of the corporations shown as plaintiffs or defendants in the two rulings.

Ms. Stafford said she was also uncertain about which court issued the rulings.

The rulings are headed, "In the United States Circuit Court of Delaware at Dover, Delaware."

However, the U.S. District Court in Delaware is located in Wilmington, and there is no U.S. Circuit Court of Appeals in the state.

Linda Jenkins, a deputy clerk at the U.S. District Court in Wilmington, said that a federal circuit court did sit at Dover earlier in the century. Ms. Jenkins added, however, that the clerk's office has received numerous calls about the two rulings and has been unable to locate them in the court's Philadelphia archives after "months" of searching.

Mr. Feaman, ICA's lawyer, said he has never seen a case number or citation for either of the two decisions.

He added, however, that ICA's sellers provided Mr. Johnson and the other investors with copies of the decisions stamped as "true copies" of court records by the clerk of the U.S. District Court for the District of Columbia, which Mr. Feaman said has custody of some of the Delaware court's archives.

Copies of the decisions stamped by the District of Columbia court clerk were later certified by the clerk and a judge of the Circuit Court for Lee County, Va.

"I rely upon the certifications," Mr. Feaman said. "The file is somewhere. Otherwise, how could they certify it?"

James F. Davey, clerk of the District of Columbia federal court, confirmed that two employees in the clerk's office stamped the two decisions more than a year ago.

However, Mr. Davey said that he has subsequently been unable to locate the decisions in the court's records or identify the case they came from. One of the clerks does not recall having stamped the decisions, while the other remembers the documents but does not recall who requested the certification or what file the decisions came from, Mr. Davey said.

Mr. Davey said that ICA's Mr. Johnson wrote to him on Feb. 13 asking for additional certified copies of the ruling. Mr. Davey said last week that he plans to reply to Mr. Johnson that the court will not provide additional certified copies until it is able to identify the cases and locate the rulings in its records.

Mr. Davey added that the Lee County Circuit Court—which based its certification on the District of Columbia court's stamp—had also recently asked the District of Columbia court clerk to identify the cases. Mr. Davey said that he will be sending copies of his letter to Mr. Johnson to the Lee County court clerk as well as to Sen. John Warner, R-Va., and to the Texas attorney general's office, both of which also have asked for information on the cases.

ICA's sellers included two corporations, First Corp. and Preferred Research Inc., Mr. Feaman said. Lawyers for the sellers could not be reached for comment.

Meanwhile, ICA's Mr. Johnson testified at a hearing on the Florida department's complaint that he believes ICA's deposit with the state—which amounted to $124,517 as of May 1, 1911—currently amounts to about $25 million after accumulated interest, Mr. Feaman confirmed.

Although Mr. Johnson testified that he believed this money to be on deposit with the state treasurer, the Florida Department of Insurance and Treasurer has no record of ever having received a deposit from ICA or its predecessor company, Pocahontas, Ms. Stafford said.

Mr. Johnson conceded during his testimony that he did not attempt to verify this deposit before the purchase of ICA, Ms. Stafford said.

Mr. Johnson did not return phone calls for comment on this story.

Mr. Feaman said that he has not been able to locate the state agency that is holding the ICA deposit, adding that "we have not gotten a lot of help from the state."

He also suggested that Mr. Johnson relied on the certified Delaware Court records, which included a list of the deposits with the various states, and that the decision not to independently verify the deposit was "a business judgment, and I don't get involved in business judgments."

Palm Beach Circuit Court Judge R. William Rutter Jr. issued an injunction against ICA on Feb. 10.

Judge Rutter denied ICA's motion to stay the injunction pending ICA's appeal of the injunction to Florida's 4th District Court of Appeals, according to Mr. Feaman.

ICA's counterclaim for declaratory judgment has not yet been litigated, Ms. Stafford of the Florida department added.

Another motion to remove Mr. Johnson and Mr. Scalise from the Florida department's action has not been decided, Mr. Feaman said.

As the Florida case proceeded, the West Virginia Insurance Department warned consumers and agents to avoid ICA.

"Based upon telephone calls from numerous states, (Commissioner) Wright believes that ICA is selling coverages nationwide and representing itself as a West Virginia-based insurance company. Wright states that ICA is not licensed to transact insurance in West Virginia nor in any other state based on information to date," an Insurance Department press release says.

At the West Virginia department's request, West Virginia Secretary of State Ken Hechler has also amended ICA's certificate of good standing to include a disclaimer noting that ICA is not authorized as an insurer in the state.

A certificate of good standing attests only to the fact that a corporation is not delinquent in paying its corporate taxes, the amended certificate notes.

This disclaimer was added "after the insurance commissioner's office received telephone calls from individuals approached to act as insurance agents for ICA and from an attorney representing individuals who had been approached to purchase the charter of ICA," according to an affidavit of Cheryl L. Davis, general counsel to the West Virginia department.

The affidavit was entered by the Florida department in its suit against ICA, which had introduced the certificate of good standing as an exhibit.

"These individuals advised the insurance commissioner's office that they had been shown ICA's certificate of good standing, which at the time did not contain the disclaimer in question and were uncertain in regard (to) the effect of the certificate of good standing on ICA's authority to transact insurance in West Virginia," Ms. Davis said in the affidavit.

Mr. Feaman said that ICA has never presented the certificate of good standing as proof of its authority to conduct insurance business.

"The certificate of good standing was never intended to be used as some kind of showing that it was some kind of certificate of authority from the Insurance Department," Mr. Feaman said. "The rights of ICA do not come from a state; they come from that federal court decision."

