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Update

Judge says Texas antitrust suit should be heard in state court

AUSTIN, Texas—The antitrust suit filed by the Texas attorney general against property/casualty insurance industry defendants will remain in state court, the presiding judge has ruled.

Defendants in the case had argued that the Texas Board of Insurance should have primary jurisdiction in determining whether the defendants violated state insurance regulations because of the board's technical expertise in insurance matters (*BI*, Nov. 7, 1988).

Continued on next page

Hall fires exec after allegations of bond fraud

By DOUGLAS McLEOD

NEWPORT, R.I.—A fired top officer of Frank B. Hall & Co. of Rhode Island Inc. faces civil fraud charges and is the target of a criminal investigation after issuing allegedly unauthorized bonds to a Rhode Island shipbuilder and pocketing the premium.

Charles T. Reilly, a former executive vp and top salesman at Hall, is accused of misappropriating a $82,736 premium paid by Robert E. Derecktor of Rhode Island Inc. for bonds covering a contract to build tugboats for the U.S. Navy.

Court papers say that Mr. Reilly issued without authorization performance, payment and bid bonds from Insurance Co. of North America covering the Navy contract and a Derecktor bid to take over a Georgia shipyard from Lockheed Shipbuilding Co., along with a contract to build landing craft for the U.S. Army.

The court papers charge that the bonds bore forged signatures of two Hall employees who held powers of attorney for Philadelphia-based INA, a CIGNA Corp. unit. INA disclaimed liability after discovering the bonds' existence last year.

INA had earlier rejected a performance bond application for another project submitted by Mr. Reilly on Derecktor's behalf because of "unsatisfactory financial data from Derecktor," INA says in court papers.

Derecktor, which lost out in its bid to take over the Lockheed yard because of the bond problems, is now suing INA, Hall and Mr. Reilly in Rhode Island Superior Court in Newport to recover damages that could amount to at least $16 million dollars.

A Superior Court judge has issued a preliminary injunction barring INA from disclaiming liability under

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2 American Mutual units placed into receivership

By STACY ADLER

BOSTON—Two subsidiaries of American Mutual Insurance Cos. placed into voluntary receivership last week may be underreserved by more than $80 million, according to the Massachusetts Department of Insurance.

The Insurance Department will announce in three weeks whether the two mutual insurance companies—Wakefield, Mass.-based American Mutual Liability Insurance Co. and American Mutual Insurance Co. of Boston—can be rehabilitated or whether it will be necessary to liquidate them.



Mr. Wortman

"There is so much water that will travel under the bridge in the next 30 days, that I don't want to speculate," said President J. John Wortman, who for the last three years has been trying to revive the ailing companies.

Peter S. Rice, first deputy insurance commissioner, said, "We have to find out just how big the hole is."

However, Mr. Wortman acknowledged that liquidation is "an option."

If it is necessary to liquidate American Mutual, guaranty funds nationwide would pay policyholders' claims up to statutory coverage limits. However, it may be possible to avoid liquidation if sales of the companies' assets, including a solvent stock company, can raise enough money.

Efforts to save the two mutuals were undermined at year-end when estimates of losses on prior years' business were found to be about $50 million short. As a result, an investment banker withdrew its offer of a $100 million capital infusion (*BI*, Oct. 3, 1988).

The Insurance Department Jan. 17 placed AMLICO, the first mutual liability insurer formed in the United States, and AMI into a 30-day receivership because of their deteriorating financial condition.

"For over 20 years, AMLICO and AMI have experienced generally poor operating results, weak loss reserves and a steady erosion of policyholders' surplus," the department said.

Although the insurers have boosted their loss reserves by more than $250 million since 1986, the companies are "presently in an unsound financial condition which may render further transaction of business hazardous to the public, policyholders and creditors," the department said.

As a result of the receivership order, AMLICO and AMI have ceased writing business in all 50 states in which they are licensed.

Under the receivership order, the two mutuals can only pay claims arising under workers compensation, private passenger automobile, long-term disability, weekly accident and health indemnity policies and obligations under all intercompany reinsurance pooling arrangements.

The mutuals have 19,824 commercial policyholders nationwide and 75,000 personal lines policyholders nationwide.

The insurers write about 25% of their business in Massachusetts. The insurers also are very active in Connecticut, Minnesota, New Jersey, New York and Pennsylvania.

Workers compensation business accounts for more than half of each insurer's volume. Both also write a large amount of general liability business, primarily for manufacturers. About 20% of their business is personal auto and homeowners lines.

The two mutuals historically pooled their writings, with AMLICO writing approximately 85% of the premium and AMI writing about 15%. Their business was written by the group's own direct sales force.

By Sept. 30, 1988, the insurers reported a net loss of $19.7

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Report assails Texas regulators

By MICHAEL BRADFORD

AUSTIN, Texas—A state senator who commissioned an investigation of alleged mismanagement at the Texas State Board of Insurance is calling for the resignation of the board's three members.

In addition, the resignation of another top board official and a call by the state's attorney general for yet another investigation into the agency are fueling the controversy surrounding the Texas insurance regulatory system.

The State Board of Insurance, which is equivalent to other states' insurance departments and is governed by the three-member board, has faced a barrage of criticism following the insolvency of Dallas-based National County Mutual Fire Insurance Co. (*BI*, Nov. 7, 1988).

The board in October found that the insurer—which primarily wrote personal automobile coverage—was insolvent by $54 million, making it the largest failure of a Texas-based property/casualty insurance company.

Then-Insurance Commissioner Doyce Lee resigned in December following criticism from state legislators that the board had ineffectively regulated insurers (*BI*, Dec. 26, 1988).

The criticism increased last week with the publication of a report by

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III seeks millions of dollars for public relations campaign
Page 3

Simple solution?

Broad copayments cut health plan cost

By DONNA DiBLASE

ELKHART, Ind.—Bucking conventional health care plan management, a small employer in the Midwest cut its claims cost by 30% after making simple alterations to its self-funded group health care indemnity plan.

Elkhart-based EFP Corp., which employs just 230 workers in the manufacture of polystyrene products, cut its costs through simple plan changes that represent a new twist on employee cost-sharing: Eliminating employees' annual deductible and instead requiring employees to pay a 25% copayment on each claim, subject to an annual out-of-pocket maximum.

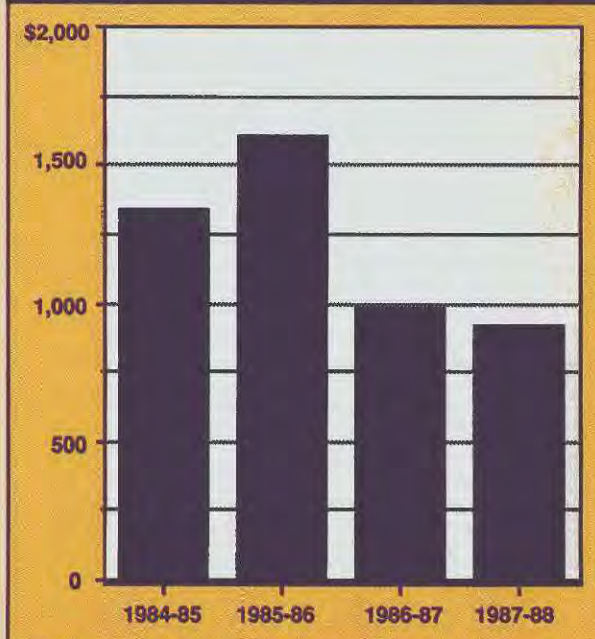
In addition to the changes in benefit plan design, EFP later negotiated preferred provider agreements with local clinics that include fee discounts.

Negotiating a PPO arrangement is not common among small employers, since they lack the large employee groups often necessary to guarantee health care providers a large volume of patients in return for discounts.

Several years earlier, EFP began self-funding its

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New plan design cuts EFP's claims costs per employee*



*Fiscal year beginning Nov. 1; New plan introduced Nov. 1, 1986.
Source: EFP Corp. Chart: Holly Seguine

NEWSPAPER

Update

Court keeps Texas antitrust suit

Continued from previous page

In a Jan. 13 hearing, State District Court Judge Peter Lowry also denied a motion to dismiss the Insurance Services Office Inc. as a defendant in the Texas case. The suit seeks to bar ISO from operating in the state, charging the policy and ratemaking organization violated the Texas Deceptive Trade Practices Act.

The Texas suit was filed by Attorney General Jim Mattox in March 1988, the same time eight attorneys general lodged federal complaints in San Francisco against insurance industry defendants (*BI*, March 28, 1988). Later, 10 more states joined the federal action. Many of the same defendants are named in both suits.

Judge Lowry's pretrial stay of discovery proceedings in the case will remain in effect for about six more weeks until other pretrial issues are resolved, said a spokeswoman for the Texas attorney general's office.

Groups urge Section 89 repeal

WASHINGTON—Thirty-five business groups last week urged House Ways and Means Committee Chairman Daniel Rostenkowski, D-Ill., to press for repeal of Section 89 non-discrimination rules for welfare plans.

Section 89 "is too complex, too expensive to administer and will drive sponsors to simplify their plans by reducing health benefit options and cutting back on subsidized health coverage," the business groups said in a Jan. 17 letter to Rep. Rostenkowski. Section 89 is a back-door attempt to tax benefits, while producing an administrative compliance nightmare for employers, the groups said.

Among the groups were the Associated General Contractors, the National Federation of Independent Business, the National Assn. of Manufacturers and the U.S. Chamber of Commerce.

The House Small Business Committee will hold hearings Jan. 24-25 on the impact of Section 89 on small firms.

NBC to appeal libel award

NEW YORK—The National Broadcasting Co. plans to appeal a nearly $6 million award to singer Wayne Newton in a libel case.

A federal jury in 1986 had awarded Mr. Newton $22.8 million after finding that NBC defamed him in 1980 and 1981 broadcasts that tied him to organized crime.

But in 1987, U.S. District Judge Myron Crocker reduced the judgment to $5.3 million, including $5 million in punitive damages, plus $225,000 for physical and mental injury and $50,000 for presumed damages to reputation (*BI*, Nov. 23, 1987).

Mr. Newton could have sought a new trial in Los Angeles but instead accepted the reduced award, which amounts to nearly $6 million with interest.

NBC is insured by Fireman's Fund Insurance Co.

N.Y. financial guarantee debate

NEW YORK—Financial guarantee insurers say they oppose a regulation proposed by the New York Insurance Department that, among other things, would establish reserve and surplus requirements for writing financial guarantee insurance.

"The contingency reserve provisions would force companies to either raise prices or cut down significantly on writings," said Robert Mackin, executive director of the Assn. of Financial Guaranty Insurors of Albany, N.Y. Mr. Mackin said he plans to prepare a written comment opposing the regulation.

In addition, multiline insurers under the proposed regulations would, in effect, have to maintain a separate surplus for financial guarantee business.

Approval of the regulation could force Continental Guaranty & Credit Corp. of New York, one of the few multiline insurers still writing financial guarantees, out of the business, said Clifton J. Brown, senior vp at the Continental Insurance Co. subsidiary.

Among Mr. Brown's objections is a provision that would require a multiline insurer to maintain a minimum 2.78-to-1 premium to surplus ratio on its property/casualty business before it could write financial guarantee insurance.

Past efforts to regulate financial guarantee insurance in New York have failed (*BI*, Oct. 10, 1988).

Insurers have until Feb. 27 to submit their comments on the proposal to the department.

New toxic exposure limits OK'd

WASHINGTON—Compliance with a new federal rule that reduces permissible worker exposure to 376 toxic chemicals will cost employers about $787 million annually, the government says.

The new Labor Department standard, effective Sept. 1, sets permissible exposure limits for 164 substances not previously regulated by the Occupational Safety and Health Administration and adopts stricter exposure limits for 212 substances OSHA currently regulates.

The standard also reaffirms existing permissible exposure limits for 52 substances.

The final rule, which was published in the Federal Register last Thursday, closely follows the proposed standard OSHA issued in June (*BI*, June 13, 1988).

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Errors & omissions

Re Capital Corp.'s reorganization to include additional senior company management involved the appointment of two company executives to the board, not four as was stated in the Jan. 16 issue due to an editing error. James E. Roberts, senior vp, and Thomas J. Linahan, senior vp, treasurer and chief financial officer, were appointed to the board. Also, J. Dennis Delafield, president of New York-based Delafield Asset Management, was elected to the board.

Insurers vow to appeal N.Y. guaranty fund ruling

By JUDY GREENWALD

ALBANY, N.Y.—Insurers will appeal a state judge's dismissal of three suits seeking the return of at least $87 million that the New York Legislature appropriated in 1982 from the state's property/casualty guaranty fund.

The siphoning of funds from the Property/Casualty Insurance Security Fund led the New York Insurance Department to assess the state's property/casualty insurers $45.7 million last year. New York-based insurers cannot offset their assessments against premium taxes (*BI*, May 9, 1988).

New York's guaranty fund, the only guaranty fund in the nation that prefunds its liabilities, requires a minimum balance of $150 million.

Insurance industry representatives discount the significance of the Jan. 5 decision by N.Y. Supreme Court Justice Lawrence E. Kahn to grant summary judgment and dismiss the three suits filed by insurers and industry trade organizations. They contend that the New York Court of Appeals, the state's highest court, ultimately would have heard the case anyway.

"It doesn't come as a surprise to us," said Michael Lovendusky, counsel for the American Insurance Assn., which filed one of the three suits (*BI*, Aug. 15, 1988).

A Supreme Court justice, who is equivalent to a lower-court judge in other states, is unlikely to rule on the constitutionality of a legislative decision involving a budgetary matter, said Mr. Lovendusky. "It's asking a lot of a trial judge."

"Round One is over and Round Two is about to begin in the Court of Appeals," summed up Kenneth Feinberg, an attorney with Kaye, Scholer, Fierman, Hays & Handler in Washington, D.C. Mr. Feinberg represents six insurance associations, led by the Schaumburg, Ill.-based Alliance of American Insurers, and 60 insurers that jointly filed one of the three suits.

"We expected that we might not achieve success initially" he said, adding: "The fight continues."

An appeal is expected in any case such as this, said Patrick J. Foley, senior vp at American International Group Inc. in New York. "Nobody likes to lose, but you haven't lost until the appeals are lost." Landmark Insurance Co., an AIG unit, was among the insurers participating in the Alliance suit.

In addition to the suits filed by the AIA and the insurance associations, a third suit was filed by three State Farm Group units: State Farm Mutual Automobile Insurance Co., State Farm Fire & Casualty Co. and State Farm General Insurance Co. (*BI*, June 6, 1988).

The Alliance and AIA suits request the return of the $87 million, plus another $37 million appropriated from the fund by the Legislature between 1979 and 1982 that was not discovered until legal research began in preparation for the suit. Both suits also seek interest the guaranty fund would have earned if the money had not been appropriated.

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D&O insurers are not liable for bank's settlement: Jury

By STACY ADLER

CHICAGO—Continental Illinois Corp. will appeal a federal jury verdict that a $17.5 million settlement of a class-action lawsuit naming both Continental and its directors and officers cannot be recovered from directors and officers liability insurers.

The jury, apparently convinced by insurer arguments that Continental made the settlement on its own behalf to protect its reputation and not to protect the directors and officers, ruled that none of the settlement was covered by insurance.

D&O liability policies only indemnify directors and officers, not corporations or other entities.

Insurer attorneys say the verdict breaks new ground in establishing standards for allocating settlements involving D&O policyholders and non-insured defendants.

However, the attorney for Continental says the case does not create new law because it was merely a jury ruling, not a judicial opinion.

The Dec. 19 verdict stemmed from one of many class-action lawsuits filed against Chicago-based Continental, subsidiary Continental Illinois National Bank & Trust Co. and five directors and officers of the parent company (*BI*, Nov. 7, 1988).

This lawsuit, filed on behalf of Continental shareholders, alleged that Continental overstated its earnings in 1983 and 1984 by understating its reserves for bad loans.

The problems stemmed from the failure of Penn Square Bank, a small shopping center bank in Oklahoma City that sold Continental about $1 billion in loans, many of which were not properly secured.

The Federal Deposit Insurance Corp. seized and closed Penn Square in 1982. News of Penn Square's failure and its relationship with Continental spurred rumors that Continental was in financial trouble.

The FDIC bailed out Continental in 1984, but the value of Continental's stock still plummeted.

Angry shareholders then filed a class-action lawsuit alleging that Continental and 25 unnamed directors and officers had been guilty of willful and fraudulent misconduct in understating its bad-loan reserves.

This lawsuit was later merged with another, smaller class-action lawsuit filed in October 1984 by shareholders that specifically named five Continental directors and officers.

On Nov. 18, 1986, Continental settled the merged class-action lawsuits for $17.5 million. On. Nov. 24, 1986, the boards of directors of Continental Illinois Corp. and Continental Bank approved the settlement. And, on. Jan. 21, 1987, a U.S. District Court approved the settlement.

Later in 1987, Continental sought indemnification for the cost of the settlement from its D&O insurers, Harbor Insurance Co. of Los Angeles and Allstate In-

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- In RMIS Commentary, consultants Michael N. Singer and David A. Tweedy analyze Anistics' withdrawal from the mainframe RMIS market. **PAGE 23**
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III seeks big money for image campaign

By KATHYRN J. McINTYRE

WASHINGTON—The Insurance Information Institute hopes to raise tens of millions of dollars in contributions from insurers to finance a three- to five-year public relations campaign to rebuild the insurance industry's image.

Responding to the public pounding that the property/casualty insurance industry has taken in the aftermath of the massive antitrust litigation filed last year and the passage of Proposition 103 in California in November, III management is recommending that insurers contribute money to a new, special fund for a far-reaching national campaign. The campaign also would include efforts targeted at certain critical states.

The III already has launched a massive public-opinion research study to help it develop a strategy for this long-term campaign.

Meanwhile, the III also has begun a public relations campaign specifically addressing auto insurance rates and hopes to raise another $6 million to support this campaign this year.

"We've got to begin the process of image building in a way that will correct the misconception that we're a huge, impersonal, distant industry concerned only with numbers and profits, not with people," said III President Mechlin D. Moore in remarks at the III's annual meeting in Washington, D.C., earlier this month.



Mr. Moore declined in an interview to put any price tag on the proposed national public relations campaign, but he did say that its "magnitude is unprecedented" and that it would cost "considerably more" than the III's Joint Industry Special Communications Program has cost during the last few years.

Last year, that program, which supported national advertising and some state-targeted programs, cost $8 million. That program cost $7 million in 1987 and $10 million in 1986.

A budget of $90 million for the new three- to five-year campaign has been mentioned by some in the industry as necessary to do the job.

Mr. Moore said the III executive committee will receive proposals for the campaign at a Feb. 1 meeting and that a budget is expected to be set by the end of February.

The budget will depend on the extent of the creative advertising services sought and the type and amount of media used, Mr. Moore said in an interview. Ultimately, insurers' contributions to the fund will determine the scope of the campaign.

The existing Joint Industry Communications Program—which includes the auto insurance campaign—and the proposed national campaign are not financed by the III's basic operating budget of about $10 million.

The III's operating budget is supported by dues paid by its 300-member insurers and revenues from the sale of publications.

III member companies and others now contribute to the Joint Industry Communications Program on a fair-share formula based on revenues.

Mr. Moore made a strong pitch for insurers to finance the new, extensive national public relations effort in his annual remarks to more than 200 property/casualty insurance company executives gathered for the III's annual meeting as well as the annual meetings of the American Insurance Assn. and the Insurance Services Office Inc. The three groups also sponsored a joint industry conference that included two panel discussions (see related stories, pages 10 and 20).

"For decades, many property/casualty insurance companies viewed themselves as

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EIL insurance for storage tanks still hard to find

By DEBORAH SHALOWITZ

Owners of underground petroleum storage tanks have new environmental impairment liability insurance alternatives, but the market still is very limited.

Two new risk retention groups are writing EIL insurance for underground petroleum storage tanks and one stock insurance company expects to begin writing policies in several states this year.

And, some insurance companies now will write EIL coverage for underground tanks if a policyholder buys other property/casualty insurance from the insurer.

However, EIL coverage for underground tanks from other insurers still is limited, especially since one of the major markets for EIL reinsurance disbanded. The Pollution Liability Insurance Assn. dissolved as of Jan. 1 because of declining membership. PLIA membership fell to 14 insurers last year from a high of 49 companies in 1983 and 1984 (*BI*, Jan. 16).

PLIA will continue to service in-force policies.

Without the backing of PLIA, a voluntary association of insurance companies, many member firms will not write new EIL risks.

And, despite rumors of a shift in policy, the general EIL insurance market's largest U.S. insurer, American International Group Inc., says it will not write EIL coverage for underground tanks.

The search for EIL insurance for underground petroleum tanks has intensified since the U.S. Environmental Protection Agency released rules last October requiring owners or operators of underground petroleum tanks to demonstrate adequate financial responsibility through insurance or other risk financing mechanisms to pay for on-site cleanups of tank leaks and to pay for resulting third-party damages (*BI*, Oct. 31, 1988).

The EPA rules, which begin taking effect this week, state that EIL policies must cover both sudden and accidental and gradual pollution. Also, defense costs cannot be included in the policy limits.