Separately, ICA may not be the only insurer named in the 1911 and 1914 court decisions that has been up for sale.

*Business Insurance* has obtained a copy of a 1986 letter that outlines a possible sale of American Mining Insurance Co., one of the 71 divisions of ICA.

The July 31, 1986, letter to a potential buyer was signed by Fred H. Quarles, vp of Commonwealth Capital Corp. of Charlottesville, Va. The letter, written on Commonwealth Capital letterhead, states that the offering price for American Mining is $2 million and that the sale will include American Mining's charter and $5.7 million in assets, "which have been lodged with the respective states and are earning approximately 10% interest."

"This company has a charter issued in the late 1800's and has powers which are very broad. It is a quick way to become qualified in all 50 states, as this company has already been admitted in all 50 states and the District of Columbia. There are no local, state, or federal requirements of any type and salesman are exempt from licensing requirements. These items have been upheld by court decisions," the letter reads.

"If you are interested please act quickly. The company is offered subject to prior sale," the letter says.

American Mining does not appear in either the property/casualty or life/health editions of Best's Insurance Reports.

Mr. Quarles refused to comment on American Mining or on any details of the letter, other than to say, "I don't even know that I sent it."

After the Commonwealth Capital letterhead was described to him in a telephone interview, Mr. Quarles said that there were "some differences" between the description and the company's actual letterhead, though he would not specify what those differences were.

Mr. Quarles also declined an offer to provide him with a copy of the letter for his verification. "I really don't want to get involved," he said. ■

## datebook

**MARCH 2-3. Auditing with the New CGL Program** seminar in Baltimore, sponsored by Premium Audit Advisory Service; $175 for subscribers; $200 for non-subscribers. **Also March 5-6** in New Brunswick, N.J.; **March 23-24** in Denver; **March 26-27** in Kansas City, Mo.; **April 2-3** in Cleveland; **May 4-5** in St. Paul, Minn.; **May 6-7** in Minneapolis; **May 11-12** in Atlanta; **July 28-29** in Worcester, Mass.; **Aug. 20-21** in Dallas; and **Sept. 29-30** in Edison, N.J. Premium Audit Advisory Service, 85 John St., New York, N.Y. 10038; 212-669-0511.

**MARCH 2-4. 1987 Loss Control Management Development Conference** in Orlando, Fla., sponsored by the Alliance of American Insurers; $190, $170 each for three or more attendees from same organization. Loss Control Department, Alliance of American Insurers, 1501 Woodfield Road, Schaumburg, Ill. 60173-4980; 312-490-8500.

**MARCH 2-6. Modern Safety Management** course in Dallas, sponsored by the International Loss Control Institute; $695. **Also March 16-20** in Atlanta, **March 23-27** in Pittsburgh, **April 6-10** in Boston and **April 27-May 1** in Atlanta. International Loss Control Institute, P.O. Box 345, Loganville, Ga. 30249; 404-466-2208.

**MARCH 3. Questions on the New Insurance Services Office's CGL Policies? Ask the Claims Department!** workshop in Austin, Texas, sponsored by the Central Texas Chapter of the Society of Chartered Property & Casualty Underwriters; $110 for CPCU members; $140 for non-members. Mari Jennings, Society of CPCU, Kahler Hall, 720 Providence Road, CB#9, Malvern, Pa. 19355; 215-251-2741.

**MARCH 4-5. Behavioral Science as an Approach to Accident Prevention** course in Los Angeles, sponsored by the University of Southern California, Institute of Safety and Systems Management; $375. University of Southern California, Institute of Safety and Systems Management, Office of Extension and In-service Programs, 3500 S. Figueroa St., Suite 202, Los Angeles, Calif. 90007; 213-743-6523.

**MARCH 4-6. Eighth Annual Petroleum Insurance Conference** in New Orleans, co-sponsored by Self-Insurance Resource Inc. and Professional Development Institute; $495; $50 for spouse activity fee. Professional Development Institute, North Texas State University, P.O. Box 13288, NT Station, Denton, Texas 76203-3288; 800-433-5676; 817-565-2483 in Texas.

**MARCH 4-6. California Self-Insurers Assn.'s 57th Annual Meeting** in Monterey, Calif.; $255 for members; $315 for non-members; $110 for spouses. California Self-Insurers Assn., 921 11th St., Suite 619, Sacramento, Calif. 95814; 916-442-4576.

**MARCH. 4-6. Shippers National Freight Claims Council's 13th Annual Claim Conference and Claims Prevention Exhibition: Liability Changes and New Challenges** in New Orleans; $295 for SNFCC; $345; less 33% for additional registrants from same organization. Shippers National Freight Claims Council Inc., 120 Main St., Box Z, Huntington, N.Y. 11743; 516-549-8984.

**MARCH 5. The Risk Bearing Phenomenon—Alternatives to Traditional Insurance** workshop in San Francisco, co-sponsored by the Northern California and Golden Gate chapters of the Society of Chartered Property & Casualty Underwriters; $125 for CPCU members; $150 for non-members. Julie Ann Juliana, Society of CPCU, Kahler Hall, 720 Providence Road, CB#9, Malvern, Pa. 19355; 215-251-2735.

**MARCH 5-6. Public Agency Risk Pooling** seminar in Clearwater Beach, Fla., sponsored by the Public Risk & Insurance Management Assn.; $150 for PRIMA members; $250 for non-members. PRIMA, 1120 G St. N.W., Suite 400, Washington, D.C. 20005; 202-626-4650.

**MARCH 5-6. The Settlement of Liability Claims: A Workshop in Dispute Resolution for Professionals** seminar in Chicago, co-sponsored by the IIT Chicago-Kent College of Law and Resolve Dispute Management Inc.; $195. Jacqueline Jones, IIT Chicago-Kent College of Law, 77 S. Wacker Drive, Chicago, Ill. 60606; 312-567-5190.

**MARCH 5-6. Ansul Fire School** in Beaumont, Texas, sponsored by Ansul Fire Protection; $450. **Also March 9-10, March 12-13, March 16-17.** Ansul Fire Protection, 1 Stanton St., Marionette, Wis. 54143-2542; 715-735-7411.

**MARCH 8-11. International Benefits Conference** in Orlando, Fla., sponsored by the International Foundation of Employee Benefit Plans; $605 for IFEBP members; $680 for non-members. Registration Department, International Foundation of Employee Benefits Plans, 18700 Bluemound Road, P.O. Box 69, Brookfield, Wis. 53008-0069; 414-786-6700.

**MARCH 29-APRIL 3. 25th Annual Risk and Employee Benefits Conference** in Las Vegas, Nev., sponsored by the Risk & Insurance Management Society. $595 for RIMS members, $645 for non-members for full week; $525 for RIMS members, $575 for non-members for partial week. RIMS Conference Department, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

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## update

# Oil tank coverage mandate

*Continued from page 2*

The requirement is part of a 1984 amendment to the Resource, Conservation and Recovery Act, which requires the Environmental Protection Agency to issue financial responsibility rules for underground storage tanks by February 1988.

The proposed rule will require tank owners to establish a financing mechanism to provide limits of $1 million per occurrence and $6 million annual aggregate—depending on the number of tanks—for both cleanup costs and third-party liability stemming from any spills or leaks of petroleum products from tanks.

These financial responsibility requirements can be met through commercial insurance, self-insurance, letters of credit, state trust funds, risk retention groups, surety bonds or indemnification contracts, according to the EPA.

Currently, owners of underground storage tanks are not required to have insurance to cover liability or cleanup costs.

These rules will not affect underground tanks used to store chemicals. The agency is planning to publish a notice in June seeking public comment on how to regulate chemical storage tanks.

# Briefly noted

The Indian judge who has presided over the **Bhopal gas leak case** since last fall has been replaced because of a conflict of interest, a Union Carbide Corp. official says. It was discovered that acting District Judge G.S. Patel was in Bhopal at the time of the accident and had filed a claim against Union Carbide. District Judge M.W. Dev has been selected to preside over the case. . . .The **Canadian Insurance Exchange** in Toronto now is expected to open for business in early May—four months after its planned Jan. 1 start-up date. CIE executives say progress was stalled because the Ontario Legislature waited until the final day of its fall session, Dec. 16, 1986, to pass the exchange's enabling legislation. Also, Edward Belton, CIE president and chief executive officer, was unable to leave his prior post to join the CIE until Feb. 1.


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# Pension proposal

*Continued from page 1*

must be drafted into legislative language, also would:

- Allow companies to remove surplus pension assets for any reason without having to terminate the plan, as currently is required.

However, withdrawn excess assets that are not used to fund retiree health care VEBAs or transferred to underfunded defined benefit plans would be subject to a 10% excise tax and current income taxes.

- Reduce the flexibility employers now have in terminating overfunded pension plans.
- Increase the liability of financially troubled companies to the Pension Benefit Guaranty Corp. following the termination of an underfunded plan.
- Tighten current minimum pension funding standards to force companies with underfunded plans to boost contributions.

While a change in minimum funding rules would boost some companies' pension costs, it would reduce the burden on the PBGC, since fewer plans would be grossly underfunded.

The administration pension proposals, which are part of a 1,000-page package intended to increase the nation's competitive position in world trade, will face an uphill battle in Congress, observers say.

"I see a real political donnybrook," observed Edward J. Davey, a vp at Johnson & Higgins in New York.

For example, labor unions, pension activists and their legislative allies are expected to object to the proposal to allow employers to withdraw surplus pension assets, arguing that the assets belong to the plan participants and should be used to fund pension benefit improvements.

Experts say the proposal to allow transfers of surplus assets to retiree health care VEBAs may have the best chance of passage.

"Congress is very interested in making retiree health care benefits more secure," noted Mr. Davey.

While benefit experts welcomed the retiree health care proposal as an important first step to improve funding of post-employment health benefits, they note the provision is complex and full of restrictions.

For companies with more than one defined benefit plan, for example, those plans generally would have to be at least 125% overfunded on an aggregate basis before assets could be shifted from an overfunded plan to a retiree health care VEBA.

Employers would not be able to transfer surplus pension assets into their existing VEBAs, also known as 501(c)(9) trusts. Instead, separate VEBAs would have to be established for retiree health care benefits. Assets in these trusts cannot be commingled with other corporate assets.

In addition, since the employer already received a tax deduction for the initial pension plan contribution, there would be no tax deduction for the surplus pension assets transferred to the VEBA.

And, the assets transferred to the retiree health care VEBA would be limited to the amount needed to pay the present value of current retirees' health benefits. Assets could not be transferred to pay for future retirees' post-employment health care benefits.

While benefit experts welcome any proposal to give employers tax incentives to fund retiree health care benefits, they said they had hoped the administration would have gone a bit further.

"I can understand the Treasury Department's reluctance to allow the transfer of funds on behalf of those well in advance of retirement, but at least they should have permitted asset transfers for those employees eligible for retirement," said Buck's Mr. Rumack.