Under the EPA rules, which are far less stringent than those the EPA proposed in April 1987, owners or operators of underground petroleum storage tanks with a monthly throughput of more than 10,000 gallons or tanks used in petroleum production, refining

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Photo: Stan Miskiewicz

Nissan is trying to control insurance costs for its dealers by helping establish an Illinois captive.

Nissan establishes captive to reinsure dealers' risks

By DOUGLAS McLEOD

CARSON, Calif.—Nissan Motor Corp. in U.S.A. and broker Rollins Burdick Hunter Co. are forming a captive to reinsure property/casualty and workers compensation risks for Nissan auto dealers nationwide.

The Illinois-domiciled captive, United Dealers Insurance Co., will be wholly owned and operated by Nissan dealers and will reinsure policies issued by units of Reliance Group Inc., Nissan announced.

Organizers are hoping to raise $12.5 million in initial capital through a limited public offering to dealers of 1.25 million shares of common stock in the captive's Delaware parent company, United Dealers Insurance Group, according to RBH officials.

United Dealers would be the first nationwide captive offering property/casualty coverages to auto dealers, said Michael D. Rice, president of Rollins Burdick Hunter Specialty Group in Chicago.

Dealers—who must be shareholders in the captive holding company to obtain coverage—are required to invest a minimum of $10,000 to participate. The maximum investment is $150,000, according to Mr. Rice, who said he expects to see at least 250 dealer-shareholders, and would like to see 300 or more.

United Dealers must raise a minimum of $7.5 million to get off the ground, he said.

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3 industries face bulk of product suits

By ALISON KITTRELL

While product liability lawsuits represent a growing burden for all types of U.S. businesses, the litigation has reached epidemic proportions for companies in only a few industries, a new study reveals.

Product liability lawsuits filed in federal courts have increased more quickly than other types of litigation between 1974 and 1986, according to the study by the Santa Monica, Calif.-based RAND Corp.'s Institute for Civil Justice.

For example, product liability case filings increased 733% to 12,666 in 1986 from 1,520 in 1974, while the total number of suits filed in federal courts during the same period rose only 144% to 241,039 in 1986 from 98,819 in 1974, the study shows.

However, much of the growth in product liability litigation can be traced to suits against companies in three industries: asbestos, pharmaceuticals and health products, and motor vehicles, according to the study.

Forty-five percent of the product liability suits filed in federal courts between 1974 and 1986 are directed against about 80 companies in these three industries, the study reveals.

And, of the approximately 19,500 companies named as a lead defendant in the product liability suits surveyed, about 17,000 were named in only one suit.

"For this group of (17,000) firms, product-related litigation grew at about the same rate as other kinds of federal civil suits," the RAND study points out.

The study, "Product Liability and the Business Sector: Litigation Trends in Federal Courts," examines 85,694 product liability claims filed in federal courts from 1974 to 1986. However, the study did not include product liability cases in state courts, where filing levels may be higher, RAND points out. Generally, suits cannot be litigated in federal courts unless the parties are from different states.

And, because the study focuses only on the lead defendant named in each suit—not co-defendants or third-party defendants—RAND cautions that the number of companies involved in product liability litigation may have been substantially underestimated.

The huge number of lawsuits filed against companies in the asbestos, pharmaceutical and automobile industries tends to support the "epidemic" theory of product liability, which holds that product liability suits are limited to only a few products and thus affect only a few industries, according to survey author Terence Dungworth.

Mr. Dungworth was one of the organizers of the Integrated Federal Courts Database, from which the survey data was extracted.

However, when cases involving the asbestos and pharmaceutical industries are not included, product liability cases have grown only at a rate of about 7% a year during the study period, Mr. Dungworth notes.

And, "the pace is slowing," he says. "In the five-year period ending in 1981, the per annum increase was 11% but dropped to just over 4% in the 1980s. This is not much greater than the figure for non-product liability torts, which were increasing 3% during the 1980s, and is substantially less than the 7% rate for all other private civil suits.

"This suggests that the filing pattern for the underlying product liability litigation—consisting of cases not involving products that individually lead to hundreds or thousands of suits—is more akin to the remainder of the federal civil caseload than it is to the litigation represented either by asbestos or by the limited number of pharmaceutical products that produced the recent surge of litigation in the pharmaceutical industry," Mr. Dungworth says.

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Georgia PPO regs could increase costs

By MEG FLETCHER

ATLANTA—Proposed regulations governing preferred provider organizations in Georgia could lead to higher costs for employers that insure their health care plans, some employers and PPOs fear.

The Georgia department's most controversial proposal would prohibit a PPO organizer—such as an insurer, hospital or health maintenance organization—from using capitation payments to compensate health care providers.

The department contends it is proposing the anti-capitation provision to reflect the intent of a recently enacted state law regulating PPOs.

The law prohibits differences in coinsurance provisions governing PPO and non-PPO services of more than 20%.

The department contends that since it would be impossible to determine coinsurance levels under a capitation plan, the law prohibits PPO capitation plans.

However, in the nationwide trend to regulate PPOs, the National Assn. of Insurance Commissioners' model PPO law states that capitation arrangements are an acceptable form of provider compensation.

Under a typical PPO capitation arrangement, a health care plan organizer prepays PPO health care providers, like dentists, a fee to provide agreed-upon benefits in the future, some at additional cost.

The goal of capitation arrangements is to require health care providers to share the risk of providing a predetermined list of benefits for employees and their dependants. If employee utilization exceeds predicted levels, the provider shares in the extra costs.

The Georgia Department's proposed prohibition could lead to higher health care costs because employers could not lock in dramatically reduced charges for long periods of time, as much as five years.

In addition, prohibiting capitation arrangements would increase employers' paperwork and expense, which would make PPOs as expensive as traditional indemnity plans and reduce providers' incentive to participate, said Lynda F. Hunnicutt, president of Chattanooga, Tenn.-based HealthStream Corp., in a recent letter to Georgia Insurance Commissioner Warren Evans. HealthStream offers capitated-based PPO services in Georgia and five other southeastern states.

Prohibiting capitation arrangements would "transform" PPOs into indemnity plans "because providers and/or plan members will be required to file claims for reimbursement," Ms. Hunnicutt said.

Prohibiting capitation arrangements may reduce PPO organizers' financial incentives to offer PPOs in the state, which could lead to reduced competition, PPO providers also point out.

Eliminating capitation also would create "an uneven playing field" for PPOs, which compete with HMOs for members, said an executive of another PPO with capitation provisions.

While the dollar impact on employers of the department's proposed regulation is "immeasurable," it "could be costly," said Walker McCune, executive vp of the Atlanta Healthcare Alliance, a broad-based health care coalition whose board is dominated by employers.

"We feel that anything that is going to restrict the ability to create innovative financial arrangements for health care reimbursements will restrict the ability of all of us working for affordable health care to achieve our objectives," he added.

"We would not like to have any area foreclosed," said Reezin Swilley, director of benefits for Atlanta-based BellSouth Corp. and its subsidiaries.

However, he noted that the Insurance Department's proposed regulations would not apply to self-insured plans, which are governed by the Employee Retirement Income Security Act.

About 92,000 of Bell's 100,000 employees are enrolled in a self-insured, multistate plan. The company now is exploring physician-PPOs.

Capitated arrangements previously were considered character-

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Very few people need $25,000,000 in D&O protection.

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BI names 2 to new posts in Chicago

CHICAGO—Kari Berman has been named associate editor in *Business Insurance*'s Chicago office, Associate Publisher and Editor Kathryn J. McIntyre announced.



Ms. Berman

In her new position, Ms. Berman will report on both risk management and employee benefit topics.

Ms. Berman, 22, joined *Business Insurance* in June 1987 as an editorial intern in the New York bureau and was named staff reporter in November 1987.

Ms. Berman graduated in 1987 with honors from Columbia University in New York where she received a bachelor of arts degree in English literature.

Before joining *Business Insurance*, Ms. Berman worked in the business section of Working Woman magazine and as an editor for the Spectator, Columbia University's daily newspaper.

Ms. Berman can be reached at 312-280-3195.

In addition, Christine Woolsey, editorial assistant in *Business Insurance*'s Chicago office, has been promoted to associate directory editor, Ms. McIntyre announced.



Ms. Woolsey

The promotion reflects Ms. Woolsey's increased responsibilities for *BI's* 13 in-publication directories, the *BI* Directory of Health Maintenance Organizations and Preferred Provider Organizations and the annual *BI* Directory of Corporate Buyers.

Prior to joining *Business Insurance* in August 1987, Ms. Woolsey, 23, graduated with high honors from the University of Illinois, Urbana-Champaign with a bachelor of science degree in journalism.

Ms. Woolsey can be reached at 312-649-5460. ■



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N.Y. prison guards secure hostage cover

Underwriters at Lloyd's of London are underwriting a unique coverage for about 22,000 New York prison guards, police officers, park police officials, deputy sheriffs, security guards and other law enforcement officers represented by a labor union.

The "captivity coverage" will indemnify members of Council 82 of the American Federation of State, County and Municipal Employees for trauma related to hostage situations that last more than 12 hours.

Union members held hostage will receive a lump-sum payment equal to half their annual salary if released unharmed. And, in cases of disfigurement or death, the policy will pay twice the hostage's annual salary.

The average salary for the 17,000 prison guards and 5,000 other law enforcement officers represented by Council 82 is approximately $27,500, according to Joseph Puma, president of Albany, N.Y.-based Council 82.

Employers do not contribute to the cost of the coverage.

The policy was brokered by Jardine Group Services Corp. of Schenectady, N.Y., a subsidiary of Jardine Emett & Chandler Inc. in San Francisco.

Mr. Puma said the coverage was constructed to compensate for the trauma related to hostage situations. He said most insurance for union members taken hostage only provides coverage in cases of death.

"They have never been insured for trauma," said Mr. Puma, who approached Jardine, Council 82's broker, with a proposal to institute some sort of trauma insurance.

The union was prompted to offer the coverage by an August 1988 hostage incident at Coxsackie state prison where five guards were taken hostage by 32 inmates and held for 15 hours. None of the hostages was killed, although some were threatened with razors and beaten with baseball bats, according to Mr. Puma.

"After the Coxsackie incident Mr. Puma said he felt helpless. . .he felt there was an insurable interest here," said Nels Carlson, Jardine executive vp in Schenectady, who drafted the policy.

Mr. Carlson said he took the proposal to about "four or five big domestic insurers" before traveling to the London market. Domestic insurers "were interested, but not interested," he said. The one-year policy, underwritten by Lloyd's non-marine syndicates 718 and 782 —managed by Oxford Syndicate Management Ltd. and Oxford Underwriting Agencies Ltd., respectively—has no limits and carries a premium of slightly more than $100,000, Mr. Carlson said.

The policy has no deductible and requires no contribution from Council 82 members, nor will union dues increase to cover the cost of the policy, Mr. Puma said.

"This program wasn't mandated by the union or brought on by a lawsuit," he said, explaining that it was simply something Council 82 wanted to do for its members.

Richard Bischert, executive director of Council 82, also is pleased with the new policy. "Having seen guys go through captive situations, one wonders if they can ever return to work. But many feel forced to go back," he said.

The captivity coverage affords traumatized guards a period of financial security while they decide whether they want to work again in a correctional facility, Mr. Bischert explained.

Both Jardine's Mr. Carlson and Council 82's Mr. Puma said they believe captivity coverage has the potential to spread throughout the country to other unions and employers of prison guards.

"Other police groups have already contacted us about this coverage," said Mr. Puma. "Hopefully, this will open doors."

Other hostage cases in New York correctional facilities prior to the Coxsackie incident include the taking of a female prison guard at Wallkill state prison in July 1985. The guard was held hostage by one inmate for six hours.

Prior to Wallkill, 17 guards at Sing Sing state prison were held hostage by 500 inmates in January 1983. The last guard was released after 53 hours in captivity.

The most infamous incident in New York prison siege history occurred in September 1971 when four guards and seven civilians, as well as 32 inmates, were killed when prisoners seized Attica state prison for four days.

—By Michael Schachner

Benefit beat

Day-care center

Children of employees at Hingham Mutual Fire Insurance Co. in Hingham, Mass., can go to work with their parents and spend the day at a company-owned day-care facility.

The insurer—which primarily writes homeowners, commercial multiperil and fire insurance policies—is opening the center today at its new headquarters in Hingham.

Hingham Fire Insurance, which wrote net premiums of $14 million in 1987, believes that the facility will benefit the company as well as its workers because a majority of its 28 employees are women with young children who must choose between staying home, or working and depending on the availability of child care, said President Brian Wilkin.

The new center is located in a new building on the Back River in Hingham.

Because day-care services in the Hingham region can range from $130 to $150 per child per week, it became important to provide a company-sponsored alternative, he said.

"We went several months (last year) when we couldn't attract new employees," Mr. Wilkin said.

The company will charge employees $70 to $90 weekly per child, depending on their ages, he said.

The charges are intended to cover the costs of teacher salaries and other direct expenses, while the company will pay for the building space and other overhead costs, Mr. Wilkin said.

Although licensed for up to 20 children, the center initially will care for about nine children, he said. "We could have over a dozen in less than a year."

The child care center is modeled after a similar operation at Wearguard, a manufacturing firm in Norwell, Mass., he said.

—By Glenn Huntley

DAVE GRUPP HAS A LOVE FOR HIS JOB



Dave Grupp is a Kemper fire protection engineering specialist who wears a number of hats.

He surveys commercial facilities for hazards that could cost lives, property and dollars. He trains loss control consultants to know what to look for in a building and what to look out for. And he teaches underwriters the facts of fire he's learned over the years.

When the heat goes out of the day, he heads home where he keeps another hat handy: Volunteer Fire Chief of Long Grove, Illinois.

As a volunteer firefighter who never stops caring, Dave is typical of the 7,700 resourceful and motivated people who make up the Kemper National Property & Casualty Companies.

These people are busy these days. Their business has grown more

At issue

Should health care plans cover mental illness the same as physical illness?



Kathryn Connors
vp-human resources
Liz Claiborne Inc.,
New York

Absolutely. The needs of those with mental problems are just as real as those with physical concerns and ought to be covered by the insurer at the same levels.



Tom Morr
general director-benefits
General Motors Corp.,
Detroit

No. Since mental illness defies specificity in terms of diagnosis and treatment, it is sometimes subject to abuse from providers and patients. Therefore, mental health coverge should be treated differently from other surgical and medical coverages.



Berne J. Scalisi
director-risk management/benefits
Ross Stores Inc.,
Newark, Calif.

Yes, with qualifications. Traditionally, mental illness was not viewed as a disease; today it is generally recognized as a treatable one. Its costs can be controlled through innovative review processes and cost containment techniques. Most plans now place the major financial burden on the employee, and this should change.



John Cogan
director-human resources
Linear Corp., Carlsbad, Calif.

The two should be treated at the same rate on an inpatient basis because, when long-term care is needed, in either case the financial hardship felt by the individual employee and family can be catastrophic. However, caps should be applied to outpatient treatment to provide cost protection for the employer.

Compiled by Christine Woolsey

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Public relations

Continued from page 3

wholesalers," Mr. Moore said. "They directed their marketing to agents and saw little or no need to communicate with their policyholders or the general public. We were a low-profile industry.

"So when insurance became front-page news with the liability crisis of the mid-1980s or Proposition 103 in California, we didn't have a lot of friends and allies."

Now, the III wants to "rebuild the industry's credibility with the public in utilizing all the contemporary techniques of communication, from national television advertising to targeted direct mail to one-on-one dialogue with thought-leaders and the media," Mr. Moore said.



Mr. Moore

Emphasizing that "ways must be found to make (auto insurance) available and affordable to all responsible consumers," Mr. Moore advised: "Working on the fundamental problems of product cost and service alone won't restore our industry's image, though certainly that's the right place to start. We've got to relate to the outside world."

He received a ringing endorsement from John J. Martin, III chairman and president of Aetna Life & Casualty Co.'s personal financial security division (see story, page 15).

Research will help III to frame its message 'in a way that will be believed,' says Mr. Moore.

To begin this new campaign, the III has launched "the most comprehensive public-opinion research study ever done in our industry," Mr. Moore reported.

The Westport, Conn.-based firm of Yankelovich Clancy Shulman is conducting 6,000 interviews across the country based on preliminary focus group research conducted over the last few months. The result will be a national sample and specific studies of public opinion in 13 states and 10 major urban areas.

The targeted states are those where "auto insurance reform is a front burner topic," Mr. Moore said. Those states are: Arizona, Colorado, Florida, Georgia, Illinois, Maryland, Massachusetts, Michigan, Minnesota, New Jersey, Ohio, Oregon and Pennsylvania.

The cities are within the 13 targeted states: Baltimore, Boston, Chicago, Cleveland, Denver, Detroit, Miami, Philadelphia, Phoenix and Newark.

This research will help the III to frame its message "in a way that will be believed and understood by the consumer," Mr. Moore said.

So far, the focus group research has shown that:

- Consumers do not like insurance companies, and their initial reaction to auto insurers and their product is negative, especially rates and cancellation of coverage. However, with more discussion, many consumers expressed positive attitudes toward the insurance industry, especially when they have had satisfactory claims experiences.
- Consumers find insurance confusing and overcomplicated, particularly the language of insurance policies and the format of insurance bills.
- Despite confusion about insurance, consumers are aware of many reasons for the increasing cost of

Continued on page 10

Opinions

Insurers accept reality

THE PROPERTY/CASUALTY insurance industry at last appears to acknowledge that a basic business operating principle that governs other industries also applies to selling insurance: You have to satisfy the customers or you are out of business.

From this basic principle springs a wealth of productive activity, like listening to customers' wants and needs and then delivering the products or services that best satisfy those needs.

Insurers have, of course, done this on a piecemeal basis. For example, some insurers began selling loss control and claims handling services to companies that decided to self-insure. And individual insurers have developed new types of insurance to cover new risks, such as product tampering. Some large commercial insurance companies also meet with groups of risk managers to find out what they want in products and services.

But, on a wide-scale basis, the property/casualty insurance industry generally has operated with the attitude that it knows what is best for the consumer and that the consumer should gleefully pay for the security that the industry-developed insurance policy delivers.

Obviously, the insurance industry didn't think that it could be vulnerable to the kind of beating that Detroit automakers took in the 1970s when they decided that the American public didn't want or need small cars.

But, at last, Proposition 103 and the threat that similar measures could spread to other states seems to have hit the property/casualty insurance industry between the eyes. Now, finally, it is aware of the power of consumers.

Many insurance company executives now profess that they want to hear what the consumer has to say about insurance and that insurers can and should tailor their products and services in response to consumer attitudes.

This change in the industry's attitude was striking at the recent joint annual meetings of three powerful property/casualty insurance associations: the American Insurance Assn., the Insurance Information Institute and the Insurance Services Office Inc. (see stories beginning on page 3).



Too often in the past insurance company executives who gathered for these meetings only harped on how the public misunderstands insurance, not on how insurers could get *their* message across to the public.

What was refreshing this year was the insurance executives' emphasis on how important it is to *listen* to what the consumer has to say and how the industry must change to satisfy consumers' needs.

Not everyone leading property/casualty insurance companies has been converted to this way of thinking. There are still some executives who believe that they can dig in their heels and weather the current storm until it blows over. They, however, will have little influence on the future of the insurance industry because they will be the ones who will be left in the dust by a new, consumer-responsive group of insurers.

It's high time that property/casualty insurers began to listen—and respond—to the people who pay the premiums.

Letters

Tort system's flaws unfairly favor lawyers

To the editor: Arthur Levine's letter, "Tort System Changes Must Be Debated," criticizing the one-sidedness of *Business Insurance*'s views on our tort liability system is so full of holes that it would take volumes to adequately respond (*BI*, Jan. 2).

In discussing collateral sources, I would ask Mr. Levine how he would treat the injured employee who collects workers compensation benefits and, at the same time, effects a recovery from a third party. Unlike his example, it is not the injured party—who has chosen to buy separate medical insurance—who suffers but the employer, which has paid for workers comp benefits as mandated by state law. In some cases, the employer must even pay twice where the third party is permitted to file a cross-claim.

Concerning joint and several liability, Mr. Levine discusses a case with two negligent defendants and believes it is appropriate for one of the two to pick up the entire tab where the other is unable to pay his fair share. In the same context, I would refer to a current case involving a major hotel fire with over 200 defendants, none of whom proximately contributed to the fire; yet the judges involved demand that all parties contribute to a settlement simply for the purposes of making the defendants whole.

Finally, it is more than naive of Mr. Levine not to recognize that it is not only the insurance industry itself that concludes that something is certainly wrong with the current system. More and more companies are assuming larger retentions or fully self-insuring their third-party exposures with the result that the entire spectrum of the American economy has been impacted by the inequities in this civil justice system.

While I normally would share Mr. Levine's desire for a more balanced approach, the facts are that no imbalance exists. The scales are too heavily weighted in favor of lawyers who are always the eventual winners—even in cases where they lose.

Norman B. Chanzis
Director of Risk Management
American-Standard Inc.
New York

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

Insurers, policyholders both can be winners

To the editor: Susan Werner, in her Dec. 12 Ask a Risk Manager column, seems to indicate that despite inadequate loss information, Ideal Mutual readily added 300 newly acquired Burger Chef restaurants to Hardee's Food System's policy. It makes me wonder whether such a pattern of careless, imprudent or "nonchalant" underwriting may have contributed to Ideal's troubles.