Still, he notes, "It is a very exciting and positive development that these excess assets could be used for employee benefit purposes without any adverse tax consequences."

And, depending on the funding level of a pension plan, employers could make additional asset transfers from an overfunded pension plan as more workers retire.

Under the proposal, an employer could withdraw surplus assets from an overfunded pension plan up to three times over a 10-year period. However, the plan could never be less than 125% overfunded after each withdrawal.

For example, assume a pension plan was 200% overfunded. An employer might withdraw surplus assets to bring the overfunding level down to 175%. Those assets then would shifted to a VEBA to pay for current retirees' health benefits. Five years later, the employer might make an additional asset withdrawal to another VEBA to fund health benefits for workers who retired during that five-year period.

The proposal would require that separate VEBAs be established for each asset transfer, a Treasury Department official said.

While the administration wants to give employers a tax incentive to fund current retirees' health benefits, it also is proposing to take away an approach—known as a 401(h) trust—that allows the prefunding of future retirees' health benefits.

This approach, however, is seldom used because the amount an employer can contribute to the trust is limited to 25% of its annual total contributions to all retiree benefits, including pension benefits (*BI*, Feb. 17, 1986). Also, contributions to a 401(h) trust must be "fresh cash" and not surplus funds from a pension plan.

The administration's proposal to also allow employers to remove surplus assets from pension plans for general purposes is aimed at curtailing the recent wave of overfunded pension plan terminations.

Federal pension officials are concerned that such terminations can harm plan participants, because there is no certainty that an employer will set up a new plan. And, if a new plan is set up, it almost certainly will not be as well-funded as the old plan.

But by allowing asset withdrawals from ongoing plans—as long as the 25% cushion remains—employers no longer will have to terminate the plans to recoup surplus assets.

That would be a relief to employers because plan terminations are administratively complex, expensive and time-consuming. In addition, even when a company establishes an identical plan to replace a terminated program, participants often worry the action somehow threatens their pension benefits.

The proposal will "simplify the human relations problem," said J&H's Mr. Davey.

On the other hand, while opening the door to asset withdrawals, the administration proposal would reduce the flexibility employers now have in terminating overfunded pension plans.

Under the proposal, an employer that terminated an overfunded pension plan would be barred from establishing a new defined benefit plan for five years. However, the employer could establish new defined contribution plans.

In addition, the proposal would bar so-called spinoff terminations in which a pension plan is divided into two plans, and the excess assets are shifted to one of the plans, which is then terminated.

Also, companies with both overfunded and underfunded pension plans could not terminate an overfunded plan without first transferring surplus assets to the underfunded plan.

Companies terminating underfunded plans would face new liabilities under the proposal. For example, a financially distressed company terminating an underfunded plan would be 100% liable to the PBGC for PBGC-guaranteed benefits, up from a 75% liability cap under current law.

Minimum funding standards also would be strengthened for companies with underfunded pension plans, and it would become more difficult for employers to win contribution waivers.

Currently, an employer generally has 30 years to amortize pension liabilities. That 30-year amortization period can leave a pension plan short of assets when a big block of workers unexpectedly retires, such as when a company experiences financial difficulty.

However, if the plan is significantly underfunded, the minimum required contribution would be at least equal to total distributions, including administrative expenses, paid by the plan that year. Currently, there is no comparable requirement.

In addition, the Internal Revenue Service—when evaluating an employer's request for a waiver from making the minimum required contribution—would have to evaluate the financial condition of the employer and all its affiliated companies, not just the condition of the unit sponsoring the plan.

Also, the maximum number of funding waivers the IRS could approve in a 15-year period for one company would be reduced to three from the current five. ■

# Property/casualty stocks

*Continued from page 3*

In fact, the two *BI* portfolios would have fared more poorly had it not been for last week's surge.

For instance, the total value of the Model Portfolio had actually declined 1% as of Feb. 13, compared with the 2.1% gain as of Feb. 18. The value of the Random Portfolio has risen 2.9% as of Feb. 13, compared with the 7% rise as of last Wednesday.

Analysts say the belief by many investors that interest rates will rise is a major factor holding back insurance stocks. "I think the primary reason is people's perception that there's going to be higher interest rates," said Samuel J. Weinhoff, first vp at Shearson Lehman Bros. in New York.

Mr. Weinhoff said insurance companies' investment portfolios typically are heavily weighted toward long-term bonds, whose values tend to fall during high-interest rate periods.

In addition, he said, investors are concerned that higher interest rates lead to higher inflation, which in turn leads to higher claim costs for property/casualty insurers.

Furthermore, he said, investors believe higher interest rates could signal a return to cash-flow underwriting.

Mr. Weinhoff said these concerns are valid, but only to an extent. There is a "big difference" between a one-half percentage-point rise in interest rates and a two-point rise, he noted, adding that he expects rates to rise by only the former amount within the next year.

A related reason why insurers have not participated more fully in the stock rally is investors' perception of a strengthened economy, analysts contend.

"Many investors believe the economy will become

*Continued on next page*

# Property/casualty stocks

*Continued from previous page*

stronger later this year and want economically sensitive stocks," said June I. Hoffer, an analyst with Prudential/Bache Securities in New York. Such stocks would include paper and chemical companies, but not insurance stocks, which "don't benefit as much from a stronger economy," she said.

"There's been a sense that we're in the midst of an economic recovery," agreed Gloria Vogel, vp at Bear Stearns & Co. in New York.

She noted that many portfolio managers were overweighted with insurance stocks and shifted their investments to other cyclical stocks in light of the slowing of premium growth.

Concern over future rate levels is another factor affecting property/casualty stocks, analysts say.

"Obviously, the rate situation seems to be leveling off," observed Michael A. Lewis, vp at E.F. Hutton in New York. He added that investors perceive this as a precursor of a return to price competition.

Performance of insurance stocks' reflects investors' fears that rate cutting will occur "sooner rather than later," said Mr. Weinhoff.

"There are those who don't believe that the improvements in earnings are going to continue," noted David Seifer, vp at First Boston Corp.. in New York.

"My feeling is that Wall Street earnings estimates for '86 and '87 have been too high" for insurers, he said.

When a company's earnings are not in line with an analyst's estimates, the analyst either blames the company or claims the company misled him. This encourages shareholders to sell.

Ms. Hoffer also noted some insurers strengthened reserves in the fourth quarter, causing a "couple of surprises" in the form of lower-than-expected earnings.

Ira Malis, a securities analyst with Alex. Brown & Sons in Baltimore, said some investors, who bought insurer stocks in 1984 as insurance rates began to rise, sold their shares in 1986 when they saw rates reaching their peak.

But now, "value" investors, who recognize the long-term value of property/casualty stocks, "are starting to take notice," and this will eventually lead to stronger insurer stock prices, he said.

"Book values should be building rapidly over the next year or two," which will further boost insurer stock prices, Mr. Malis said.

Eventually, Mr. Seifer agreed, investors will recognize that insurers will continue to report good earnings over the next three to four years. "Somewhere in there, investors will decide the doubters are wrong."

However, analysts generally could not explain why stocks in the Random Portfolio performed somewhat better than those in the Model Portfolio, which are recommended by the analysts.

However, Mr. Weinhoff said he believes the difference could be partially attributed to the stocks' yields. He estimated that stocks in the Model Portfolio have an average yield of about just less than 2%, while the average yield of the stocks in the Random Portfolio is close to 3%.

In the meantime, analysts have made few changes in their stock picks. The stocks most widely recommended include:

● American International Group Inc. AIG is a "non-duplicatable" company, said E.F. Hutton's Mr. Lewis. It is a major factor in all phases of insurance both in the United States and abroad and has a distinguished, proven underwriting record.

## *BI* Random Portfolio

| Stock | No. of shares | July 25 purchase price | Total | Oct. 23 price | Total[1] | Percent change | Feb. 18 price | Total[1] | Percent change |
|---|---|---|---|---|---|---|---|---|---|
| CIGNA | 40 | $62.50 | $2,500.00 | $54.63 | $2,211.00 | (11.6)% | $64.38 | $2,601.00 | 4.0% |
| CNA | 40 | 55.50 | 2,220.00 | 55.88 | 2,235.00 | 0.7 | 62.25 | 2,490.00 | 12.2 |
| Aetna | 35 | 60.50 | 2,117.50 | 56.25 | 1,991.85 | (5.9) | 64.00 | 2,263.10 | 6.9 |
| Continental | 40 | 46.63 | 1,865.00 | 45.38 | 1,841.00 | (1.3) | 52.50 | 2,126.00 | 14.0 |
| Home Group | 40 | 23.75 | 950.00 | 19.25 | 770.00 | (19.0) | 21.63 | 865.00 | (9.0) |
| Cash | | | 347.50 | | 352.50 | 1.4 | | 358.34 | 3.1 |
| Total | | | 10,000.00 | | 9,401.35 | (6.0) | | 10,703.44 | 7.0 |
| S&P 500 | | | 240.22 | | 239.28 | (0.4) | | 285.42 | 18.8 |

[1] Includes dividend payments.

Chart: Amy Palmer

"We think the company could be a growth company in a cyclical industry," he said.

Because of its emphasis on specialty lines of business, AIG is likely to see a relatively late return to competition, said Ms. Vogel.

● General Re Corp. Gen Re is not only the top-performing reinsurance company, but also a "very, very significant factor in the overall industry," said Mr. Lewis. The reinsurance industry is expected to enjoy the benefits of the tight market longer that direct insurers, he added.

Underwriting discipline in the reinsurance industry will continue longer, which will allow reinsurers to build higher earnings, agreed Mr. Seifer, who recommends AIG for the same reasons.

"I think we still see, for the most part, very little competition in the U.S. casualty market from either London or any of the other European markets," said Shearson's Mr. Weinhoff, who also includes Gen Re on his list of stock picks.

● Chubb Corp. "We think it's a good value," said Alex Brown's Mr. Malis. He added that investors have forgotten Chubb's previous involvement in medical malpractice insurance. Early last year, Chubb purchased a $285 million excess-of-loss reinsurance policy to avoid having to add any more to what were judged inadequate medical malpractice loss reserves, (*BI*, Jan. 20, 1986).

The transaction reduced Chubb's fourth-quarter 1985 earnings by $2.97 a share.

Hutton favors Chubb because of its position as, if not the best, then among the best, commercial insurers in terms of underwriting quality, said Mr. Lewis.

● Fireman's Fund Corp. Fireman's Fund's recovery could outlast the overall industry's because of its plans for managing its capital, said Ms. Vogel, who recently added the firm to her recommended list.

She explained that analysts expect Fireman's Fund to announce a large stock buyback, which would increase the insurer's earnings per share even after its underwriting profit has peaked.