Ms. Werner says that working through the chaos of a primary insurer's liquidation is an experience that reinforces the merits of being distanced from the insurance industry. Why equate the entire insurance industry with one troubled insurer? If one commercial bank is liquidated, should all depositors in all banks hide their money under the mattress?

She states, "We placed our property insurance with a captive owned by our parent company." Fine, so long as the parent company understands that from the parent's viewpoint such a procedure can be more aptly described as self-insurance, not insurance.

Intriguing is Ms. Werner's reference to insurance being a numbers game, followed by her wonder at "who the winners are." Numbers game is an oversimplification.

One such "game" is life insurance, which usually involves a broader, more homogeneous and more credible statistical base, coupled with improvements in medicine that lengthen lives beyond that predicted by the mortality tables. Contrast that with the imponderables besetting our actuarial virtuosos, who must cope with toxic torts, 30-year delayed accident (occurrence) reporting, runaway jury awards, etc., etc.

It is hoped that both insurers and policyholders will be winners in the long run.

Edward J. King
Denville, N.J.

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Public relations

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insurance, such as fraud, lawsuits, uninsured motorists and the increasing cost of auto repairs.

- Insurance is seen as dull and boring, and therefore not attracting the best and the brightest individuals to the business.
- Many consumers think that insurance companies make too much profit.
- Ralph Nader has more credibility with consumers than insurers. But on the issue of regulation, most consumers do not believe that insurers are regulated now and say they would favor government regulation. After they understand how additional regulation would apply, they say that they would prefer that free enterprise govern the insurance system.
- Positive stories about how insurance companies have helped the public through loss control have been well-kept secrets and should be better publicized. But some consumers were skeptical that insurer loss prevention activities are conducted out of self-interest.

The insurance industry is facing "a severe communications challenge," according to John Gilfeather, executive vp of Yankelovich, who presented the focus group findings at the III meeting.

"We're no longer a low-profile industry," Mr. Moore told the III members. "More and more consumers have their ears to the ground about our business. That's an open door for us as we embark on a new level of communication and interaction with the public."

The public relations campaign on auto insurance began Jan. 3, with full-page ads in The Wall Street Journal, USA Today, The New York Times and The Washington Post. "The ads described why auto rates have increased and offered readers a background paper on the the issues," Mr. Moore said.

'More and more consumers have their ears to the ground about our business,' says Mr. Moore.

These ads were the first in a series that will continue with a new ad in the next couple of weeks.

"We're reaching out to consumers through media appearances by industry spokespersons, editorial board briefings, an expanded speakers bureau, auto safety conferences, direct mail and other communications," Mr. Moore said.

The III effort supports the legislative efforts of the three major trade associations—the American Insurance Assn., the Alliance of American Insurers and the National Assn. of Independent Insurers—and is conducted in consultation with the Independent Insurance Agents of America and the Professional Insurance Agents of America, he said.

In addition, the three insurer trade associations and the two agents' associations will co-sponsor with the III a National Conference on Auto Insurance Issues in Washington, D.C., March 16-17.

Technical advisers for the conference include the Insurance Institute for Highway Safety and the Insurance Services Office Inc.

Regional safety conferences also are being held around the country "to bring together auto safety professionals to discuss ways to lower the toll auto accidents take," Mr. Moore said.

The III also is "redoubling our efforts to strengthen our working relationships with interest groups," including the many citizen groups with a stake in auto insurance, Mr. Moore said. ■

Rapid rate hikes set stage for revolt

By KATHRYN J. McINTYRE

WASHINGTON—The rapid increase in commercial property/casualty insurance prices in the mid-1980s set the stage for today's consumer revolt against high personal automobile insurance premiums, says an insurance company executive.

"The recent discomfort with insurers came from the rapid increase in commercial insurance prices," says Wilson H. Taylor, president and chief executive officer of CIGNA Corp.

"The entire spillover effect from general unhappiness with insurance companies affects all insurance companies. It doesn't matter what lines are being talked about," Mr. Taylor said during a panel discussion at the Joint Industry Conference sponsored by three insurance associations earlier this month in Washington, D.C.

The panel, "Staying Profitable in Perilous Times," was jointly sponsored by the American Insurance Assn., the Insurance Services Office Inc. and the Insurance Information Institute.

Personal auto insurance receives more public attention because more voters are directly affected by high auto insurance premiums, Mr. Taylor pointed out. But, the same factors that have driven up auto insurance premiums also have affected commercial liability insurance prices, he said, citing liability costs, health care costs and general inflation.

Now, the revolt against high personal auto insurance costs is spilling over into commercial insurance markets, he said, noting that "Proposition 103 rolled in commercial lines."

Proposition 103, narrowly approved by California voters in November, requires, among other things, that most property/casualty insurance "charges" in California be rolled back 20% from November 1987 levels. That provision, however, has been stayed pending a California Supreme Court review of an insurance industry challenge to its constitutionality.

"A solution needs to be found" to high insurance prices, Mr. Taylor said. "We should work openly with any interested groups that can help solve the problem."

Mr. Taylor noted that with commercial insurance buyers, who are more knowledgeable insurance consumers, "we can get a better understanding that it's the underlying cost that needs addressing, not the insurance premium price."

In trying to solve the problem of the high cost of personal auto insurance in urban areas, Richard J. Haayen, chairman and chief executive officer of Allstate Insurance Co., asserted: "It is high time we look at what should that product be and does it serve the needs at this time.

"People who live in urban areas are saying, 'You have to do something. It costs too much.' "

Continued on next page

NO UNDOTTED i'S

Continued from previous page

Ronald E. Compton, president of Aetna Life & Casualty Co., said, "We need to do more to get a bigger constituency" for programs that can reduce loss costs. He cited specifically tort reform, adoption of meaningful no-fault statutes, controlling bodily injury claim costs through health care cost containment programs and controlling car repair costs.



Mr. Compton

But John P. Mascotte, chairman and chief executive officer of Continental Corp., pointed out: "There are powerful interest groups on the the other side of those issues."

Dean R. O'Hare, chairman and chief executive officer of Chubb Corp., suggested that losses could be reduced by accomplishing more in the areas of highway safety and enforcement of seat belt regulations, to which Mr. Compton interjected, "And get the drunk drivers off the road."

'It takes more than the information' to stop rate cutting. Insurers must have 'the will' and the ability to "quickly and effectively change what you are doing" through effective communications with underwriters, says Mr. Compton of Aetna.



Mr. Mascotte



Mr. O'Hare

Nevada Insurance Commissioner David A. Gates, who also is president of the National Assn. of Insurance Commissioners, suggested that insurers should rewrite their auto policies to state that they will pay only "for the reasonable cost of repair" to control repair costs.

While personal auto insurance buyers complain about the high cost of their insurance, commercial insurance buyers are seeing their premiums fall, the panelists agreed.

Mr. Taylor of CIGNA pointed out that the growth of alternative risk financing arrangements in the last 10 to 15 years—including captives, risk retention groups and self-insurance—has resulted in "more competition or a somewhat smaller market than there would otherwise have been."

While acknowledging that insurers are going to lose commercial clients' business "if we don't meet their needs," Mr. Taylor also said that he is "concerned that we keep a level playing field" between the attractiveness of alternative financing and conventional insurance.



Mr. Taylor

"If regulatory actions raise costs, cause inefficiencies, limit flexibility, limit innovation, we don't have a level playing field," Mr. Taylor said.

Mr. Gates responded, "If you provide good insurance, people will buy it. They are more interested in getting on with their normal business than worrying about insurance products."

Regarding regulation, Mr. Gates offered, "We're inclined toward a good, competitive environment for the insurance business."

Continental's Mr. Mascotte asked: "What happens if there is a sufficient migration of business that those of us seen as conventional providers of products begin to bear an unbalanced burden of the guaranty fund, of residual pool business?



Mr. Gates

"It's a little difficult to see how a level playing field is going to be effective in that environment," he said.

Also related to the competitive pricing environment, most of the panelists agreed that insurance companies have better price monitoring systems today to determine how much they are charging for their products and whether those prices are adequate.

"Whether it affects what happens" to rates in the competitive market "and whether we have the will to use that information is an individual company determination," according to Mr. Taylor of CIGNA.



He noted that there were "not many companies in '82 or '83 that didn't know prices were getting too low. They may not have known precisely, but there was a fair amount of knowledge."

Mr. Compton of Aetna agreed. "It takes more than the information" to stop rate cutting. Insurers must have "the will" and the ability to "quickly and effectively change what you are doing" through effective communications with underwriters.

Martin J. McFadden Jr., a managing director in the Chicago office of Marsh & McLennan Inc., observed: "Insurance companies may have the most sophisticated pricing monitoring devices, but I'm not sure anyone is looking at them now. We see very competitive markets."

There are "definite property decreases at renewal," he said, while in casualty lines "jumbo accounts" are renewing at about the same premium.

Umbrella policy premiums are being reduced 5% to 10% and "maybe 15%," according to Mr. McFadden.

Referring to the larger price reductions reported in *Business Insurance* earlier this month (*BI,* Jan. 2), Mr. McFadden said he is "not sure reductions are as widespread as people believe."

Mr. Gates referred to current market conditions as "predatory pricing," citing an agent who told him that a 48-room motel that was quoted $4,000 to $7,000 by most insurers for its liability insurance but paid only $784 at renewal.

"I hope that is an aberration and that someone misplaced a decimal point," he said.

Mr. Gates also pointed out that "we can identify the players" engaged in predatory pricing and that it "is not systemwide."

As a result, he said, insurance regulators will seek underwriting files from agents and ask insurers how they developed a premium for a particular risk if it appears to be underpriced.

Mr. O'Hare of Chubb dissented from the panel's general agreement

Continued on next page

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Industry panel

Continued from previous page

that insurers' price-monitoring systems are vastly improved from the last competitive cycle.

Suggesting that the management information systems in use today "really aren't that different from the management information systems of five to 10 years ago," Mr. O'Hare said, "It all boils down to: Are we going to have the discipline?"

Many of the panelists agreed that there are factors that should dampen the amount of rate cutting by insurers.

Mr. O'Hare pointed to current interest rates that are 50% to 55% of what they were in 1981, "which is a period of time that was pretty similar to where we are now."

He also cited the increased taxes to be paid by insurers under the Tax Reform Act of 1986, a "less accommodating reinsurance market" and the cost of toxic waste claims.

'The over-arching issue that faces this industry over the next couple of years is the intensive public scrutiny,' not only involving the cost of insurance but also the taxation and regulation of the industry, says Mr. Mascotte of Continental.

"All argue for a cycle without extreme peaks and troughs as the last one," he said.

However, Mr. O'Hare said that he is concerned that foreign investors may make major acquisitions in the United States and then may fuel more rate cutting in an effort to increase the market shares of those acquired insurance companies.

Mr. Compton of Aetna opined that if U.S. insurers really were "making all the money that our detractors say," they would be far more often the target of hostile takeovers.

Mr. Compton suggested a factor controlling the amount of rate competition in the current market is the "absence of capital being driven by people who have never been in the business." The last competitive cycle included many new entrants to the insurance business.

Mr. Haayen of Allstate also noted that, in the last ccmpetitive cycle, insurers sustained income by taking capital gains "in large quantities."

That source of income won't be available in this competitive cycle if the stock market remains level, he said.

Mr. Mascotte stressed that insurers are going to pay more in taxes in the next two years than they have in the last two years. Insurers have to be careful not to underestimate the cash-flow implications of new taxes and to take the proper steps in managing their portfolios, he said.

Mr. O'Hare said that, as an industry, insurers will pay $15 billion more under tax reform than they would have without it, not $7 billion as originally projected for five years.

Mr. Compton expressed concern that the combination of tax reform and changes in accounting standards governing prepaid taxes have driven even further apart the two accounting systems of generally accepted accounting principles and statutory accounting principles.

As a result, insurance companies are going to show more GAAP earnings than they can add to statutory surplus.

It is statutory surplus that stands behind the loss reserves and is the payment integrity of the company and it is statutory surplus that defines the stability and capacity of the industry, Mr. Compton explained later in an interview.

Furthermore, insurers are allowed to write business as a multiple of their statutory surplus, not their GAAP surplus, he added.



Mr. McFadden

So if insurers don't add money to their statutory surplus, it will limit their ability to write business, he said.

Mr. McFadden of M&M suggested that an important factor in the current marketplace is that the "quality of people working for insurance companies is much better than 10 years ago. If corrections have to be made, you have the right people to make those decisions."

Looking to the future at the request of moderator Fred R. Marcon, president of the Insurance Services Office Inc., Mr. Taylor of CIGNA predicted: "This coming period will be difficult years for public policy and discussion. We will be distracted by offshoots or aftermaths of political actions."

Noting that insurance buyers—of both property/casualty insurance and health insurance—say that costs are ridiculous, Mr. Taylor said: "We will see a great deal of pressure on our industry because we're the easier target to get at. The providers that bring in the cost are much more dispersed than we."

Mr. O'Hare predicted an economic period of low interest rates and low inflation, which would benefit insurers. But, he added, "I worry that we're all talking about the cycle changing in '90. We did that in '81, and then in '83-'84."

Mr. Mascotte of Continental said: "The over-arching issue that faces this industry over the next couple of years is the intensive public scrutiny," not only involving the cost of insurance but also the taxation and regulation of the industry, including the future of the McCarran-Ferguson Act.

"We are all going to be under a microscope," he said, adding, "I am intrigued with the level of discomfort that this industry has when thrust into that kind of spotlight. We have to be much more effective in the public sector than we have been in the past."



Mr. Haayen

"I second that," said Mr. Haayen of Allstate.

"Tort reform and Proposition 103 pulled Ralph Nader out of the grave and put him out in front of the public and reinstituted his funding, made a hero out of him and he isn't going to go away.

"This industry is going to be under major public attack over the next several years. We're still not well-organized and structured to resist those attacks."

Mr. Compton of Aetna advised that insurers will need to "restructure and rethink our relationship to the consumer."

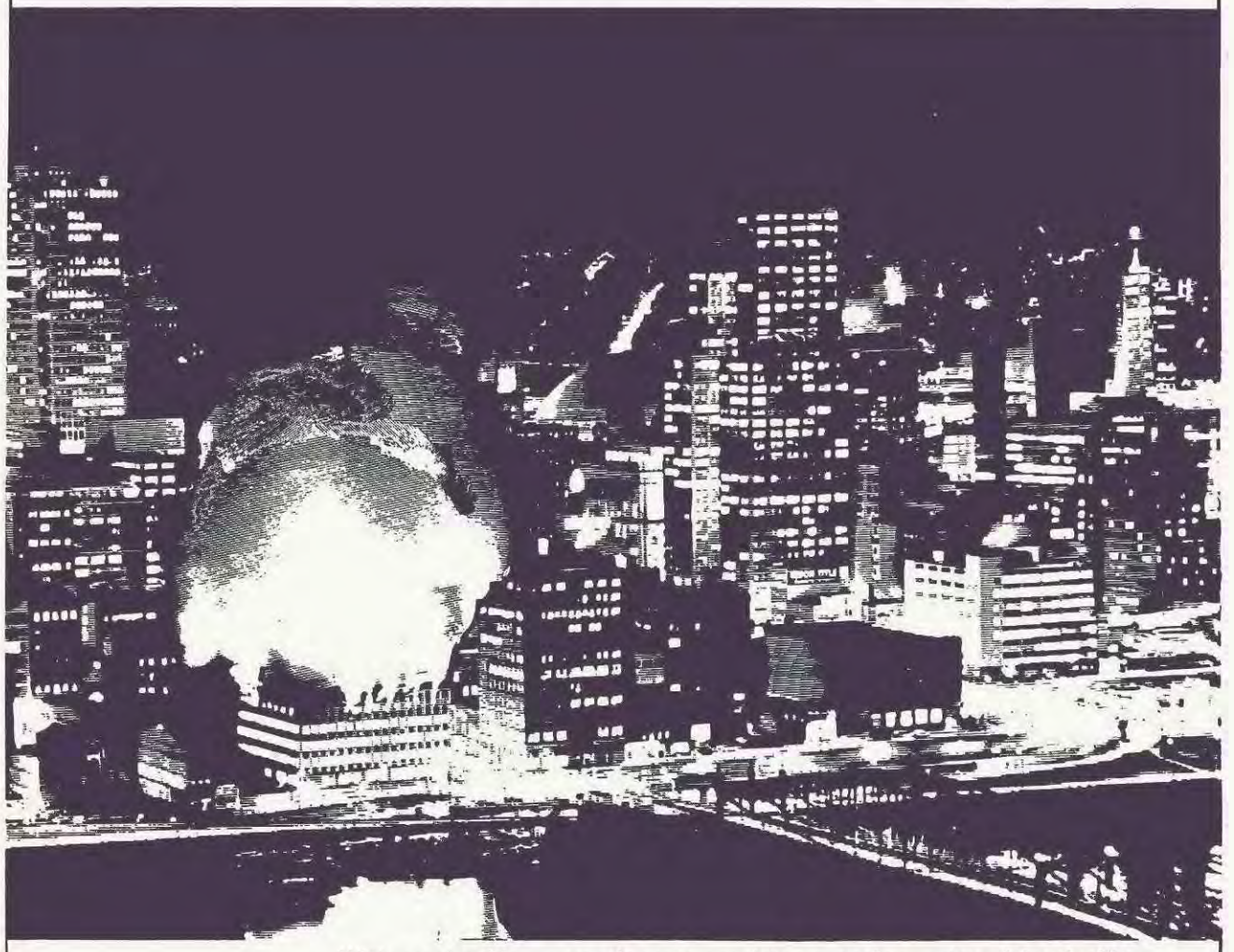
And, insurers need to convey to consumers that "we are willing to deal with responsible groups to solve problems and we are not ripping you off."

Consumers can be convinced of that when they analyze the return on equity and see that "insurers are not making an outrageous return on equity," Mr. Compton commented.

Property/casualty insurers' return on equity in 1987 was 12.9%, according to ISO. ■

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ISO vows to fight back to ensure its survival

By KATHRYN J. McINTYRE

WASHINGTON—The Insurance Services Office Inc. intends to fight for its survival as the property/casualty insurance industry's rate-making and policy form advisory group.


Mr. Marcon

Under attack in antitrust litigation filed by 19 state attorneys general last year and in efforts to repeal the McCarran-Ferguson Act and state laws granting antitrust protection for collective activities, ISO intends to develop and implement "long-term strategies to ensure that ISO's products and services continue to be valuable—and deliverable—in an evolving political, regulatory and business atmosphere," says ISO President Fred R. Marcon.

ISO provides advisory rating, statistical and actuarial services, policy language and related services to its 1,400 property/casualty insurance company members.

Delivering remarks after his first full year as ISO's president at ISO's annual meeting Jan. 11 in Washington, D.C., Mr. Marcon defended ISO against its critics.

ISO critics contend "that insurers can do without the information that organizations like ISO provide to help insurers write their business and price their products," Mr. Marcon said.

"A strong, effective ISO is critical to the health and stability of this industry," Mr. Marcon asserted before an audience of about 200 property/casualty insurance company executives, who also were gathered for the annual meetings the same day of the American Insurance Assn. and the Insurance Information Institute (see related stories).

The property/casualty insurance industry and those who regulate insurers need the type of information that organizations like ISO provide, Mr. Marcon said.

"Threats to collective activity that constrict the amount of information that can be made available to insurers do nothing to stimulate competition or attract risk takers," Mr. Marcon said.

"Nor is greater ignorance, which will result from a lack of information, the antidote to insurance cycles," he said.

"ISO policy forms, written in simplified language and format, help agents know what they're selling and consumers know what they're buying, so both can compare prices and coverages among insurers," Mr. Marcon said.

"Advisory pricing information makes our industry more competitive, not less competitive, by making it easier for more companies to compete in more markets."

Insurance industry critics, Mr. Marcon said, fail to mention "escalating loss adjustment expenses" as a reason for higher insurance costs. About half the cost of loss adjustment expenses are attributable to the legal defense of insured claims, he pointed out.

For all lines of insurance, "industry loss adjustment expenses in 1988 increased 50% faster than incurred losses," he reported.

Mr. Marcon also cited the $1.4 billion in guaranty fund assessments paid by property/casualty insurers in 1984-1987, which is three times as much as the assessment in the prior 15 years.

The net cost to insurers of guaranty fund assessments, however, is lower since most states permit insurers to offset state premium taxes by their assessments.

Citing ISO's continued service to the industry as the "more critical objective," Mr. Marcon outlined ISO's other 1989 objectives as:

- Providing useful, accurate and timely pro-competitive pricing information to insurers.
- Providing policy form products and services that are timely and responsive to regulatory, legislative and judicial changes.

Continued on next page

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ISO strategy

Continued from previous page

- Determining and meeting insurers' needs—both present and future—through an expanded product research and development process.
- Enhancing the value and quality of ISO's data base.
- Continuing ISO's role in producing studies and analyses of industry directions, trends, financial conditions and other issues as they emerge and fulfilling its role as technical experts by educating legislative and regulatory leaders on these subjects.
- Implementing a financial plan for ISO and its subsidiaries that measures performance relative to premium-assessable expenses and that includes programs to increase ISO's reliance on usage-sensitive unit pricing for its products and services.

'Threats to collective activity that constrict the amount of information that can be made available to insurers do nothing to stimulate competition or attract risk takers,' Mr. Marcon says. 'Nor is greater ignorance, which will result from a lack of information, the antidote to insurance cycles.'