Mr. Mallis recommends Fireman's Fund because of its "solid turnaround." He said that the company's progress has been marked by improved underwriting, a "top-notch" investment performance and "one of the most forward-looking managements in the industry."

Fireman's Fund last week announced plans to raise its quarterly dividend to 10 cents per share of common stock from 7.5 cents per share, payable March 25, to shareholders of record March 4.

● USF&G Corp. The stock has a high yield, said Mr. Malis, noting that the company has a history of raising dividends, including a planned dividend increase next month.

A company spokeswoman said the insurer has a policy of boosting its dividend annually by the inflation rate, plus an additional two or three percentage points. The Consumer Price Index rose by 1.1% in 1986, according to the Bureau of Labor Statistics, which means USF&G's quarterly dividend could be expected to increase to about 60 cents from 58 cents.

Mr. Malis also noted that USF&G's earnings are expected to rise this year.

In addition, the company has been able to avoid problem lines, such as asbestos and medical malpractice, noted Ms. Vogel.

● Aetna Life & Casualty Co. Aetna is a "quality play" among multiline insurers, said Mr. Lewis.

Ms. Vogel said she favors the company because it is active in large group accident and health accounts. These accounts are less vulnerable to competitive pressures in the group insurance business because many are retrospectively rated, she said.

● American General Corp. American General is now reaping the consolidation benefits of past acquisitions, said Ms. Vogel.

"They're going to see more good growth," she added.

"They keep earning money," observed Mr. Seifer, who recommends American General stock warrants. The company, which posted per-share earnings of $2.60 in 1986, could earn $4.30 per share this year, he said.

● Ohio Casualty Corp. Ms. Vogel described this insurer as a "very solid play" in the property/casualty business. She noted that Ohio Casualty is one of the few property/casualty insurers that did not dilute its per-share earnings with a stock offering during the past several years.

Furthermore, she noted, the company had good investment growth in 1986, has redundant reserves and has a disciplined balance sheet.

● CIGNA Corp. Mr. Lewis said CIGNA has a "less than enviable track record" but has made the necessary moves to clear up problems in its property/casualty operation. The company also offers a superior yield, he said.

*Business Insurance* does not recommend the stocks in either portfolio, and *BI* reporters and editors do not invest in insurance industry stocks. Readers should contact a licensed stockbroker or investment adviser before making any investment. ■

## *BI* Industry Stock Report

February 19, 1987 2/13/87 thru 2/19/87

### Brokers

| | | Price | % Chg. | P/E | $ Div. | % Yld. | High | Low | Vol.(000) |
|---|---|---|---|---|---|---|---|---|---|
| Alexander & Alexander Svcs | NYSE | 28.50 | 0.0 | 407.1 | 1.00 | 3.5 | 28.75 | 27.63 | 364.0 |
| Baldwin & Lyons Inc | OTC | 19.00 | 0.0 | 15.4 | 0.20 | 1.1 | 19.00 | 19.00 | 0.1 |
| Corroon & Black Corp | NYSE | 32.63 | 1.2 | 14.8 | 0.65 | 2.0 | 32.88 | 32.25 | 522.4 |
| Gallagher Arthur J & Co | OTC | 28.00 | 4.7 | 20.0 | 0.40 | 1.4 | 28.00 | 27.50 | 73.5 |
| Hall Frank B & Co Inc | NYSE | 17.88 | -2.1 | 0.0 | 0.00 | 0.0 | 18.00 | 17.63 | 127.8 |
| Marsh & Mclennan Cos Inc | NYSE | 65.88 | 1.7 | 20.0 | 1.90 | 2.9 | 65.88 | 65.00 | 1,422.6 |
| Poe & Assoc Inc | OTC | 13.00 | 4.0 | 16.5 | 0.40 | 3.1 | 13.00 | 12.75 | 6.0 |
| | | | | ===== | | ===== | | | |
| AGENTS/BROKERS | AVERAGE | | | 20.8 | | 2.4 | | | |

### Conglomerates & Holding Cos.

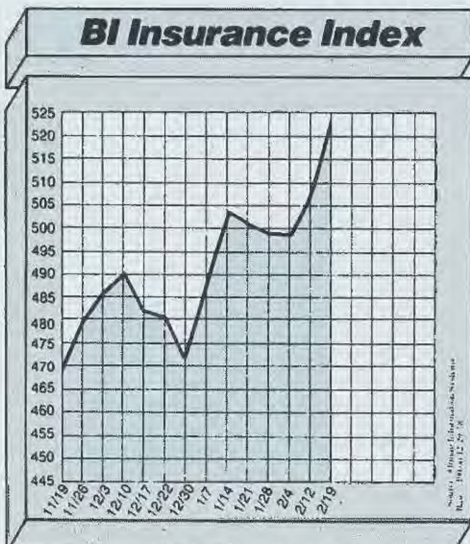
| | | Price | % Chg. | P/E | $ Div. | % Yld. | High | Low | Vol.(000) |
|---|---|---|---|---|---|---|---|---|---|
| Anderson Clayton(Ranger/PanAm) | NYSE | 65.63 | 0.0 | 18.8 | 0.00 | 0.0 | 0.00 | 0.00 | 0.0 |
| Armco Inc | NYSE | 8.50 | 1.5 | 0.0 | 0.00 | 0.0 | 8.88 | 8.38 | 1,404.0 |
| Berkley W R Corp | OTC | 31.25 | 7.8 | 17.3 | 0.24 | 0.8 | 31.25 | 30.50 | 609.0 |
| Berkshire Hathaway Inc Del | OTC | 3295.00 | 6.3 | 191.1 | 0.00 | 0.0 | 3295.00* | 3080.00 | 3.1 |
| CIGNA Corp | NYSE | 65.50 | 8.0 | 10.3 | 2.60 | 4.0 | 65.50 | 61.63 | 1,307.6 |
| CNA Finl Corp (CNA) | NYSE | 63.88 | 13.1 | 16.1 | 0.00 | 0.0 | 63.88 | 59.00 | 351.8 |
| General Re Corp | NYSE | 63.63 | 6.9 | 23.2 | 1.00 | 1.6 | 63.63 | 60.63 | 1,726.3 |
| ITT (Hartford Group) | NYSE | 62.88 | 3.5 | 25.9 | 1.00 | 1.6 | 63.13* | 61.88 | 3,188.8 |
| Sears Roebuck & Co. (Allstate) | NYSE | 51.75 | 9.5 | 14.3 | 2.00 | 3.9 | 51.75* | 47.75 | 6,982.0 |
| Transamerica Corp (Occidental) | NYSE | 36.00 | 4.3 | 10.1 | 1.76 | 4.9 | 36.00 | 34.63 | 1,418.5 |
| | | | | ===== | | ===== | | | |
| CONGLOMERATES/HOLDING COS. | AVERAGE | | | 82.6 | | 0.2 | | | |

### Insurers

| | | Price | % Chg. | P/E | $ Div. | % Yld. | High | Low | Vol.(000) |
|---|---|---|---|---|---|---|---|---|---|
| Aetna Life & Cas Co | NYSE | 66.00 | 7.8 | 11.5 | 2.64 | 4.0 | 66.00 | 61.50 | 2,203.9 |
| American General Corp | NYSE | 41.75 | 6.4 | 11.6 | 1.25 | 3.0 | 41.75 | 40.25 | 1,441.4 |
| Amern Heritage Life Invt Co | NYSE | 43.00 | 0.0 | 14.9 | 1.32 | 3.1 | 43.25 | 42.75 | 2.1 |
| American Indty Finl Corp | OTC | 17.75 | -2.7 | 0.0 | 1.12 | 6.3 | 18.25 | 17.75 | 33.8 |
| American Intl Group Inc | NYSE | 74.63 | 12.6 | 21.3 | 0.25 | 0.3 | 74.63 | 68.25 | 2,097.1 |
| Aneco Reins Ltd | OTC | 3.00 | -4.0 | 0.0 | 0.00 | 0.0 | 3.13 | 3.00 | 19.6 |
| Avemco Corp | NYSE | 37.25 | 3.1 | 16.5 | 0.50 | 1.3 | 37.38* | 36.75 | 52.2 |
| Business Mens Assurn Co Amer | OTC | 29.13 | 1.3 | 0.0 | 1.10 | 3.8 | 29.13 | 28.75 | 42.7 |
| Chubb Corp | NYSE | 67.25 | 4.1 | 11.9 | 1.68 | 2.5 | 67.25 | 65.25 | 817.2 |
| Combined Intl Corp | NYSE | 58.75 | 1.7 | 10.7 | 2.24 | 3.8 | 59.25 | 58.00 | 207.4 |
| Continental Corp | NYSE | 54.25 | 10.7 | 15.0 | 2.60 | 4.8 | 54.25 | 50.75 | 899.6 |
| Crown Life Ins Co | OTC | 345.00 | 0.0 | 11.9 | 6.40 | 1.9 | 345.00 | 345.00 | 0.4 |
| Durham Corp | OTC | 43.50 | 2.4 | 14.6 | 1.36 | 3.1 | 43.50 | 42.50 | 1.4 |
| Farmers Group Inc | OTC | 49.00 | 6.5 | 16.3 | 1.20 | 2.4 | 49.00* | 46.25 | 538.8 |
| Fairmont Finl Inc | AMEX | 19.00 | 4.8 | 13.1 | 0.00 | 0.0 | 19.00 | 18.13 | 297.6 |
| Fireman Fd Corp | NYSE | 39.88 | 8.1 | 17.0 | 0.30 | 0.8 | 39.88 | 37.50 | 1,021.0 |
| Fremont Gen Corp | OTC | 16.75 | 0.7 | 0.0 | 0.48 | 2.6 | 19.50 | 18.75 | 278.7 |
| Great West Life Assurn Co | OTC | 700.00 | 0.0 | 14.4 | 18.00 | 2.6 | 700.00 | 700.00 | 0.0 |
| Home Group Inc | AMEX | 23.38 | 13.3 | 6.3 | 0.20 | 0.9 | 23.38 | 21.13 | 837.3 |
| Hanover Ins Co | OTC | 70.00 | -0.4 | 14.9 | 0.56 | 0.8 | 70.00 | 69.50 | 19.8 |
| Harleysville Group Inc | OTC | 17.13 | 6.2 | 10.9 | 0.32 | 1.9 | 17.25* | 16.13 | 81.2 |
| Hartford Steam Boiler Insptn | OTC | 63.00 | 3.3 | 14.8 | 1.60 | 2.5 | 63.00* | 61.25 | 66.2 |
| Kans City Life Ins | OTC | 28.50 | 0.0 | 11.0 | 0.96 | 3.4 | 28.50 | 27.75 | 32.2 |
| Kemper Corp | OTC | 36.25 | 8.2 | 14.4 | 0.60 | 1.7 | 36.25* | 34.00 | 884.4 |
| Liberty Corp S C | NYSE | 39.00 | 5.4 | 13.7 | 0.72 | 1.8 | 39.00 | 37.50 | 61.4 |
| Lincoln Natl Corp Ind | NYSE | 51.25 | 3.5 | 11.2 | 2.16 | 4.2 | 51.25 | 49.25 | 270.5 |
| Mission Ins Group Inc | PAC | 0.81 | 0.0 | 0.0 | 0.00 | 0.0 | 4.38 | 0.69 | 7.8 |
| Monumental Corp | OTC | 55.63 | 0.0 | 18.8 | 0.00 | 0.0 | 55.63 | 55.63 | 1.1 |
| Nac Re Corp | OTC | 28.75 | 2.7 | 44.2 | 0.00 | 0.0 | 28.75 | 28.50 | 42.0 |
| Nobel Ins Ltd | OTC | 16.50 | -2.9 | 12.4 | 0.37 | 2.2 | 17.00 | 16.50 | 30.6 |
| Northwestern Natl Life Ins | OTC | 30.63 | -4.3 | 9.2 | 0.86 | 2.8 | 30.88 | 30.63 | 349.9 |