Recounting ISO's recent successes, Mr. Marcon pointed to ISO research studies that have documented the greater-than-expected impact of the Tax Reform Act of 1986 on insurers' profits and that the property/casualty insurance industry has a long-term average return on net worth below the average for other industries.

For example, insurers' return on equity from 1971-1986 averaged 10.3% annually on a GAAP basis compared with 11.4% for 92 other industries, ISO says.

Mr. Marcon also pointed to ISO studies that warn that the uncertainties in the stock market, the possibility of additional insurer insolvencies, more restrictive rate regulation and the emergence of alternative insurance mechanisms "all threaten continued insurer profitability."

Mr. Marcon also cited the recent study conducted by ISO and the National Assn. of Independent Insurers that demonstrates that auto insurance costs are higher in some urban areas because those areas have more auto accidents and claims than the statewide averages.

The study, "Factors Affecting Urban Auto Insurance Costs," also found that the relatively high number of claims for injury, not claims for damage to autos and other property, was a major contributor to the greater frequency of claims in cities with higher auto insurance costs.

Mr. Marcon also counted among ISO's achievements its Claim File Data Analysis project, which analyzed how changes in tort laws can reduce claim costs. ■

Advisory rates are necessary: Hartford exec

WASHINGTON—If insurance industry critics took the time to understand the fundamentals of the business, they wouldn't be so critical of advisory rates, contends the outgoing chairman of the Insurance Services Office Inc.

The advisory property/casualty insurance rates prepared by ISO allow insurance producers, consumers and regulators to make informed judgments, says Dale R. Comey, ISO's chairman last year and president and chief operating officer of Hartford Fire Insurance Co.

"ISO is deeply in the public interest. It is pro-competitive," he asserted.

ISO advisory rates are important in a business that doesn't know its actual costs until sometimes long after the product is sold, Mr. Comey explained, referring to the long-tail nature of liability insurance.

Regulators use ISO's benchmark rates to help them in their examinations of insurance companies for solvency, Mr. Comey pointed out. ISO advisory rates provide "a powerful tool in loss-reserve evaluations and should be a powerful tool for regulating for solvency," he said.

And, he said, the continued expansion of ISO's data base will provide some of the tools needed to achieve "strengthening in regulation for solvency and a consequent reduction in destructive market volatility.

"The inherent competitiveness of our business combined with the fundamental difficulty of forecasting losses contributes to volatility in markets—volatility that is an increasing concern to our various publics," he said.

"Enlightened strengthening of solvency regulation may, at least, be part of the answer," he suggested.

Furthermore, Mr. Comey said, properly drafted policy forms and appropriate rules and classification rating systems provide "the mechanisms for economically sound, fair and non-discriminatory allocations of costs associated with risk transfer."

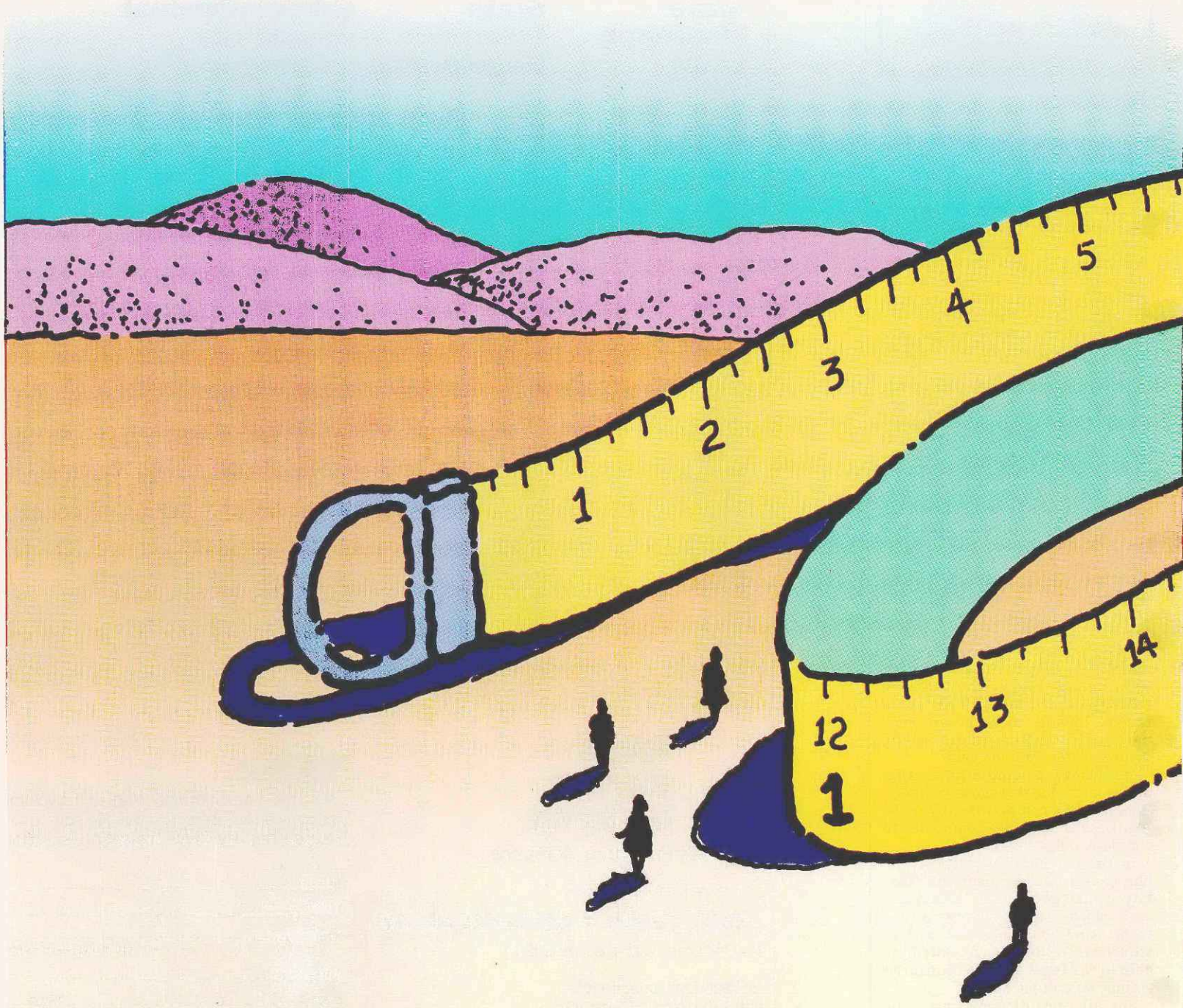
Insurers have the "responsibility to ensure that risk-transfer costs are allocated effectively to the activities or exposures that generate them," Mr. Comey commented. "ISO executes that responsibility well."

If loss costs are to be allocated on some other basis, then that "should operate outside of private enterprise, be identified as a taxing mechanism and benefit provider and be controlled and managed," he said.

It's important to keep the fundamentals of insurance pricing in view as solutions to insurance problems are debated, he concluded.

—By Kathryn J. McIntyre

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Industry's survival imperiled: III chairman

By KATHRYN J. McINTYRE

WASHINGTON—The future of the property/casualty insurance business as a profit-making, private enterprise is threatened, says the chairman of the Insurance Information Institute.

"The insurance bashing in the press, the outrageous and politically motivated antitrust suit, the consumer initiative in California, the reforms recently proposed in Michigan, Virginia, Arizona and elsewhere are not isolated instances," according to John J. Martin, who also is president of the personal financial security division of Aetna Life & Casualty Co.

"They are part of a larger effort to restructure the property/casualty insurance industry as we know it today," Mr. Martin said in his remarks at the III's annual meeting in Washington earlier this month.

"While I am certain they do not have the vision to determine how the insurance mechanism can realistically serve consumers in the future, I am convinced that a small and narrowly focused but eloquent group has successfully capitalized on the uncertainty and confusion of the public and is set on a mission to totally revamp this industry," he said.

Joint Industry 1989 Conference

Unless the insurance industry becomes active in the public debate over insurance regulation, insurance company executives will find themselves caretakers of a restructured business that is "very different than the one we know today," he said.

"The public's perception of our industry has deteriorated to an alarming extent. The reality of what insurance is, what it can do, and what it cannot do, has been tragically skewed in the public's mind," Mr. Martin said.

It has been difficult for insurers to explain to the public that to provide essential insurance products, insurers must "have the ability to exercise some control over our loss costs."

Mr. Martin also pointed out that insurers are "profit-making companies with a responsibility to our stakeholders—our customers, employees, agents, our boards and our shareholders."

"We are not a charitable institution. We are not a public utility. We are not permitted to run in the red. And we are contractually obligated to keep every promise we make, no matter what it costs us to do so."

And, if one insurer goes broke, "the rest of us pick up the tab," he said, referring to state guaranty funds.

Mr. Martin cited four reasons it has been so difficult for insurers to convey their message.

"One, we are in a very complicated business. The explanations are neither simple nor particularly comforting. People do not like to hear that their costs, or their status, are in any way affected by the actions and experience of others.

"Two, we are financial giants," Mr. Martin continued. "We manage great wealth, and while little of it is our own, we incur the mistrust and even the anger of those who think we roll around in the vault after the janitor goes home.

"Three, some of our products are either legislatively mandated or forcefully recommended," Mr. Martin said. "Many people balk at such strong and often expensive medicine, and certainly we can understand their feelings.

"And fourth, we suffer from an uneasy relationship with our customers and claimants. Often that relationship is adversarial, so it is rare that we are able to foster a sense of equality between us."

While acknowledging that insurers may have accepted their poor image in the past as "the nature of the beast," he advised, "it cannot be our position any longer."

Mr. Martin called on insurance executives to "work diligently and collectively to improve those areas of our business where the public's concerns are legitimate."

He also called on the executives to "get out of the tower and in front of a microphone, to give people the balanced viewpoint they need to make rational, informed decisions about how insurance will be made available to them in the future."

In addition, he advocated that insurance industry leaders help "marshal the imagination and the energy of nearly 1 million employees, agents and brokers in our business, who can, if properly educated and motivated, be intelligent consumer advocates for our side."

And, Mr. Martin called on the executives to "commit to an industry-sponsored public education effort based on what we and our customers stand to lose rather than on what we think we can afford to spend" (see story, page 3).

Mr. Martin disagreed with critics who say the insurance industry cannot muster the commitment or make the sacrifices required to change public opinion.

He also disagreed with suggestions that insurers "fear to act harmoniously because of recent legal threats made against some of us," that insurers are incapable of working together or that they are still "unaware of the degree of the problems we face."

Commenting that he has been in the insurance business for 30 years, Mr. Martin said, "I will gladly take issue with anyone who suggests that the leadership of this industry is either fearful, arrogant or simply not too bright." ■

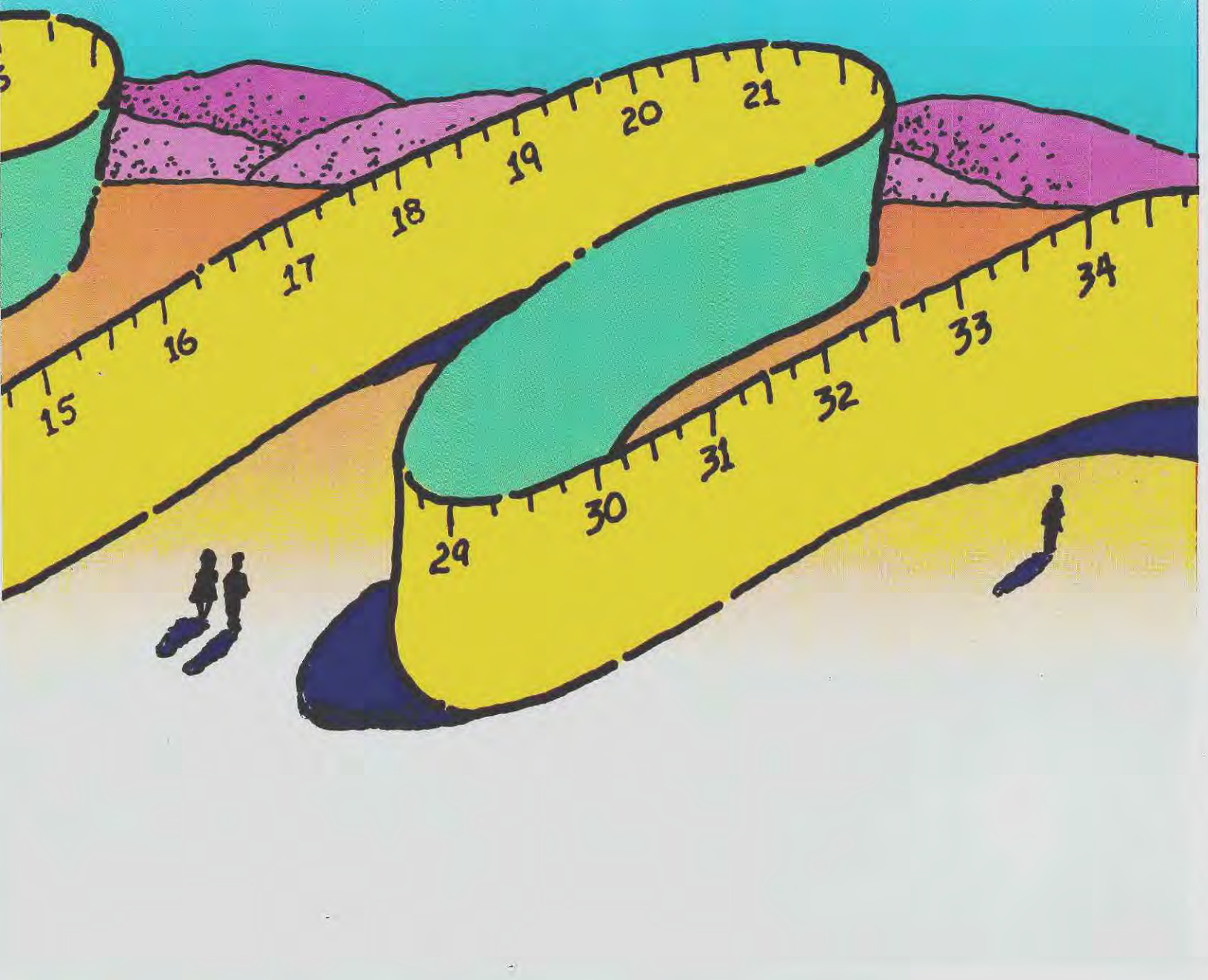
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Industry associations select leaders

WASHINGTON—Insurance company executives who will help shape policy at three powerful industry associations were elected at the annual meetings of the organizations earlier this month.

New officers and new board members were elected by the Washington-based American Insurance Assn., the New York-based Insurance Information Institute and the New York-based Insurance Services Office Inc.

The AIA elected as its chairman Wilson H. Taylor, president and chief executive officer of CIGNA Corp. He succeeds DeRoy C. Thomas, president and chief operating officer of ITT Corp. and former chairman and CEO of ITT's Hartford Insurance Group.

In addition, Robert J. Vairo, president and CEO of Crum & Forster Inc., was voted chairman-elect of the AIA.

The AIA also elected two vice chairmen: Robert J. Haugh, chairman, president and CEO of The St. Paul Cos. Inc., and Dean R. O'Hare, chairman and CEO of Chubb Corp.

The AIA's executive committee is composed of the elected officers, the immediate past chairman and AIA President Robert E. Vagley.

Elected to the AIA board of directors for three-year terms were: William E. Buckley, president and chief operating officer of Royal Insurance Group; John C. Corcoran, chairman and CEO of General Accident Insurance Cos.; Joseph C. Eanes Jr., president and CEO of Fidelity & Deposit Co. of Maryland; Donald R. Frahm, chairman and CEO of Hartford Insurance Group; William M. McCormick, chairman and CEO of Fireman's Fund Insurance Cos.; Jack Moseley, chairman and CEO of United States Fidelity & Guaranty Co.; and Maynard R. Stufft, president of PHICO Insurance Co.

Kenneth J. Duffy, president and CEO of Commercial Union Insurance Cos., was newly elected to the AIA board, joining directors whose terms expire in 1991. CU reaffiliated with the AIA as of Jan. 1.

The AIA represents 195 property/casualty insurance companies.

The Insurance Services Office Inc. elected as its chairman Gerald L. Maatman, president and chief insurance officer of Kemper Group's national property and casualty companies. He succeeds Dale R. Comey, president and chief operating officer of Hartford Fire Insurance Co.

The Insurance Information Institute re-elected as its chairman John J. Martin of Aetna.

Elected vice chairman of ISO was William E. Thiele, senior executive vp of Continental Corp.

In addition, Mr. Thiele was elected to ISO's board of directors for a three-year term, as were Robert G. Brakey, senior vp of United Services Automobile Assn.; Caleb L. Fowler, president of CIGNA Corp.'s Property & Casualty Group; Robert A. Leibold, president-business insurance at Allstate Insurance Co.; Bradford W. Mitchell, chairman and CEC of Harleysville Mutual Insurance Co.; Paul J. Scheel, president and chief operating officer of United States Fidelity & Guaranty Co.; Russell J. Seifert, president and chief administrative officer of Republic Insurance Co.; and Edward K. Trowbridge, chairman and CEO of Atlantic Mutual Cos.

ISO is a non-profit corporation that provides advisory rating, statistical and actuarial services to its 1,400 insurance company member owners.

The Insurance Information Institute re-elected as its chairman John J. Martin, president of the personal financial security division of Aetna Life & Casualty Co.

The III also re-elected as vice chairman James J. Cutec, vice chairman and chief administrative officer of Crum & Forster Inc.

Member companies elected to serve on the III's board of directors were Aetna Life & Casualty Co.; Allstate Insurance Cos.; Chubb & Son Inc.; Continental Corp.; General Accident Insurance Co.; Kemper Group; The Travelers Insurance Cos.; United States Fidelity & Guaranty Co.; and United Services Automobile Assn.

The III is a non-profit educational, fact-finding and communications organization supported by about 300 insurance companies. ■

Associations honor execs for support

WASHINGTON—Two leaders in the commercial property/casualty insurance business who are no longer in day-to-day management of primary insurance companies were recognized during the Joint Industry Conference earlier this month.

William O. Bailey, who recently retired as vice chairman of Aetna Life & Casualty Co. after 34 years with Aetna, and DeRoy C. Thomas, who last year was promoted from chairman and chief executive officer of Hartford Insurance Group to president and chief operating officer of parent ITT Corp., were honored by the three insurance associations that annually meet together.

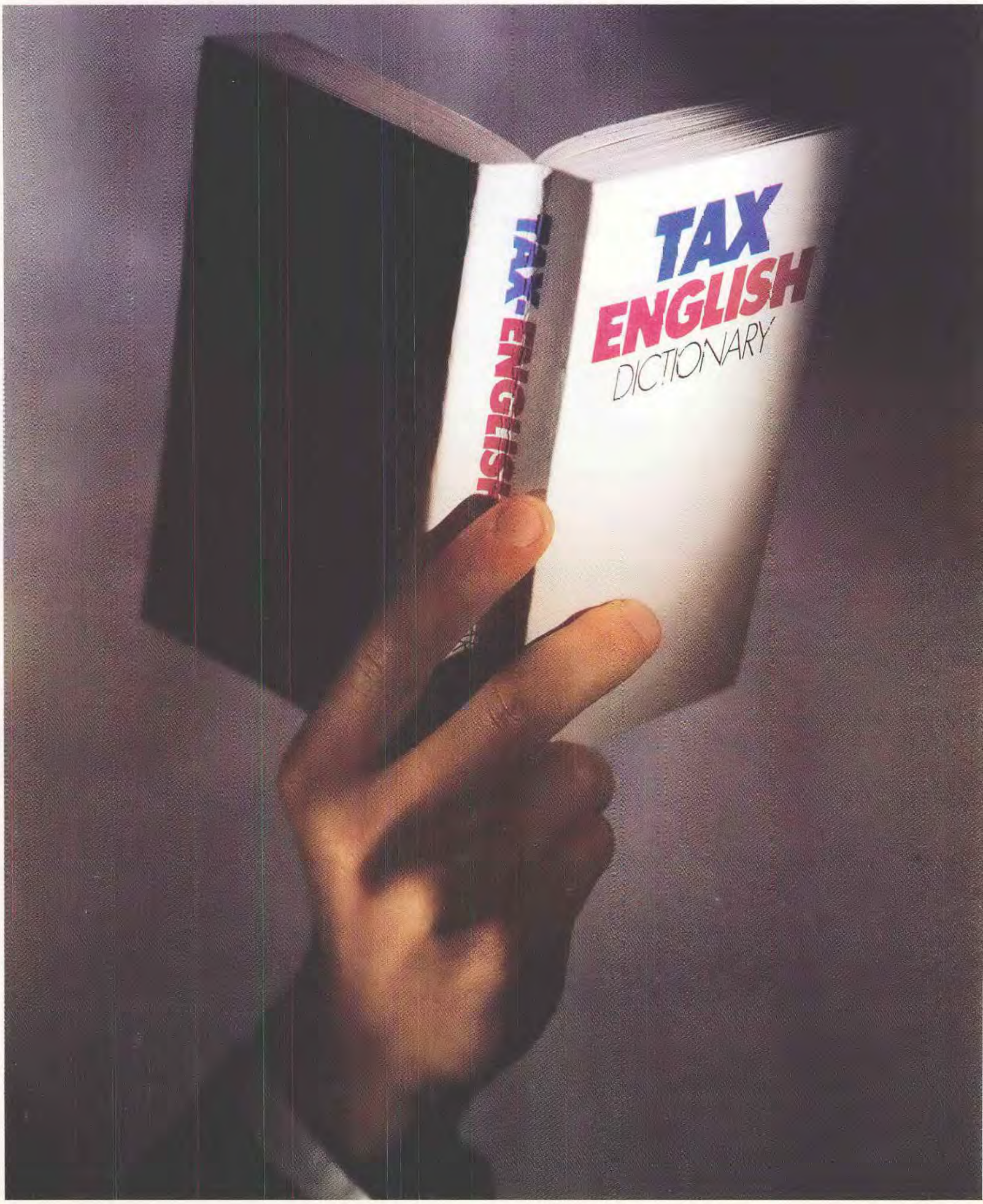
The American Insurance Assn., Insurance Services Office Inc. and Insurance Information Institute presented the two insurance industry executives with impressive eagle statutes and thanked them, in the words of AIA President Robert Vagley, for the "enormous impact" they have had on the three groups.

Both executives influenced the policies and directions of the three organizations during their insurance careers as leaders in the organizations. Among the offices they held, Mr. Thomas served as chairman of AIA and III, and Mr. Bailey served as chairman of the AIA.

Mr. Bailey joined Aetna in 1954 as an assistant secretary. He was Aetna's president for 11 years, until December 1986. Mr. Bailey remains chairman of the Municipal Bond Investors Assurance Corp.

Mr. Thomas started his insurance career in 1959 as assistant general counsel of the former Assn. of Casualty & Surety Cos. in 1959. Five years later he joined Hartford as counsel in the law department.

The contributions to the insurance industry of Mr. Bailey and Mr. Thomas include influencing the development of the nuclear insurance pools and advocacy of tort reform. ■



AIA's Thomas says insurers can rebound

By JERRY GEISEL

WASHINGTON—The property/casualty insurance industry can recover from the beating it took when California voters passed Proposition 103, says the outgoing chairman of the American Insurance Assn.

"This is no time to give up. We can turn this discouraging situation around," said DeRoy C. Thomas, who also is president and chief operating officer of New York-based ITT Corp. and former chairman and chief executive officer of Hartford Insurance Group, an ITT unit.

Speaking earlier this month at the Joint Industry Conference—which combined the annual meetings and conferences of the AIA, the Insurance Information Institute and the Insurance Services Office Inc.—Mr. Thomas minced no words about the insurance industry's failure to communicate its views before California voters approved Proposition 103 in November.

'Our story was totally missed. The plaintiffs' bar and Ralph Nader did a better job. In the immortal words of Gen. (Joseph) Stilwell, we got the hell beat out of us,' says DeRoy C. Thomas, outgoing chairman of the American Insurance Assn.

"Our story was totally missed. The plaintiffs' bar and Ralph Nader did a better job. In the immortal words of Gen. (Joseph) Stilwell, we got the hell beat out of us," he said.

But opportunity can be found in the ashes of defeat in California, Mr. Thomas said.

The property/casualty insurance industry has the resources to make its case for sound legislative changes, but only if it relentlessly pursues an informational campaign, he said.

"It cannot be a one-shot effort. It must be a long-range campaign that we stick with, and we are going to have to make up our minds to spend whatever is necessary to do the job," he said.

Mr. Thomas said the insurance industry failed to get its message across to California voters on why auto insurance rates have climbed so much.

Soaring medical care costs, large increases in the price of auto parts, and more auto thefts, accidents and paid bodily injury claims—factors largely beyond the industry's control—have led to rate hikes, he explained.

"Our industry has little control over many of these costs. But this is a story we haven't adequately told—the story of how rates are impacted. We haven't explained clearly and repeatedly what these costs are all about," Mr. Thomas said.

It's time that the insurance industry makes its case with the public that enactment of certain proposals—such as meaningful no-fault automobile statutes—can help contain insurance costs, he said.


Mr. Thomas

Mr. Thomas cited New York's no-fault statute as an example of how such a law can work. In the 11 years that New York's law has been on the books, some 90% to 95% of auto injury claims have been handled outside the courtroom.

The New York law has never been seriously challenged, while rate increases have been what Mr. Thomas described as "reasonable."

If the plaintiffs' bar opposes no-fault, it is up to the industry to fight back, he said.

"There are some people in our industry who feel if we don't bother the plaintiffs' lawyers, they won't bother us. That's ridiculous. Plaintiffs' lawyers pursue their agenda without pause. We are losing the battle to them," he said.

Joint Industry 1989 Conference

The insurance industry can take plenty of other steps to make the public more aware of what insurers are doing to help hold the line on auto insurance costs, he said.

The insurance industry has been a leader in battles for safer roads, campaigns to fight drunken driving and moves to improve car design to reduce thefts and lower repair costs, he noted.

"These are areas in which we have been a quiet leader for many generations. It is time for us to make the American people aware of our role and to solicit their support at the same time," he said.

Mr. Thomas said the industry must fight for good legislation and convince itself that it is pursuing worthwhile causes.

"We've got to make up our minds that we are going to win these battles. Unless we do, we are not going to serve the American people in the manner they deserve," he said.

Alluding to prior costly internecine battles, Mr. Thomas called for a united industry front.

"We will be successful only if we have a united industry with a single purpose. We have lost in the past because opponents found that it was easy to split our business—to divide and conquer. The issues are too big to allow us to be fragmented," he said.

Progress has been made to overcome the problem of the insurance industry speaking with many different voices, Mr. Thomas said, citing the cooperation of AIA President Robert Vagley and III President Mechlin Moore.

"This is the only sensible course to follow," he said.

Mr. Thomas pledged that a strong effort will be made to work with consumer groups, while additional advertising will be placed in major newspapers explaining the industry's views.

And, Mr. Thomas called on insurers to give the AIA the resources it needs to represent the industry.

"Each of us must make a solid commitment to keep the AIA strong. . . .It needs from each of us the necessary financial backing and enthusiastic support," Mr. Thomas said. ■

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AIA should watch personal lines: Vagley

By JERRY GEISEL

WASHINGTON—The passage of Proposition 103 demonstrates that problems in any line of insurance may lead to serious repercussions in all other lines, says the president of the American Insurance Assn.

Insurers' defeat in California also underscores the industry's need to work more closely with the public, form alliances with other industries and bolster its poor public image, said AIA President Robert E. Vagley.

"The most urgent task then and now is to assess the damage, make requisite repairs and to get back on course," Mr. Vagley said.

While the AIA is a leader in speaking out on commercial lines issues, it now also must take a leadership position on personal lines, he said.

Indeed, Proposition 103 was propelled by voters' revolt against personal auto insurance costs, which are among the nation's highest.



"We have learned to our dismay that problems in any line—commercial liability, personal auto, workers comp, even life or health—have political repercussions in all of the others," he said.

The passage of 103 also has made several other points clear, Mr. Vagley said in his report to the Joint Industry Conference on Jan. 11-12, which included the annual meetings of the AIA, the Insurance Information Institute and the Insurance Services Office Inc. Those points include:

- The public is angry at and frustrated with the industry.

The public "expects us to get our hands on the cost problems," he said. "We are better served asking their (the public's) help to cut costs than to say, 'Don't blame us.' We must engage the public more to help shape solutions to our mutual problems."

- The industry has to be more flexible and creative in responding to a politically charged environment.

"When large segments of the public reject certain ways we do business, we need to confront that reality—and respond with alternative solutions."

- Short-term legislative victories have little meaning if they undercut insurers' long-term goals.



Mr. Vagley

"Our effectiveness in containing proposals we dislike, ironically, may allow pressure for change to build until it explodes uncontrollably," Mr. Vagley said.

- The insurance industry must expand its political strength.

Proposition 103 was approved by only 51.1% of California's voters. However, the industry-sponsored initiative that would have established no-fault auto insurance was supported by only 25.3% of the voters despite an insurer-financed $60 million campaign (*BI*, Nov. 14, 1988).

In addition, the passage of Proposition 103 illustrates the importance of developing and building alliances with other non-industry organizations, according to Mr. Vagley.

"In California, we had few non-insurance allies and the effect was even greater polarization. We need such allies to mitigate the 'us and them' syndrome and to help us sell our positions," he said.

Insurers' defeat in California also provides overwhelming evidence that the industry has a serious credibility problem that must be addressed.

"We have felt from the very beginning that image was a serious, bottom-line issue for this industry. Certainly our structure, programs and our strategies evolve from our concerns about the industry's credibility and the impact on our effectiveness. Spending tens of millions of dollars and still losing the initiative ought to bring that same conviction home to those who may have doubted it in the past," he said.

Long before the California setback, the AIA had been on course to improve the effectiveness of the 195-member trade association.

Since Mr. Vagley, a former Washington attorney, assumed the helm of the AIA in 1986, the trade group has significantly expanded and improved its lobbying capabilities. To keep better track of activities in the nation's capital, the AIA moved its headquarters to Washington from New York.

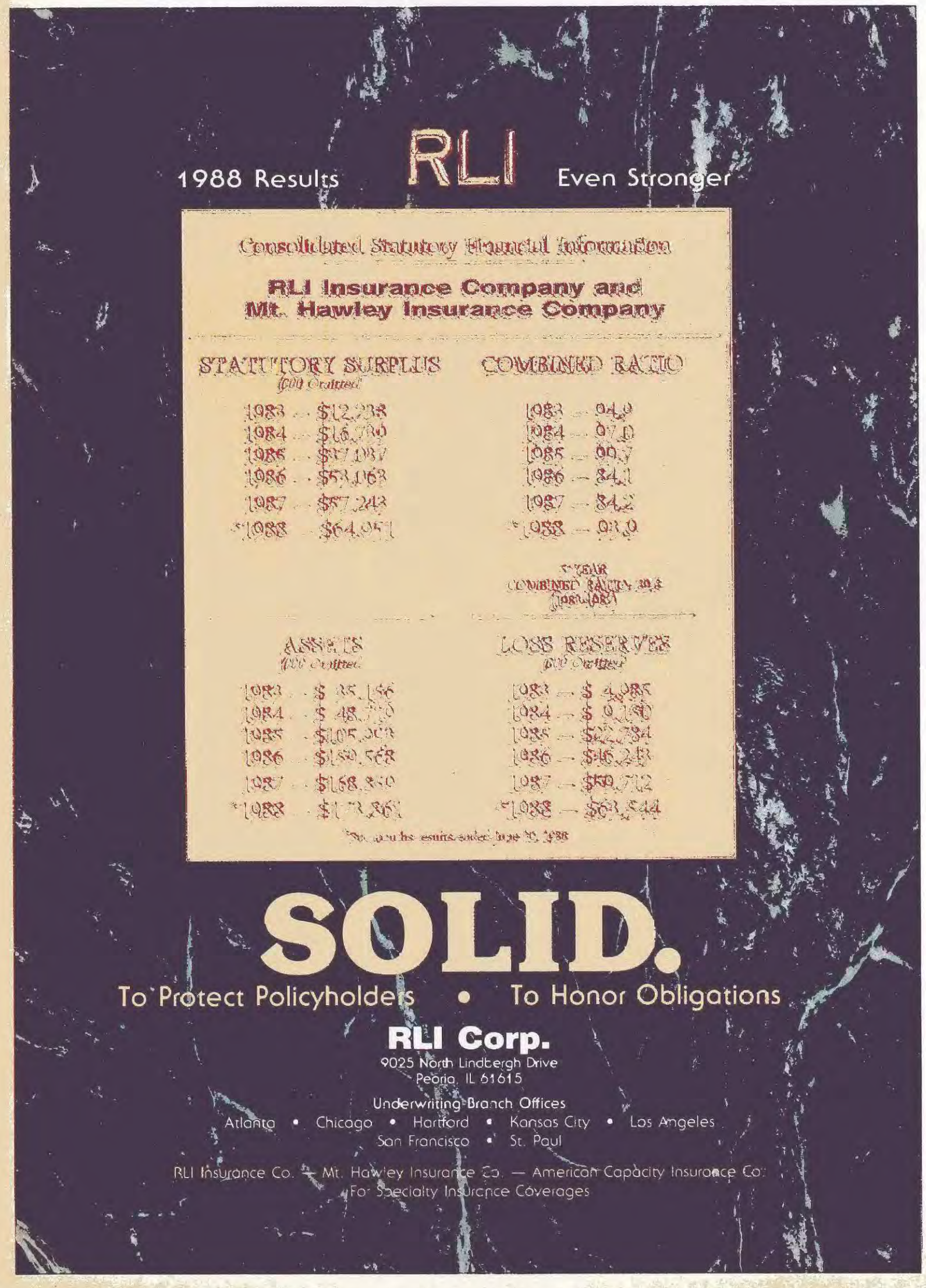
And, the AIA has responded to issues facing the industry. For example, it held a forum with the III in Washington last June on the antitrust litigation filed by state attorneys general (*BI*, June 13, 1988).

"That discussion had multiple benefits for our industry and effectively got the message across to all of our key audiences," he said.

At the same time, the AIA has spent a great deal of time developing lobbying strategies to deal with several vital issues the industry faces.

"Name any of the issues of critical importance to our industry—McCarran, workers compensation, environmental liability, solvency, taxation, rate regulation, auto insurance—we have a process, a strategy tailored to address each," he said.

This year, the AIA has to "run faster and hit harder" to avoid a repetition of the California defeat. "We simply cannot afford to wait until everyone is on board to press forward. There is no other effective choice—the stakes simply have gotten too high," he said. ■



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S&L mess could block banks' drive to expand insurance activities

By JERRY GEISEL

WASHINGTON—The financial problems of the savings and loan industry are making legislators think twice about the wisdom of deregulating financial services in general, a congressman says.

If deregulation allowed thrift institutions to "get so far afield," Congress is likely to rethink the merits of deregulation for other industries and activities, said Rep. Howard Berman, D-Calif.



Rep. Berman

This trend could stall banks' efforts to win congressional approval to expand insurance underwriting and brokering operations.

Still, regardless of the possible congressional backlash against more deregulation, it will be up to critics to detail why banks should not be given additional entry into the insurance marketplace, he said.

"Congressmen will be asking for reasons why banks should not be in the insurance industry," Rep. Berman told a special political panel session at the Joint Industry Conference and the annual meetings of the Insurance Services Office Inc., the Insurance Information Institute and the American Insurance Assn., held Jan. 11-12 in Washington, D.C.

Joint Industry 1989 Conference

Rep. Berman also said he expects a renewed drive during the current congressional session to repeal the McCarran-Ferguson Act, the 1945 law that provides insurers with a partial exemption from antitrust law and leaves primary regulation of the insurance industry with the states.

That drive, which didn't get very far last year, is likely to be led by industry critic Sen. Howard Metzenbaum, D-Ohio, said Rep. Berman.

Much of the panel discussion, though, centered on remedies to ease the federal budget deficit.

Frank Fahrenkopf Jr., the outgoing chairman of the Republican National Committee, blamed Congress for the deficit, charging that Congress, as an institution, can't live within a budget.

To address that problem, Mr. Fahrenkopf recommended, among other things, a line-item veto in which the president would have the authority to reject portions of congressionally approved spending bills he considered excessive. The president now must either accept or reject an entire bill, even if he disagrees with a portion of the legislation.

"The president needs a line-item veto. Until we have those kinds of things in place, we won't have a balanced budget," Mr. Fahrenkopf said.

But Sen. Wendell Ford, D-Ky., said he is opposed to a line-item veto as an infringement on congressional power.

Sen. Ford, though, favors a two-year budget to ensure better financial planning and to give Congress more time to consider other issues.

If Congress were not constantly tied up with hammering out a budget and approving appropriations bills, there would be more time for analysis, he said.

Sen. James Exon, D-Neb., suggested a special tax on consumer products along the lines of the value-added tax, which most Western European countries now use to raise revenue.

"We may have to go that route," Sen. Exon said.

Mark Shields, a syndicated political columnist, doubted whether the nation has the will to come to grips with the budget deficit anytime soon.

"It is too abstract. . .and doesn't (directly) touch economic lives," he said. ■

Municipal bond insurer sees increase in business

By JUDY GREENWALD

NEW YORK—The total volume of tax-exempt municipal bonds covered by financial guarantee insurers could increase by nearly one-third this year, an insurer predicts.

The projected increase is based on two factors: a larger volume of new issue, long-term, tax-exempt municipal bonds and insurers writing a larger share of the market, according to David H. Elliott, president and chief operating officer of White Plains, N.Y.-based Municipal Bond Investors Assurance Corp.

The total volume of tax-exempt municipal bonds issued is expected to increase 7.6% to $119.7 billion from $111.3 billion in 1988, Mr. Elliott said, citing an MBIA-sponsored survey at a recent seminar MBIA sponsored in New York.

And, insurers' share of the market could increase to 28.8% from 23.5% in 1988, according to the survey of more than 570 investment professionals.

If the survey's predictions are accurate, this means the dollar amount of bonds insured by financial guarantee insurers will increase 32.2% to $34.5 billion from $26.1 billion.

Mr. Elliott, who moderated the seminar, said he is bullish about municipal bond market this year. "We feel the 1989 market is bringing a revitalization of the municipal bond market," with municipal bond insurers covering a record level of bonds, he said.

Another favorable trend is the fundamental shift in the market toward individual investors, who bought more than 90% of 1988's new issues, Mr. Elliott said. Those investors are replacing institu-

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Continued from previous page
tions, which have been discouraged from investing in tax-exempt bonds by provisions of the Tax Reform Act of 1986.

The secondary market could be another growth area for the financial guarantee market, he said. "Divestiture by institutions of their tax-exempt investments could result in increased secondary market activity for financial guarantors in late 1989 and early 1990," Mr. Elliott said.

As these institutions sell their tax-exempt bonds in the secondary market, the most likely buyers will be individuals, tax-exempt unit investment trusts and mutual funds, and all have shown a strong preference for insured bonds, he said.

"MBIA is optimistic about the future of the municipal market and the financial guarantee industry because of the vast infrastructure needs of our states and municipalities and the growing retail demand for insured products," he said.

'Divestiture by institutions of their tax-exempt investments could result in increased secondary market activity for financial guarantors in late 1989 and early 1990,' says David H. Elliott of Municipal Bond Investors Assurance Corp.

John E. Petersen, senior director of the Government Finance Research Center in Washington, D.C., said that much of the nation's growing infrastructure needs will be financed by tax-exempt municipal bonds.

Mr. Petersen, who recently completed an MBIA-commissioned study of future infrastructure needs and financing, said that until recently, the need to replenish and expand the nation's infrastructure has been ignored.

Current state and local spending for public works projects is now at $80 billion annually, he said. But, studies estimate that between $10 billion and $70 billion in additional funding is needed, he said.

Specifically, more funding is needed for highways, streets and bridges, he said. State and local governments are now spending $17 billion to $20 billion in these areas, of which the federal government provides $12 billion to $14 billion, he said. However, total capital spending of $25 billion to $35 billion is needed, he said.

Other areas in need of tax-exempt financing include solid waste disposal, for which spending should be increased $400 million to $1 billion, and airports, for which an estimated $24 billion over the next decade is needed, he said.

Spending also is needed for public transit, water supply and distribution and wastewater treatment facilities, he said.

"Given budget restraints at all levels of government, tax-exempt borrowing will be the primary source of infrastructure funding," Mr. Petersen said, noting the recent decline in federal financing of infrastructure improvements.

While the needs of state and local governments are increasing, the federal government is rolling back the level of assistance it provides, agreed Austin Koenen, managing director of Shearson Lehman Hutton Inc.'s public finance group.

Nevertheless, "the state and local governments fill right in there," Mr. Koenen said.

Issuing tax-exempt bonds for public works projects is more efficient than building a "massive federal bureaucracy," he said.

"Economic restrictions, however, could deter these projections," Mr. Petersen noted, saying a recession is possible. Nevertheless, popular support for infrastructure improvements will continue to increase, he predicted.

In addition, the Bush administration may try to limit the amount of interest that can be earned on a tax-exempt basis to help reduce the federal government's massive deficit, warned John T. McEvoy, a partner with Washington-based law firm Kutak Rock & Campbell.

This could be a high limit at first, he said. But, he warned, "it will only be the beginning."

Last year, the Supreme Court overturned a 93-year-old precedent and ruled Congress has the power to tax income from municipal bonds (*BI*, May 9, 1988). The municipal bond industry's challenge will be to convince Congress "why that would be a bad idea," Mr. McEvoy said.

Nearly three-fourths—74.6%—of the MBIA survey's respondents felt that municipal bonds' tax-exempt status should be protected by a constitutional amendment.

But, Mr. McEvoy said he does not anticipate a constitutional amendment this year to protect the tax-exempt status of municipal bonds.

"The demands in our market are going to be there and are going to be met," whether it is on a taxable or tax-exempt basis, said Mr. Koenen of Shearson Lehman. "I think the future of our business is great," he said.

Also speaking was James A. Lebenthal, chairman of New York-based Lebenthal & Co., a municipal bond firm. ■

Court halts AMBAC divestiture

WASHINGTON—The American Insurance Assn.'s efforts to force Citibank to divest itself of municipal bond insurer AMBAC Indemnity Corp. were set back when a federal appellate court partially reversed its own earlier decision.