| Ohio Cas Corp | OTC | 46.00 | 7.0 | 15.2 | 1.50 | 3.3 | 46.00 | 42.75 | 481.2 |
| Old Rep Intl Corp | OTC | 30.25 | -5.1 | 12.7 | 0.78 | 2.6 | 31.88 | 29.50 | 293.0 |
| Orion Cap Corp | NYSE | 28.50 | -1.3 | 0.0 | 0.76 | 2.7 | 28.75 | 28.50 | 41.6 |
| Protective Corp | OTC | 19.00 | -4.4 | 10.4 | 0.70 | 3.7 | 19.75 | 19.00 | 109.2 |
| Provident Life & Acc Ins Co | OTC | 27.75 | 6.2 | 12.9 | 0.84 | 3.0 | 27.75 | 26.63 | 296.3 |
| St Paul Cos Inc | OTC | 54.75 | 13.5 | 15.9 | 1.76 | 3.2 | 54.75* | 48.75 | 1,720.0 |
| SAFECO Corp | OTC | 60.75 | 6.1 | 12.6 | 1.70 | 2.8 | 60.75 | 57.75 | 418.3 |
| Scor U S Corp | OTC | 13.50 | 3.8 | 27.0 | 0.00 | 0.0 | 13.50* | 13.25 | 352.9 |
| Seibels Bruce Group Inc | OTC | 17.00 | 3.0 | 0.0 | 0.80 | 4.7 | 17.50 | 16.75 | 64.2 |
| Selective Ins Group Inc | OTC | 23.25 | 2.2 | 10.7 | 0.92 | 4.0 | 23.25 | 22.75 | 108.9 |
| Statesman Group Inc | OTC | 4.88 | 0.0 | 0.0 | 0.05 | 1.0 | 5.00 | 4.88 | 100.1 |
| Tokio Marine & Fire Ins Co | OTC | 68.50 | 0.0 | 77.0 | 0.17 | 0.2 | 68.50 | 68.50 | 5.9 |
| Torchmark Corp | NYSE | 30.63 | 6.1 | 11.3 | 1.20 | 3.9 | 30.63 | 28.88 | 1,038.6 |
| Travelers Corp | NYSE | 51.75 | 2.7 | 11.6 | 2.28 | 4.4 | 51.75 | 50.25 | 1,405.1 |
| Trenwick Group Inc | OTC | 17.25 | -4.2 | 132.7 | 0.00 | 0.0 | 18.00 | 17.25 | 14.3 |
| United Fire & Cas Co | OTC | 31.75 | 2.4 | 14.9 | 0.80 | 2.5 | 31.75 | 31.00 | 23.1 |
| United States Fid & Gty Co | NYSE | 47.63 | 5.2 | 13.2 | 2.32 | 4.9 | 47.63* | 45.50 | 2,085.4 |
| Unum Corp | NYSE | 31.00 | 2.9 | 9.1 | 0.40 | 1.3 | 31.00* | 29.50 | 781.2 |
| Uslife Corp | NYSE | 44.50 | 2.0 | 11.5 | 1.20 | 2.7 | 45.38 | 44.13 | 200.9 |
| Washington Natl Corp | NYSE | 30.50 | 0.0 | 13.9 | 1.08 | 3.5 | 30.88 | 30.50 | 58.8 |
| Zenith Natl Ins Corp | OTC | 24.75 | 4.2 | 18.9 | 0.80 | 3.2 | 25.00 | 23.75 | 275.1 |
| | | | | ===== | | ===== | | | |
| INSURANCE COMPANIES | AVERAGE | | | 13.8 | | 2.4 | | | |

System design: Altman Information Systems

## *BI* Insurance Index




**The *Business Insurance* index surged 16.0 points last week, closing at 522.9 points, up from 506.9 points on Feb. 12. Leading gainers included: The St. Paul Cos. Inc., up 13.5%; The Home Group Inc., up 13.3%; CNA Financial Corp., up 13.1%; American International Group Inc., up 12.6%; and Continental Corp., up 10.7%. Stocks posting the largest losses were: Old Republic International Corp., down 5.1%; Protective Life Corp., down 4.4%; Northwestern National Life Insurance Corp., down 4.3%; United Fire & Casualty Co., down 4.2%; and Aneco Reinsurance Co. Ltd., down 4.1%. The *BI* index's average 3.2% increase kept pace with the major stock market indicators: The NYSE composite rose 3.3%, while the Standard & Poor's 500 average climbed 3.6%.**

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