In August, the U.S. Court of Appeals for the District of Columbia ruled that the comptroller of the currency should not have approved Citibank's 1985 acquisition of AMBAC without first requiring Citicorp, the bank holding company that controls Citibank, to obtain the Federal Reserve Board's approval (*BI*, Sept. 5, 1988). The Fed oversees enforcement of the Bank Holding Company Act, which limits banks' non-banking activities.

The appellate court ruled the comptroller mistakenly thought the act did not apply to the AMBAC acquisition.

But, following a rehearing of the case, the appellate court said earlier this month that it was "inappropriate" for the court to have considered the BHCA question.

AIA counsel Michael Lovendusky, who called the decision a "bit of a setback," said the association has several options, including asking the Fed to rule either on just the question of AMBAC's acquisition or on the broader issue of bank holding companies' involvement in insurance activity. Another option is to ask the Supreme Court to review the latest decision, he said.

—By Judy Greenwald

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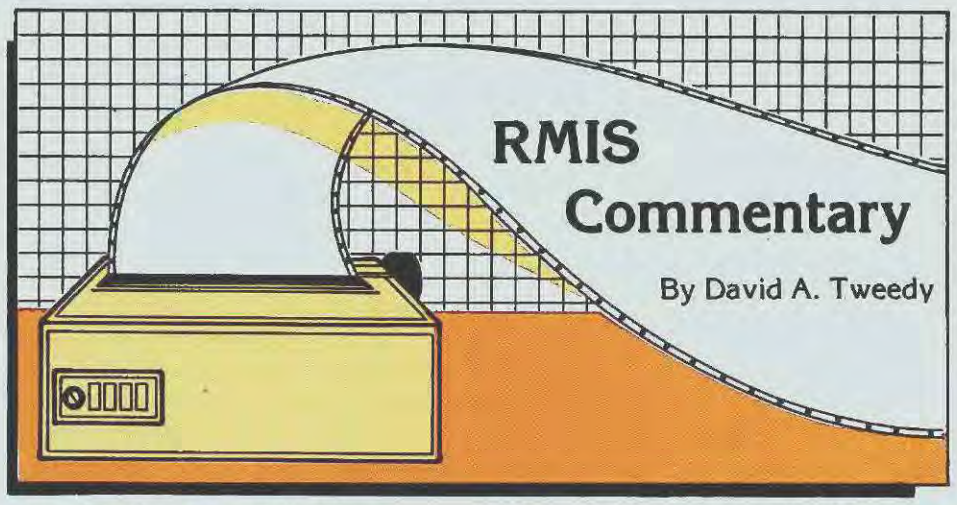
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Anistics' decision raises questions



ANISTICS INC.'S announcement last month that it would phase out its mainframe-based risk management information system came as a surprise to many in the risk management community (*BI*, Dec. 26, 1988). After all, it had been a power in the RMIS industry since the early 1970s.

The decision raises some serious questions for any risk manager with a vendor-supported system: How did this happen? Can it happen to me? What do I need to do to reduce any negative impact on my operation if it does?

Anistics, the technical subsidiary of broker Alexander & Alexander Services Inc. and one of the leaders in the area of RMIS, was highly regarded both within A&A and in the risk management community. For the past several years, Anistics was prominently mentioned in A&A's annual reports and for many years Anistics was the only part of A&A to maintain a booth at the annual Risk & Insurance Management Society conferences.

Therefore, its decision to abandon the RMIS timesharing business was quite a surprise to many of us in the RMIS field.

Anistics has been a major provider of RMIS mainframe timesharing services—second only to Corporate Systems Inc. of Amarillo, Texas, in number of clients. A pioneer in this field, Anistics started providing mainframe RMIS timesharing services in the mid-1970s and has been expanding the operation ever since. When it started it had one office, one computer and no network. Now it has several offices, six computers at a separate computer center and a very extensive data communications network.

That Anistics and A&A should abandon such an operation seems to be a drastic measure that must have been prompted by significant circumstances.

The Anistics decision also raises two very important questions for the risk manager:

- What does this imply for the future of RMIS?
- How does a risk manager protect the corporation's investment in an RMIS?

Any risk manager with a system may wonder where the RMIS industry is going. If the Anistics decision is the bellwether, then the field is going to microcomputer-based systems. This is hardly surprising because the same trend has been overwhelmingly apparent throughout all of data processing.

Year after year, new microcomputer-based RMIS are shown at the RIMS conference. The only new mainframe system in several years was announced by Anistics at the Las Vegas RIMS conference in 1987.

Is it inevitable that other mainframe vendors will go the way of Anistics? The answer is "not necessarily," for reasons explained below.

This is a situation where a new technology is slowly but inexorably taking over an old technology. In just a few short years we have seen microcomputers go from a slow machine with only floppy disks to very fast machines with hundreds of millions of characters of permanent storage.

The economics behind the technology takeover, however, are questionable.

Micros are wonderful machines and we all like to have our own computer on our desk. They can do many of the tasks the mainframe did for us. But economies of scale will always keep the mainframe at the top of the efficiency chart.

If we ignore data communication costs, then timesharing many tasks on a mainframe has to be cheaper than the cost of many microcomputers that sit idle most of the time. Data communication costs are easily isolated and turn out to be—though significant—not the determining factor in the trade-off between micros and mainframes.

The major determining factors for choosing a micro over a mainframe are psychological and the level of service. The psychological factor is simple: Most of us like to have control of our own resources. The service levels of the data processing department are all too often just plain frustrating.

Another factor to consider is the fact that the RMIS industry has moved into the mature stage.

Anistics, as a start up, did well with little competition. The management books tell us that as an industry moves into the mature stage, additional competition enters the field and the inefficient performers are forced to

Continued on next page

Contributing to this article was Michael N. Singer, president of Risk Information Systems Consulting in Huntington, N.Y. Mr. Singer worked at Anistics for 10 years, most recently as deputy managing vp, overseeing applications development.

David A. Tweedy is a senior consultant for D.A. Betterley Risk Consultants Inc. in Worcester, Mass. He is the editor of Betterley Risk Management Commentary and the author of RMIS Update, a yearly publication analyzing major risk management information systems and vendors. Mr. Tweedy's column on risk management information systems appears the third Monday of the month.



Consequences of risk financing choices

By The Insurance Institute of America

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

This month's material, based on a recent examination in ARM 56-Risk Financing, explores some of the ways that an organization's risk financing strategies and overall financial management are interrelated, and how a change in either is likely to effect the other.

Q: An organization's risk financing decisions usually should be guided by sound financial principles. For each of the three statements given below explain why the statement is true and explain how the statement is likely to affect an organization's choice of risk retention levels.

- Every organization needs cash with which to operate, but holding too high a percentage of total assets as cash tends to lower the expected present value of the organization's future aftertax net cash flows.
- Making an organization's needs for cash smaller and more predictable allows it to decrease its liquidity and, therefore, to increase its operating efficiency.
- The matching of cash sources with cash needs implies that short-term cash needs usually are fulfilled from highly liquid cash sources, while long-term needs are met from less liquid sources.

A: • When an organization's assets are highly liquid, it is able to move its resources quickly from one commitment to another, thus reducing its risk. Lower risk, however, typically is associated with lower rates of return, reduced current profits and, consequently, a lower expected present value for the organization's future net cash flows. Increasing an organization's retention levels usually requires increasing its liquidity, principally its cash holdings, tending to reduce the organization's expected present value of future cash flows and its rate of return on its overall assets.

A.R.M. exercises

- When an organization's cash needs are reduced or made more predictable, the organization can hold less of its total assets in cash and is therefore able to reduce its liquidity. Requiring less liquidity, the organization can then devote more of its assets to longer-term commitments, thus tending to raise its overall rate of return and its operating efficiency. To successfully reduce liquidity, however, the organization often also must be willing to reduce its retention levels, leaving less cash to pay for accidental losses as they occur.
- Meeting short-term cash needs requires being able to generate predictable amounts of cash quickly from liquid assets. However, longer-term needs for cash at definite times in the more distant future can be met through cash generated over longer periods from more fixed, less liquid assets. Retaining accidental losses typically requires significant short-term or near-cash holdings for often unpredictable amounts of numbers of such losses. An organization for which the availability of short-term funds is restricted may, therefore, need to reduce its risk retention levels.

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

RMIS Commentary

Continued from previous page

drop out.

The pioneers of the industry are the ones who invested heavily in research and building the market. Then the copiers come along and compete with less need for research in an already developed marketplace. They can avoid the errors and copy the successes of the pioneers. This may seem unfair but it is a fact of life. Anistics was a pioneer.

Frederick P. Brooks Jr., in his book, "Mythical Man-Month: Essays on Software Engineering," refers to another common phenomenon among computer firms: the second system phenomenon. According to Mr. Brooks, there is a tendency to build the first system by hook and crook just to get it working.

Although this first system works, it is usually difficult to use and maintain. Flushed with success and frustrated by the difficulty of having to add a large number of changes, the developers then begin to build another system with good organization that includes every function that anyone ever asked for. The project is then so huge that it is never finished.

This is exactly what happened to Anistics.

After announcing a truly excellent system at the Las Vegas RIMS, then going into on-site testing without check-writing capability, then finding it was too slow and finally adding the check-writing portion, it was forced to scrap the entire project.

Another problem that Anistics faced was the use of old technology. When Anistics first developed its RMIS, it was based on its own state-of-the-art data base management system.

The reason for developing its own DBMS was simple—there was none commercially available. Since then, DBMS became readily available, but Anistics chose to stay with its own DBMS rather than invest in a migration effort. So Anistics had to support an RMIS and a DBMS on only RMIS revenues.

Furthermore, this DBMS worked only on a computer that was abandoned years ago by the manufacturer. So Anistics was also forced to use a computer with no upgrade possibilities. This did not help its efficiency. These factors are important for the risk manager and will be discussed next month.

It should be noted that these problems did not plague the other RMIS pioneer—Corporate Systems. By using a more mainstream technology, Corporate Systems was able to take advantage of hardware and software upgrades as well as a significantly simpler migration between hardware environments.

Furthermore, Corporate Systems has demonstrated a sophisticated marketing strategy through the years, diversifying both its product line (mainframe, micro- and minicomputers) and its target market (risk managers and service providers).

Next month, we will discuss what a risk manager can do when an RMIS vendor drops a product line or, worse yet, goes out of business.

Attorney helps employers manage their legal fees

"Putting A Lid on Legal Fees: How to Deal Effectively With Lawyers"
By Raymond M. Klein
Published by InterLink Press, 908 Kenfield Ave., Los Angeles, Calif. 90049
$12.95

By Kevin M. Quinley

Books & ideas

One risk manager gave me his whimsical definition of waste as "a bus load of attorneys plunging over a cliff. . .with two empty seats."

Runaway jury awards and settlements receive lots of headlines, but what about skyrocketing legal fees? Risk managers spend millions on legal services annually, yet they often view attorneys' costs like the weather: Everyone talks about it, but nobody can change it.

Attorney Raymond M. Klein disagrees in "Putting a Lid on Legal Fees." This is a gem of a how-to guide for risk managers seeking common sense tips on cutting legal fees without cutting the quality of service. That includes nearly all risk managers, who are increasingly subject to pressures to improve their bottom lines.

This is not a "how to be your own lawyer" book, as Mr. Klein makes clear right upfront.

There is no substitute for good legal advice and you get what you pay for, he stresses. (Maybe Mr. Klein did not want to have to wear a flak jacket to the next bar association meeting.)

While questioning a legal bill may not get you invited back to the law firm's Christmas bash, it does have a salutary effect on attorney cost-consciousness.

Mr. Klein is an attorney himself, practicing in Los Angeles, and can hardly be accused of having an ax to grind against lawyers. "Putting a Lid on Legal Fees" is an insider's scoop to cost cutting and could have been called, "Confessions of a Defense Attorney."

Chapter One's title, "The Lawyer is the Expert but You're the Boss," sums up the book's tone. Why do some lawyers get this backwards, prompting risk managers to ask (shout), "Whose case is this anyway?"

Mr. Klein stresses the need for preventive law. In defense of attorneys, he says that too many businesses use lawyers as emergency rooms, bringing problems to counsel only when a situation is already hopeless.

However, Mr. Klein's preventive law checklist is of limited help. It focuses less on risk management problems than on general business questions of incorporation and partnership.

Yet employee benefit specialists may find interesting the checklist on employment practices.

Don't expect lawyers to love Mr. Klein's techniques. Discovery has become a narcotic of the defense bar, yet risk managers are subsidizing the habit.

And risk managers will want to delve into protection of patents, trade secrets, copyrights, trademarks and especially product liability.

While the book is not aimed at risk managers, they will find this a gold mine of good ideas for controlling litigation costs.

One point Mr. Klein makes loud and clear in his book is that controlling legal fees is a hands-on endeavor.

Businessmen and risk managers must get involved in litigation management, which requires a substantial time commitment at a point when overworked risk management departments are already being trimmed to the bone.

Frequent monitoring of the litigation process will pay dividends, Mr. Klein says.

Among Mr. Klein's tips for cutting legal fees are:

- Require that your lawyer draft a budget.
- Shop around for the best lawyer, not necessarily the lowest price.
- Require that bills be itemized in tenths of an hour.
- Collate, gather and photocopy documents on-site, instead of paying a firm's paralegals $50 an hour to perform this non-legal work.
- Choose a lawyer, not a law firm. Juries aren't plugged into who's in the legal fraternity and couldn't care less about a big firm's prestige.

Don't expect lawyers to love Mr. Klein's techniques. Discovery has become a narcotic of the defense bar, yet risk managers are subsidizing the habit.

Getting lawyers to estimate costs in advance is like trying to wrestle a python coated in Crisco oil.

And, while questioning a legal bill may not get you invited back to the law firm's Christmas bash, it does send a signal that has a salutary effect on attorney cost-consciousness.

Some may warn that Mr. Klein's prescriptions will make it hard for risk managers to find a lawyer. Yet with the glut of lawyers nowadays, it's a buyer's market and Mr. Klein would probably say, "Keep on looking."

Although the 189-page "Putting a Lid on Legal Fees" lacks an appendix, the table of contents is detailed enough to make one unnecessary.

Remaining chapters are titled:

- "Select the Right Lawyer"
- "The Fee Agreement: From the Client's Viewpoint"
- "Taking Advantage of a Law Firm's Economics"
- "Strategies to Control Business Legal Costs"
- "Containing the Cost of Litigation"
- "Alternatives to Litigation"
- "The In-House Counsel"
- And, "More Bang for Your Buck."

Eleven appendices cover everything from drafting a sample litigation budget to how to write a job ad for an in-house counsel.

Look at it this way: If the book helps you reduce your legal fees by one hour, then it has paid for itself four times over!

Kevin M. Quinley is claims manager for MEDMARC Insurance Co. Risk Retention Group Inc. and subsidiary Hamilton Resources Corp., both of Fairfax, Va. Mr. Quinley holds the Chartered Property & Casualty Underwriter and Associate in Risk Management designations.

Other texts may help risk managers

Several attorneys have written guidebooks to improve the risk manager's bottom line:

- **"The Terrible Truth About Lawyers"**
By Mark McCormack
Beech Tree Books, 105 Madison Ave., New York, N.Y. 10016
$17.95
- **"101 Ways to Cut Legal Fees and Manage Your Lawyer"**
By Erwin Krasnow and Jill MacNeice
Broadcasting Publications, 1735 DeSales St. N.W., Washington, D.C. 20036
$29.95
- **"Kill All the Lawyers? A Client's Guide to Hiring, Firing, Using and Suing Lawyers"**
By Sloan Bashinsky
Prentice Hall, Route 9 W, Englewood Cliffs, N.J. 07632
$12.95



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U.K. asbestos litigation more efficient: Report

By CAROLYN ALDRED

OXFORD, England—Companies based in England and their insurers are coping with asbestos-related claims more cost-effectively than U.S. companies, according to an Oxford University research fellow.

British asbestos defendants from the outset adopted a more conciliatory and structured approach to claims, which reduced their costs while still providing claimants with compensation comparable to that received by U.S. claimants, asserts researcher Robert Dingwall.

Asbestos-related compensation "could have been better managed in the U.S. if manufacturers accepted their liabilities earlier and produced a planned settlement of claims," said Mr. Dingwall, who works for the Centre of Socio-Legal Studies at Oxford's Wolfson College.

Mr. Dingwall's comments are based on a comparative study of asbestos litigation in the United Kingdom and the United States that he is conducting with William L.F. Felstiner of the Chicago-based American Bar Foundation. The study is due to be completed in 1991.

In Great Britain, asbestos producers and insurers have settled most cases without trials and those negotiated settlements have resulted in consistent compensatory payments, as well as lower legal costs, Mr. Dingwall said.

Meanwhile, U.S. manufacturers vigorously fought asbestos cases in the courts and thus have incurred huge legal bills. In addition, inconsistent jury awards made the defendants' position unpredictable and heightened U.S. claimants' expectations, which further increased claims costs, he said.

"It was all part of a vicious circle which increased the defensive attitude of manufacturers and insurers and encouraged the level of litigation and adversarial approach by claimants in the U.S.," he explained.

"There is good evidence that U.S. defendants were much more unwilling to accept liabilities than U.K. manufacturers," Mr. Dingwall said. As a result, "a lot of money was transferred by the insurers to lawyers which could have been used to compensate the victims."

An interim report by the researchers estimates that the average award, using 1986 values, to U.K. claimants in British courts was 55,130 pounds ($82,695). The average U.S. award was $213,000. However, because a U.K. claimant does not have to pay medical and legal fees from his award, a U.K. award is equivalent to a U.S. award of $155,000.

British asbestos litigation "is more efficient, more equitable, less slow and imposes lower public costs," than U.S. asbestos litigation, according to the report.

And, by the time the Wellington Agreement was signed in 1985 to speed the resolution of claims, "it was too little and too late," said Mr. Dingwall.

The Wellington Agreement, signed in the United States by 34 asbestos producers and 16 insurers, became the foundation for the Asbestos Claims Facility. The facility was devised to settle asbestos bodily injury claims and provide a joint defense against claims brought by asbestos victims (*BI*, Aug. 1, 1988).

The Asbestos Claims Facility was dissolved last year, but some producers and insurers formed a successor facility, called the Center for Claims Resolution (*BI*, Oct. 17, 1988).

British defendants and claimants "have evolved ways of conducting the litigation which have contained the transaction costs and led to comparatively quick, predictable and apparently equitable settlements," according to the report.

For example, British asbestos claims are handled by a small number of law firms that specialize in asbestos-related litigation. As a result, much of the preparation work in trying a claim has become routine and more cost-effective, according to Mr. Dingwall. Most plaintiffs' law firms interviewed by the researchers had handled hundreds, and in one instance, thousands of individual cases.

Defense work also is dominated by about four law firms the report says.

Defense litigation costs have been reduced through an informal arrangement that apportions liability according to the length of a claimant's employment with each defendant, rather than trying to establish the degree of exposure to asbestos at each employer. This arrangement also provides for the coordination of the defense by one lawyer, usually the representative of the insurer defending the employer with the longest period of exposure.

Mr. Dingwall estimates that no more than 2% of asbestos claims go to trial in Britain, whereas most U.S. asbestos claims have been settled by trial.

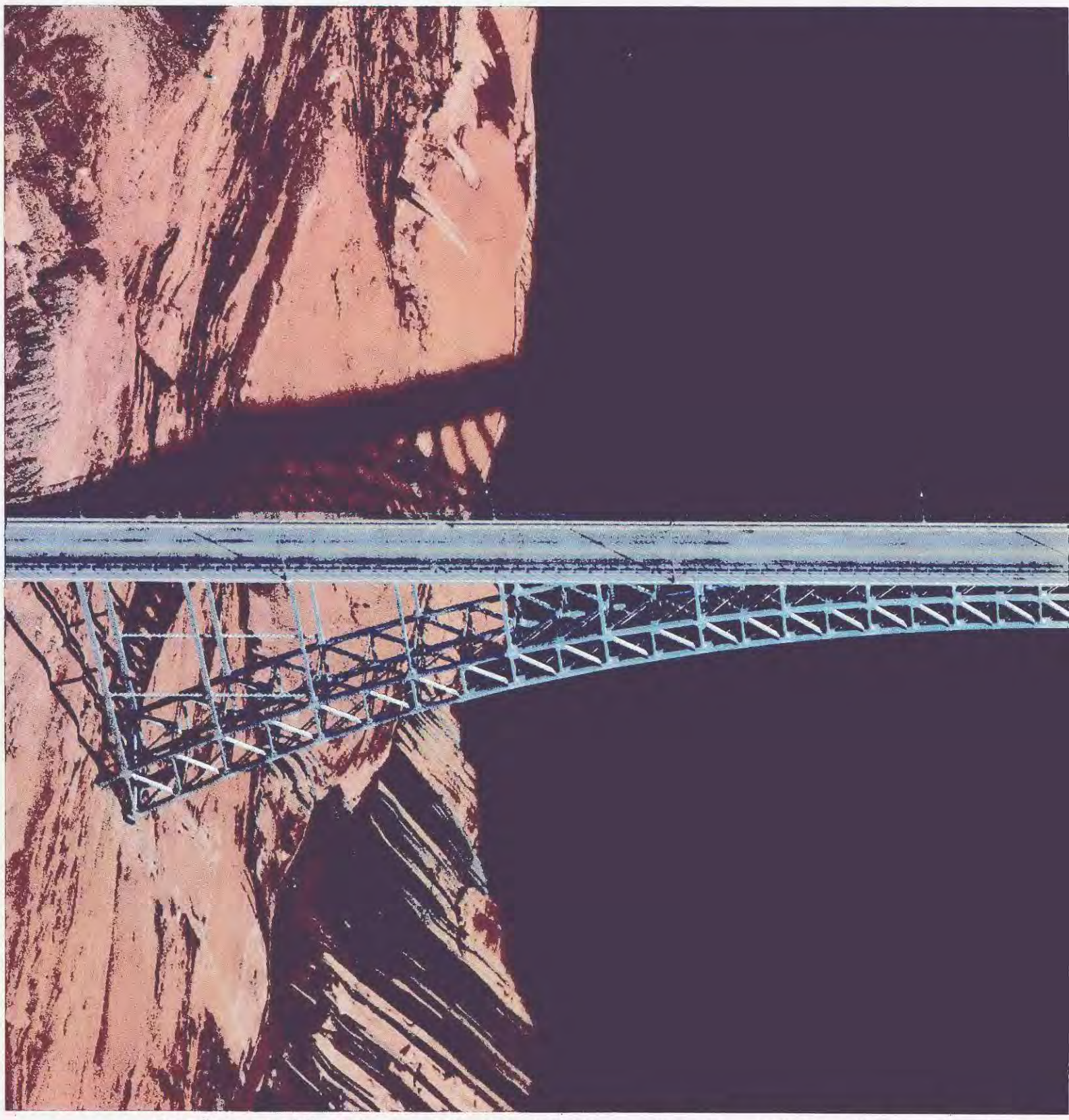
While Mr. Dingwall is critical of the U.S. manufacturers' and insurers' handling of asbestos claims, he agrees that U.K. defendants have several advantages over U.S. defendants.

For example, in Britain "the financial liability of defendants has been diffused among a larger number of firms and their insurers over a longer period and the system has had sufficient time and flexibility to respond," the researchers' interim report concludes.

In the United States, most claims were filed against a handful of major asbestos producers under U.S. product liability laws. However, in the United Kingdom, plaintiffs have sued their employers for failing to provide a safe working environment under regulations, dating back to the 1930s, that restricted the amount of as-

Continued on next page

Between the need and the ability to control insur



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Continued from previous page
bestos dust in the workplace.

"These regulations were widely ignored and largely unenforced until the 1960s so that employers are liable in tort for their breach of a statutory duty," the report states.

As a result, U.K. asbestos claims have "not imposed a stress on any individual company in any way comparable to the burden imposed on U.S. manufacturers and their insurers," the report states.

In addition, costs in general in the U.K. legal system are much lower than in the United States.

British plaintiffs' lawyers charge fees by the hour rather than on a contingency fee system as in the United States and plaintiffs' legal costs for out-of-court settlements in Britain usually amount to about 3% to 15% of recoveries, the report states.

'There is good evidence that U.S. defendants were much more unwilling to accept liabilities than U.K. manufacturers,' Mr. Dingwall says. 'A lot of money was transferred by the insurers to lawyers which could have been used to compensate the victims.'

Defendants' legal costs in Britain usually amount to about 5% of recoveries.

As a result, legal costs for cases settled out of court in Britain probably never exceed 25% of recovery. In the United States, total legal costs for out-of-court settlements can amount to more than 125% of recovery.

Meanwhile, trial costs, including fees for medical and other expert witnesses, also are much less in Britain.

The total cost of cases decided by trial in Britain average about 35% of a claimant's recovery, compared with total legal system costs of 189% in the United States, the report estimates.

One of the major differences between the two legal systems is the method by which legal costs are paid, the report notes.

In the British system, if a case is decided by trial, the losing party pays the costs for each side. In the United States, plaintiffs and defendants both commonly pay attorneys' and court costs, no matter which side wins.

In addition, damage awards are decided by a judge in British trials instead of by a jury, producing lower and more consistent awards, said Mr. Dingwall.

For example, "it is clear that in Northern Ireland, where until recently jury trials persisted, the awards and transaction costs were higher" than in the rest of Britain "because of the unpredictability of the jury," he said.

However, compensation received by British asbestos victims is comparable with compensation actually received by U.S. victims, despite higher court awards in the United States, according to Mr. Dingwall.

The report states that the average asbestos compensation awarded in U.K. courts between 1970 and 1987 was 55,130 pounds, converted into 1986 values. This is slightly lower than compensation payments made through out-of-court settlements in the United Kingdom, the report says.

However, after considering that legal fees and expenses in U.S. cases that reach trial make up about 47% of the total recovery and a U.S. award provides for medical expenses—which in Britain are paid by the government in most cases—"the real value of a U.K. award to an American plaintiff would be of the order of $155,000," the report calculates, using an exchange rate of $1.50 to the pound for 1986.

This compares with an average U.S. trial award in asbestos cases during the early 1980s of $205,000, which, after subtracting an average of 15% for punitive damages and converting to 1986 values, represents compensation of about $213,000 before attorneys' costs, the report says.

"As with all international comparisons, one should not place too much weight on the exact figures, but they do suggest that plaintiff recoveries at trial, net of legal costs and medical expenses, do not differ by an order of magnitude between the two systems," the report says.

Meanwhile, many potential asbestos-related claims are never filed in the United Kingdom, according to the researchers.

About the same number of asbestos claims are brought in the United States and Britain as a percentage of total population, though the incidence of asbestos-related diseases in Britain is likely to be higher because a greater number of trade workers were exposed to the material, the report says.

In addition, the types of asbestos used in Britain may have been more likely to induce mesothelioma, according to the report.

"The U.K. might be expected to generate significantly more litigation than in the U.S. but seems to come up with about the same amount, suggesting that there is a loss of potential cases somewhere in the system," the report says.

The British system is "much less effective at mobilizing possible cases and there are indications of a significant pool of uncompensated victims" of asbestos-related diseases, the report notes.

Trade unions, law firms and medical staff in the Britain could all make "greater efforts to mobilize cases," the report says.

For example, British doctors are much less likely to establish a link between asbestos and asbestos-related diseases and, even if a link is established, the doctors are less likely to advise patients to pursue legal action, the report says.

British lawyers also are less likely to petition potential claimants, partly because of stricter regulations on lawyers' advertising.

Other reasons cited by interviewees for the lower level of litigation in Britain include victims':

- Reluctance to pay both sides' costs if they lose a trial.
- Concern over the prospect of paying a lawyer just to be told that they do not have a case.
- Loyalty to former employers that would be named as defendants.
- Discouragement because the government's Department of Health and Social Security already has rejected a claim for industrial injury benefits. ■

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W.R. Grace appoints two to risk management posts

Comings & goings: buyers

Dennis J. Fichtel, 36, has been named senior claims manager of corporate risk management at W.R. Grace & Co. in New York. In this position he is responsible for Grace's insured and self-insured property/casualty claims. He replaces **Harry L. Bauer**, who retired earlier this year, and reports to Jeffrey M. Posner, assistant vp and director of corporate risk management. Prior to joining Grace, Mr. Fichtel was a litigation analyst with The Home Insurance Co. in New York. He holds a bachelor of science degree from Manhattan College in Bronx, N.Y. In addition, Mr. Fichtel holds the Chartered Property & Casualty Underwriter, Associate in Risk Management and Associate in Claims designations.

Also at Grace: **Charles L. Moleski**, 39, named director of safety and loss prevention. In this position he oversees the company's environmental health, safety and loss prevention programs. He replaces **Kevin W. O'Connell**, who transferred out of the risk management department, and reports to Jeffrey M. Posner, assistant vp and director of corporate risk management. Previously, Mr. Moleski was corporate safety and loss prevention manager for National Medical Care Inc. in Boston. He holds a bachelor of arts degree from Columbia University in New York and attended the Harvard University School of Public Health in Cambridge, Mass.



Mr. Rhoads

* * *

Jeff Rhoads, 41, named director-benefit planning and administration at TRINOVA Corp. in Maumee, Ohio. In this position, he oversees the administration of corporate employee benefits as well as the planning, design and implementation of new benefit programs. He replaces **Marilyn Hursh**, who retired,. and reports to J. Rodney Glansdorp, vp of human resources. Prior to joining TRINOVA, which manufactures power and motion control systems and plastics, Mr. Rhoads was manager-corporate benefits for Champion International Corp. in Hamilton, Ohio. He holds a bachelor of science degree in business administration from Bowling Green State University in Bowling Green, Ohio, and a master of business administration degree from Xavier University in Cincinnati. Mr. Rhoads is a member of the International Foundation of Employee Benefit Plans.

* * *

Jon H. Schmieden, 29, promoted to senior analyst-risk management and insurance at Alcon Laboratories Inc. in Fort Worth, Texas. In this newly created position he has increased responsibility for the administration, coordination and management of Alcon's worldwide risk management and insurance functions. He reports to Larry B. Long, director of corporate risk management and insurance. Mr. Schmieden, who joined Alcon in 1987, most recently served as analyst-risk management and insurance. Prior to joining Alcon, which manufactures pharmaceuticals, surgical instruments and ophthalmic goods, Mr. Schmieden was a staff consultant at T.E. Brennan Co. in Milwaukee. Mr. Schmieden received a bachelor of business administration degree in risk management and a master of business administration degree in finance, risk management and insurance from the University of Wisconsin at Madison. He holds the Associate in Risk Management designation and is a deputy member of the Risk & Insurance Management Society. In addition, Mr. Schmieden is working toward to obtain the Chartered Property & Casualty Underwriter designation.

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

Kennedy plan too expensive, economist says

By JERRY GEISEL

WASHINGTON—Requiring employers to offer group health care plans will increase health care inflation, lead to the loss of hundreds of thousands of jobs and make it more difficult for U.S. companies to compete in the international market, an economist says.

"By any measure, mandated benefits will be an expensive proposition for the economy," argues Norman Ture, president of the Institute for Research on the Economics of Taxation, an economic consulting firm in Washington, D.C.

But the chief author of legislation that would require all employers to provide health care coverage to meet minimum federal standards disagrees.

A federal health care mandate will increase costs, "but it is affordable and efficient," said David Nexon, a health care aide to Sen. Edward Kennedy, D-Mass.

Estimates of job losses from a federal health care mandate are exaggerated, Mr. Nexon said, adding that opponents have inflated the impact and cost of mandating employer-provided coverage.

"All estimates are not equal," Mr. Nexon said, adding that the Congressional Budget Office has put the job loss that could result from mandating employer-provided health care coverage at 60,000 to 70,000, a fraction of what opponents say the impact would be.

These differing views were expressed at a Jan. 10 health care symposium in Washington, D.C., sponsored by the Assn. of Private Pension & Welfare Plans, a benefits lobbying organization.

The symposium reflected the ongoing debate in Congress over whether the federal government should require companies to offer health care coverage to workers and their dependents.

Sen. Kennedy sponsored such legislation, S. 1265, during the last session of Congress. The proposal was approved by the Senate Labor and Human Resources Committee but never received a vote in the full Senate (*BI*, Feb. 22, 1988).

Sen. Kennedy is preparing new legislation, which could be introduced around the end of March, said Mr. Nexon, the primary draftsman of the Kennedy legislation.

Continued on next page

Benefits: Health Care Cost Control

Directory of Utilization Review Providers

On February 20 Business Insurance readers will benefit from our special feature issue on health care cost control. Editors will deliver hard facts and figures on how to control costs, focusing on some of the 'big ticket' health care items — prescription drugs, mental health care, and chemical dependency treatment costs.

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Kennedy bill debate

Continued from previous page

The latest Kennedy proposal is different from S. 1265 in at least one aspect: Small employers will receive unspecified tax breaks or subsidies for offering health care coverage, Mr. Nexon said, defining small employers as those with "under 25" employees.

But the new proposal is expected to follow the basic lines of the previous Kennedy bill. That measure, among other things, generally required employers to offer a health care plan with individual and family deductibles of $250 and $500. It also generally required employers to pay 80% of the premium for individual and family coverage and 100% of the premium for very low-wage workers.

Mr. Ture, a former senior official at the Treasury Department, argued that such a mandate will have a devastating effect on employment.

"We will have fewer jobs," Mr. Ture said, adding that companies will hire fewer lower-paid workers because of the high cost of providing health insurance to these employees.

Mr. Ture noted that a health insurance mandate would damage the nation's ability to compete internationally by increasing labor costs.

"This legislation will increase labor unit costs," Mr. Ture said.

But Mr. Nexon dismissed that argument, observing that companies most likely to compete overseas—big manufacturers—already provide generous health care coverage. At the same time, small companies, which would be most affected by a health care mandate because they either don't offer a plan or provide minimal benefits, often lack foreign competition.

Mr. Ture says a health insurance mandate would damage the nation's ability to compete internationally by increasing labor costs. 'This legislation will increase labor unit costs,' he says.

"You don't go to Tokyo to have your sink fixed," Mr. Nexon said.

Mr. Ture also warned that enactment of a federal health care mandate would add new fuel to the already roaring fires of medical care inflation by boosting the demand for health care services.

"It must increase the demand for services. . .but not the supply. Health care costs inexorably must go up," Mr. Ture said.

However, Mr. Nexon doubted that mandating employer-provided coverage would be inflationary. Additional medical care inflation would be unlikely when there is an oversupply of physicians and hospital beds in many areas of the country, he said.

In fact, an increase in demand for health care services would enable hospitals to make better use of underutilized medical equipment, Mr. Nexon said.

Mr. Ture predicted that a health care mandate would erode the federal tax base of billions of dollars in revenue, no small concern during an era of huge federal budget deficits. Presumably, revenues would be eroded because more employers would take tax deductions for health care expenses, lowering corporate taxable income.

Mr. Nexon said an employer mandate is the most efficient way of providing health care coverage. While there are costs that accompany a mandate, those costs are a small price to pay for expanding coverage to 23 million American workers and dependents not now covered under an employer plan, he said.

Finally, Mr. Ture asked whether the federal government has the right to dictate the content of an employer-provided benefit package.

"Health insurance is not a gift provided to employees. It is part of the pay package," he said.

Mr. Nexon countered that there is ample precedent in which the government has forced employers to pay for other benefits, citing Social Security, for which companies pay half the cost, and workers compensation programs.

"Our society is richer rather than poorer" as a result of those other mandates, Mr. Nexon said. ■

Hartford Steam, Gen Re form international venture

General Reinsurance Corp. and The Hartford Steam Boiler Inspection & Insurance Co. are forming a joint venture to provide property insurance and loss control services to companies located outside of North America.

The companies have signed a final agreement to form the Engineering Consulting Group, which will write property coverage and provide sophisticated engineering and loss control services to large companies in Asia, the Pacific, Europe and South America.

William Zindel, currently senior vp-underwriting and reinsurance at Hartford Steam Boiler, will head the new company.

Engineering Insurance Group is still in the process of being capitalized and should begin writing coverage in March.

For more information, contact Mr. Zindel at The Hartford Steam Boiler Inspection & Insurance Co., 1 State St., Hartford, Conn. 06102; 202-728-0570.

After March, Mr. Zindel can be reached at Engineering Insurance Group, Waterside 6 Office Park, Farmington, Conn. 06032.

Markets

CIGNA buys MCC Corp.

Hartford, Conn.-based CIGNA Corp. has acquired MCC Cos. Inc., a Minneapolis-based firm that provides utilization review services for mental health care.

MCC offers a range of psychiatric managed care services to employers and health maintenance organizations to help them evaluate patients' mental health care needs and monitor treatment (*BI*, Feb. 15, 1988).

MCC reported annual revenues of about $30 million in 1988.

MCC customers include more than 20 HMOs.

New financial reinsurer

Financial reinsurer Accord Re Ltd. plans to begin underwriting in Hamilton, Bermuda, next month with capital of $20 million.

The new reinsurer is a joint venture of New York-based Continental Corp. and two financial reinsurance specialists—Roger Beach, who for the past five years has run R.J. Beach Inc. reinsurance consulting in New York, and Stephen Edwards, president of First Reinsurance Intermediaries of New York.

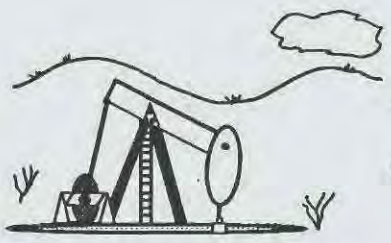
Mr. Beach, Mr. Edwards and Continental will each have an equity participation in the new reinsurer, although the shareholding structure has not been decided, said Mr. Beach, Accord Re president.

"Continental is going to be supporting the raising of initial capital of $20 million, which is there and ready to come in," he said.

Mr. Beach, who will underwrite for Accord Re, said he hopes to see Accord Re writing about $100 million in premiums during its first year.

New York-based Continental Reinsurance Corp., a Continental Corp. unit, has been involved in the formation of the new financial reinsurance underwriter.

"Accord Re marks our heightened interest" in writing financial reinsurance, said Continental Re President Nigel R.H.O. Harley. ■



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Rand litigation study

Continued from page 3

The study shows that a lion's share of product liability litigation is filed against defendants in three industries:

• Asbestos. Claims against asbestos industry defendants represented 20,888—or 24.4%—of the 85,694 cases filed during the period studied. However, these 494 companies comprised only 2.5% of the 19,456 lead defendants named in the suits under consideration.

And, asbestos litigation is growing rapidly, the study shows. Asbestos cases represented only slightly more than 1% of the federal product liability caseload in 1976, but grew to 7.7% of the total in 1979.

"In the 1980s, the volume of asbestos filings began to increase rapidly. . .and by 1986, asbestos cases comprised more than 44% of the entire federal product liability caseload," says Mr. Dungworth.

The defendants named in asbestos suits are changing, the study also points out.

In the early stages of the asbestos litigation explosion, the suits usually named asbestos producers as the lead defendants, the survey says. In fact, Mr. Dungworth says, "almost 98% of all cases filed between 1974 and 1983 were filed against major producers."

However, only 86% of the cases filed during the next three years named major producers as the lead defendants, while 14% named other defendants, such as asbestos installers or the owners of buildings where asbestos was installed.

"It can thus be seen that the asbestos net is being cast across a steadily rising number of companies," Mr. Dungworth says.

• Pharmaceuticals. Companies in the pharmaceuticals and health products industry were named as lead defendants in 11,292 federal product liability cases between 1974 and 1986, or 13.2% of the total suits filed, the study shows. However, only five companies were named as lead defendant in about 72% of those cases.

Continued on next page

Bigger liability risks alter business routines

By ALISON KITTRELL

The expansion of corporate liability is changing the way U.S. companies do business, a recent RAND Corp. study suggests.

"Legal liabilities represent an important behavioral influence on corporations—and one that is only partly captured in indemnity and defense payments," says Peter Reuter, author of "The Economic Consequences of Expanded Corporate Liability: An Exploratory Study."

For example, increasing environmental liabilities are changing the way companies dispose of hazardous wastes; increasing employer liability has prompted personnel management changes; and a recent surge in product liability litigation has prompted some companies to restrict innovation.

And, even though little substantive change is apparent in the area of directors and officers liability, many corporations are becoming more selective about who sits on their governing boards, according to Mr. Reuter.

The study, sponsored by RAND Corp.'s Institute for Civil Justice, does not draw conclusions on how such changes have affected economic growth, productivity and U.S. competitiveness.

Rather, the study attempts to quantify the costs and benefits of these trends through an examination of existing data and through interviews with individual officials and four focus groups.

Mr. Reuter explains that while the legal concept of liability exists to deter companies or individuals from taking potentially harmful actions, real questions arise about whether, in the attempt to stop certain potentially harmful occurrences, the expanded doctrines of liability cause other problems that may be equally or even more costly to society.

In focusing on four types of liability—environmental, employment related, product, and directors and officers—Mr. Reuter explains:

• The passage of the Comprehensive Environmental Response, Compensation and Liability Act in 1980—better known as the Superfund Act—and especially its provision for joint and several liability, greatly expanded the environmental liability of corporations in the United States.

"The extension of environmental liabilities has potentially far-reaching effects on corporate behavior," Mr. Reuter concludes.

First of all, "all the focus-group participants agreed that expanded environmental liabilities had made their firms more sensitive to the environmental impact of their decisions; the size of the potential liabilities was simply too large to be ignored," he said.

In addition, companies have begun to worry not only about their own environmental liabilities, but also about the potential liabilities of other companies with which they might be considering merger or acquisition activity. As a result, "Corporate acquisition decisions have also been affected," Mr. Reuter asserts.

And, companies have changed the way in which they dispose of their hazardous waste, according to the RAND study. Several companies for example, reported that they had centralized decisions about waste disposal that previously had been handled by individual plants.

And, Mr. Reuter notes that while expanded environmental liability may have some results that are beneficial to society, there are other results that are not.

"Of course, added care in waste disposal may have desirable consequences, but the net effect of joint and several liability on individual firms is far more complex," he says.

"Some large corporations, fearing exposure to liability stemming from negligence on the part of other firms, have decided to avoid mixing their wastes with those of other firms. This will tend to raise the cost of disposal unnecessarily (from society's point of view), since there will be too many disposal sites, and economies of scale will not be tapped," Mr. Reuter predicts.

• Beginning in about 1980, the courts have been increasingly likely to redefine traditional employee-employer relationships to benefit the employee.

Particularly, many states abandoned the employment-at-will theory, and now are requiring employers to meet certain procedural requirements before they can fire a worker.

The purpose of this expanded liability is to protect employees from unfair or discriminatory job treatment. But, Mr. Reuter says, there are other, less desirable, effects.

"First, employers may be hampered in their ability to adjust their employment levels expeditiously, since in many circumstances the new doctrine requires that employers follow fairly lengthy procedures before they may dismiss a worker," he says.

Also, "employer-employee relationships will become increasingly formal, with more paperwork created to ensure that any subsequent dismissal decisions can be justified."

Mr. Reuter notes that good employees still will leave their jobs for better opportunities; "it is primarily poor workers whose exit is impeded."

• There has been an unquestionable increase in the number and size of product liability cases being filed (see related story). Mr. Reuter says, "Apart from the possible increase in product safety, the expansion of corporate product liability may have affected corporate behavior in a number of ways."

Some companies, for example, have stopped doing business with other companies that cannot secure product liability insurance. This is especially detrimental for smaller firms, which have more trouble getting such coverage.

In addition, Mr. Reuter says, "The rate of product innovation may decline as well, since new products represent unknown hazards; more investment must be made in pinpointing those hazards and presenting the results to management and insurers."

• Problems obtaining D&O insurance have caused corporations to include more business people—rather than public officials or people outside the field—on their boards, the study shows.

In addition, corporate officials now document meetings more carefully and have increased the amount of information provided to their board members.

But, "in summary, we found little evidence suggesting that the growth of D&O liability, or even the drying up of insurance for such liability, had significantly affected the behavior of firms," Mr. Reuter says. "It may have induced some change in the composition of boards, but it seems less likely to have changed the boards' decision-making processes or the outcomes of those processes."

Mr. Reuter stresses that his study does not present any empirical evidence that expanded corporate liability is causing what opponents charge it is: impaired productivity, decreased product innovation and difficulty for U.S. companies to compete on an international scale.

But, he says, "The material presented here suggests that liability may have induced critical changes in the way firms carry out their business, if not in their outcomes (productivity, product variety, etc.). Yet we have only begun to explore the range of behavioral changes induced by expanded liability."

RAND is planning further studies in this area because, as Mr. Reuter says, "While we cannot quantify the effect of expanded liability on firm-level outcomes, let alone its aggregate consequences, the depth of the induced changes in firm behavior seems profound enough to suggest that such influence may be substantial."

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Copies of "The Economic Consequences of Expanded Corporate Liability: An Exploratory Study," are available for $7.50 each from the RAND Corp., Publications Department, 1700 Main St., P.O. Box 2138, Santa Monica, Calif. 90406-2138. Request number N-2807-ICJ.

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RAND study

Continued from previous page

For the five major defendants, cases peaked at almost 2,400 filed in 1985, and then fell off precipitously to about 600 in 1986, which can be attributed to cases involving the Dalkon Shield intrauterine device, manufactured by the A.H. Robins Co., and Bendectin, a morning-sickness drug linked to birth defects manufactured by Merrell Dow Pharmaceuticals. Both of these products have been removed from the market, and the litigation involving their use is ending its journey through the legal system.

The conclusion of the Dalkon Shield and Bendectin litigation likely will reduce the phenomenal number of product liability suits against pharmaceutical companies, Mr. Dungworth says, "unless other products such as the Dalkon Shield or Bendectin come along."

"This possibility cannot, of course, be ruled out. One of the most prominent characteristics of this industry is that large companies market certain drugs or pharmaceutical preparations that are widely used, sometimes by millions of consumers. If only a small percentage of these consumers experience injuries that they believe, rightly or wrongly, to be associated with the use of the product, an 'epidemic' of lawsuits can quickly ensue," Mr. Dungworth adds.

And, he notes that even among the non-major pharmaceutical defendants, product liability lawsuit filings have increased steadily to about 500 in 1986 from about 100 in 1974. The number of pharmaceutical companies being sued also has increased to 136 in 1986 from 71 in 1976.

• Motor vehicles. Automobile and other motor vehicle manufacturers accounted for 6,564, or almost 8%, of the product liability suits filed during the study period.

Almost two-thirds of these suits were concentrated among five major defendants: General Motors Corp.; Ford Motor Co.; Chrysler Corp.; American Motors Corp., which was acquired by Chrysler in 1986; and Honda Motor Co.

Suits against automakers have increased at an average rate of 9% a year, the study says, adding that the increase in the number of suits filed throughout the period—for both the major defendants and the industry as a whole—has been steady and the number of defendants has been stable, which contrasts with experience in the asbestos and pharmaceutical industries.

While Mr. Dungworth concedes that only three industries face an epidemic of product liability litigation, he still stresses that the number of product liability cases has continued to grow steadily each year during the survey and that the number of defendants affected by product liability cases also has grown steadily.

Specifically, the study notes that:

• Product liability cases filed between 1974 and 1986 represented 3.8% of the cases filed in federal courts during the entire period and about 5.3% of the cases filed in 1986.

However, Mr. Dungworth notes, "Product liability suits tend to involve substantially greater stakes and transaction costs than do other kinds of torts; as a result, they tend to have a greater impact on both plaintiffs and defendants.

"Product liability actions, on the average, have a larger number of plaintiffs associated with each suit than do other kinds of litigation."

• As might be expected, personal injury torts accounted for 87.7% of the product liability suits filed during the study period. However, 5.8% of the suits involved property torts, and 6.5% involved contracts.

• While a relatively few defendants were named in the majority of the suits affecting the asbestos, pharmaceutical and motor vehicle industries, the reverse was true in other industries.

In fact, cases against asbestos, pharmaceutical and motor vehicle defendants involve fewer than 1,600 defendants, while almost 18,000 defendants are spread across the rest of the industries.

"The most important general conclusion to be drawn from this research is that it makes little sense to talk about product liability litigation as if it were a homogeneous entity. It is not," Mr. Dungworth says.

"In particular, a distinction must be drawn between the tiny number of defendants named in thousands of suits and the thousands of defendants named only once or twice. The cases involving the former are the source of the view that a litigation explosion has occurred. . . .It is the litigation involving the thousands of rarely named defendants that supports the contention that product liability is an increasingly widespread phenomenon for U.S. businesses."

Mr. Dungworth concludes: "There are different worlds within product liability litigation. . . .Policy and law that is developed to deal with the situation must therefore take into account the complexities that exist in product liability lawsuits as well as recognize that a given approach may be suitable for one facet of the litigation but inappropriate for another."

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Copies of "Product Liability and the Business Sector: Litigation Trends in Federal Courts," are available for $7.50 from the RAND Corp., Publications Department, 1700 Main St., P.O. Box 2138, Santa Monica, Calif. 90406-2138. Request number R-3668-ICJ.

Guaranty fund

Continued from page 2

The State Farm suit seeks the return of only the $87 million, plus interest.

All three suits also seek return of assessments insurers have paid to make up for the shortfall created by the appropriation.

According to the Insurance Department, insurers can expect the quarterly guaranty fund assessments to continue through 1990.

"Unless the decision is ultimately reversed, the policyholders will eventually have to pay the additional cost" of the assessments, said Phillip Schwartz, vp-financial reporting and associate general counsel at the AIA.

Insurance groups' earlier efforts to block the 1982 appropriation of $87 million by the financially strapped state Legislature were unsuccessful (*BI*, April 19, 1982).

The state Court of Appeals ruled in 1985 the state did not have to return the money appropriated from the property/casualty guaranty fund, stating that the fund did not need the money (*BI*, March 4, 1985).

In granting summary judgment and dismissing the most recent suits earlier this month, Justice Kahn referred to a 1984 decision by the Supreme Court's appellate division that approved the state's appropriation of $190 million from the State Insurance Fund, the state's competitive workers compensation fund. The $190 million was taken at the same time as the $87 million appropriation from the guaranty fund.

The appellate division also had made a similar ruling against insurance industry plaintiffs in the property/casualty guaranty fund appropriation.

Both cases subsequently reached the appeals court, the state's highest court. That court, however, modified the appellate division's decision in the property/casualty guaranty fund case, ruling that the suit was "not then ripe for consideration."

In the State Insurance Fund case, however, the Court of Appeals supported the appellate division's argument, and affirmed its decision against Methodist Hospital of Brooklyn and other plaintiffs.

In that 1985 decision, the Court of Appeals ruled that the state work comp fund is a state agency. "The surplus being state money, the state could have simply taken it with no strings attached," the court said.

"By transferring $190 million from one state pocket (the State Insurance Fund) to another (the general revenue fund), the state has relieved the fund's commissioners of the necessity of exercising investment discretion with respect to part of the funds previously entrusted to them, but has done so in the exercise of its prerogative as owner of the surplus funds and, therefore, without infringing upon separation of powers."

The U.S. Supreme Court subsequently refused to consider the case.

In the most recent decision, the state Supreme Court said the Methodist Hospital decision is applicable to the insurers' suits in the guaranty fund case.

"This court agrees with those determinations and the principles of law cited therein," Justice Kahn said. "They are directly on point with respect to this new litigation, and mandate that summary judgment be granted in favor of defendants, dismissing all three complaints in the consolidated action."

The AIA's Mr. Lovendusky, however, disagreed that the two cases are comparable. The law that created the State Insurance Fund does not include a pledge of "safekeeping," which is in the law that created the property/casualty guaranty fund, he said.

And, while the State Insurance Fund, which is part of the state Labor Department, has many of the characteristics of a state agency, the property/casualty insurance security fund does not, insurers contend.

The Supreme Court gave "short thrift" to these arguments, said Mr. Lovendusky, adding he is confident the appellate court will decide to hear the case. It "won't be able to ignore it," he said.

"I think he (Judge Kahn) just punted because he knew it was going to be appealed anyway," said Mr. Foley. "I think he didn't review the case carefully. This is just, 'Get it upstairs.' "

Referring to the earlier Methodist Hospital decision, he said, "It certainly is not controlling in my opinion."

Meanwhile, a New York Insurance Department spokesman said the $45.7 million raised through May, August and November assessments of property/casualty insurers in New York state brought the guaranty fund's assets to $134.5 million as of year-end 1988.

The department spokesman said the amount of next month's scheduled assessment has not yet been determined. It will be based on the department's estimate of how much the fund must pay to policyholders of insolvent insurers, he noted.

Under state law, once the fund reaches $150 million at the end of any given year, assessments must continue for one more year to provide the fund with a cushion, the spokesman added. This means the assessments will continue at least through the end of 1990. ■

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Syndicate seeks recovery for U.S. losses

By CAROLYN ALDRED and STACY SHAPIRO

London

LONDON—Lloyd's of London syndicate 342, managed by Bankside Syndicates Ltd., is seeking damages from six subsidiaries of London broker C.E. Heath P.L.C. for failing to arrange adequate reinsurance protection for the syndicate's American casualty business between 1979 and 1984.

As a result of mounting U.S. liability losses, syndicate 342 has been forced to keep open its 1984 underwriting account, which was due to close in 1987 under Lloyd's three-year accounting system.

Syndicate 342 had a 1984 premium capacity of only 4.4 million pounds ($8.4 million at the year-end 1987 exchange rates). However, the syndicate reported total losses of 1.1 million pounds ($2.1 million at year-end 1987 exchange rates) as of Dec. 31, 1987.

The syndicate currently is negotiating a settlement with C.E. Heath, said a spokesman for Squire & Co., the London law firm acting for Bankside Syndicates. He would not specify how much the syndicate is seeking.

However, the syndicate also filed a protective lawsuit in London's High Court, seeking unspecified damages from the brokerage for misrepresentation, breach of duty and negligence.

The lawsuit was filed to prevent the statute of limitations from expiring. It will be served on C.E. Heath only if no settlement is reached before November, said the spokesman.

Named as defendants are C.E. Heath (North America) Ltd.; Heath Fielding Reinsurance Broking Ltd.; C.E. Heath Insurance Broking Ltd.; Heath Fielding Insurance Broking Ltd.; Heath Fielding LMX Ltd.; and C.E. Heath (U.K. Network Holdings) Ltd.

The six units "held themselves out as and continually represented that they were experts in the field of reinsurance of the type which the (syndicate) would require in respect of (American casualty) risks when, as the (brokers) ought to have known, they were not," the suit claims.

The brokers "represented that the reinsurance cover which they obtained for (the syndicate) was appropriate to deal with (its) liabilities. . .when it was not."

In particular, the lawsuit claims that the brokers:

- Placed coverage with reinsurers that the brokers "ought to have known, would not or could not provide any or any adequate security."
- Advised the syndicate to enter into contracts of reinsurance that failed to include "provisions necessary to ensure full and adequate cover against" the liabilities.
- Failed to obtain "any sufficient or adequate or appropriate 'runoff' reinsurance cover at any time and, in particular, following cessation of the contracts of reinsurance in December 1984."
- Failed to act "with the care and skill reasonably to be expected of an expert or any reinsurance broker" about obtaining reinsurance to cover the syndicate's liabilities and advising the syndicate "on a continuing basis."

Energy risks

London marine underwriters should change the way they write insurance for energy companies in the aftermath of the massive Piper Alpha North Sea oil rig loss, according to a report by The Mercantile & General Reinsurance Co. P.L.C.

The oil rig exploded last July, killing 167 people and injuring 62 others (*BI*, July 11, 1988). About 80% of the total loss, which is estimated at between $1.2 billion and $1.5 billion, eventually will be paid by the London insurance market through reinsurance collections, the report says.

The rest of the loss is spread among the U.S. market, with about 5% of the risk; the Scandinavian market, with about 5%; and the rest of the world market, with about 10%.

"A major disaster is very often the catalyst for change," the report says.

An increasing amount of energy insurance has been written as package policies by London marine insurers, the report says. These policies include risks in which marine underwriters "have less technical experience," including business interruption, on-land property damage and third-party liability risks for plants engaged in dangerous chemical processes.

And, the energy insurance packages "have not always been correctly priced, considering the amount of cover given," and intense competition has prevented underwriters from introducing adequate rates, the report says.

"If the protection (that the oil industry) needs is to continue to be provided by the insurance industry, insurers need to make a return on their business," the report says.

Changes that may be required include covering energy risks in a new and "completely separate market."

The Mercantile & General report also expressed concerns about the effect of the Piper Alpha loss on London's excess-of-loss reinsurance market.

While total capacity for the energy insurance and reinsurance market is often quoted at $2 billion to $3 billion, the genuine capacity is "more realistically $150 million to $200 million if the actual net retentions after all outward reinsurance of all underwriters are added together," the report estimates.

"If through its very success the LMX market is not to choke itself to death, some solutions will need to be found," the report says.

AGF in London

Assurances Generales de France, one of France's largest insurance companies, has established a London-based insurer to write international property and liability insurance and facultative reinsurance.

The formation of AGF London Ltd., with an authorized share capital of 50 million pounds ($88.8 million), "is a significant move in AGF's strategy of positioning itself in the key international insurance markets in the lead-up to European deregulation" in 1992, the company says.

"AGF International is making local offices in various European countries into subsidiaries to show commitment to the local markets," said Richard Sell, non-marine manager for AGF London Ltd.

AGF London, which began underwriting Jan. 1, is a direct subsidiary of AGF Holdings (U.K.) Ltd., the London-based holding company set up by state-owned AGF last year to oversee its U.K. operations.

AGF has been writing insurance in the London market for more than 30 years through a branch office. Last year, it acquired personal lines insurance company Sentry (U.K.) Ltd. and its subsidiary, City of Westminster Assurance Co., both now based in Milton Keynes, England.

AGF London Ltd. will write new non-marine business and will operate in conjunction with AGF's London branch, which will write marine business and non-marine renewal business.

No-fault fund

Many British patients who suffer injuries during medical procedures could seek compensation from a no-fault fund financed by physicians and state-financed health authorities without having to prove negligence, according to proposals outlined by the British Medical Assn. this month.

The medical profession currently spends about 90 million pounds ($159.8 million) a year on medical malpractice insurance premiums, "of which less than 50% actually reaches damaged patients" in the form of compensation, said David Bolt, chairman of a BMA working party on no-fault compensation. The BMA represents practicing physicians in the United Kingdom.

"Evidently, there is a substantial margin for improvement in the application of the profession's money if the element of litigation could be reduced in favor of providing help in a non-adversarial manner for those with real need," said Mr. Bolt at a Jan. 13 conference in London sponsored by the BMA and the Royal Society of Medicine.

The no-fault compensation fund would reimburse victims of a medical accident for financial loss or expenses incurred because of injury. However, the system would exclude compensation for certain types of damages, like psychological damage and injuries due to the natural progression of disease for which the patient was already receiving treatment.

Global cover survey

About 70% of Britain's multinational companies have global insurance programs, according to a survey conducted for Alexander Stenhouse U.K. Ltd., a British subsidiary of Alexander & Alexander Services Inc.

But only 18% of the companies responding to the survey have global programs that include each of the five types of insurance surveyed: property, business interruption, liability, fidelity, and marine insurance.

The survey, published this month, was conducted by the research department of Michael Forsyth Ltd., which canvassed the United Kingdom's top 500 multinational companies about their global insurance programs.

Global coverage is defined in the survey as "a centrally directed and coordinated insurance program controlled from corporate headquarters for a company with one or more overseas subsidiaries."

According to the study, 83% of the companies that reported overseas revenues of more than 100 million pounds ($177.6 million) have some form of global coverage, compared with 75% of companies with overseas revenues of between 50 million pounds ($88.8 million) and 100 million pounds and only 42% of companies with overseas revenues of less than 50 million pounds.

About 30% of the companies that have global coverage have some form of captive participating in their multinational insurance program, according to the survey.

Of those companies with no global insurance program, 40% claim they have "insufficient exposure to warrant this type of cover." However, 25% of those with "insufficient exposure" have overseas revenues of more than 100 million pounds, and 15% pay international insurance premiums of more than 500,000 pounds ($887,750).

Another 25% of companies without a global program said "the need to give insurance autonomy to local management" was the main reason, while 20% admitted the main reason was "inertia."

Nearly 50% of the companies with overseas revenues of more than 100 million pounds pay global property/casualty insurance premiums of more than 1 million pounds ($1.8 million).

All companies with overseas revenues exceeding 100 million pounds placed coverage with more than one insurer.

The leading global insurers of the survey respondents are CIGNA U.K. Holdings Ltd.; General Accident Fire & Life Assurance Corp. P.L.C.; the Guardian Royal Exchange P.L.C.; Lloyd's of London syndicates; Royal Insurance P.L.C.; Sun Alliance & London Insurance P.L.C.; and Zurich Insurance Co.

The London-based insurance brokers used most frequently by the companies in the survey are Alexander Stenhouse; C.T. Bowring & Co. Ltd.; Sedgwick Group P.L.C.; and Willis Faber P.L.C.

Comings & goings

David P. Trezies has been appointed chairman of Sedgwick Aviation Ltd., succeeding **Geoffrey A. Hargreaves**, who remains a senior director of the company.

Geoffrey A. Barnard and **Graham C. Pickering** have joined Alexander Howden Ltd. as directors of the North American division. Both men, who specialize in North American commercial automobile insurance and trucking business, previously worked for PWS Holdings P.L.C. **Lesley J. Barratt** and **Michael J. Warwicker** have both been promoted to directors of the department. ■

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EFP's health plan

Continued from page 1

health plan, even though many experts warn small employers against self-insurance.

After implementing its health care cost containment program for the plan year beginning Nov. 1, 1986, EFP's health care claims costs decreased by $90,000—or 30%—over two years to $210,000 for the 1987-88 plan year from $300,000 for the company's 1985-86 plan year, even though its number of employees increased by 30%.

Thus, EFP's average health care claims cost per employee dropped 43.1% to $913 for the latest plan year from $1,604 for the 1985-86 plan year, an average savings of $691 per employee.

EFP's health care cost savings are quite an accomplishment in an era when many employers' health care costs are increasing 20% to 50% or more, with small employers usually facing the greatest increases, observed Charles S. Speas, corporate director of personnel for EFP, who devised the plan without the aid of a benefits consultant.

"This new plan did two things for us: First, it helped employees think about how they were going to spend their health care dollars. And second, it made employees think twice before over utilizing health care" or receiving basic health care in an inappropriate setting, like a hospital emergency room, Mr. Speas said.

"Everything in this plan goes hand in hand. Employees can get some financial assistance when they need it. But, they have to use this wisely. It puts the responsibility on the employee to search out the most cost-effective, but quality, health care," he said.

EFP first took action to control its health care costs in 1979, when the company began self-insuring its health care plan after researching the causes of health care inflation and its effects on EFP's costs.

"We looked at what was going on in the industry and our own group," Mr. Speas explained. "I know my people very well, since I do a lot of claims analysis. We wanted to pay for health care based on our own claims experience, so we made the switch to self-insurance."

Often, small employers that purchase group health insurance from commercial insurers pay premiums based on the claims experience of a pool of small employers.

There was one hitch to EFP's plan to self-insure: Because EFP had only 100 employees, finding a third-party claims administrator interested in servicing a small group was not easy, Mr. Speas recalled.

However, the company happened upon Indianapolis-based Independent Benefit Plans Inc., a TPA that was expanding its business, he said. IBC still administers EFP's claims.

Lincoln National Life Insurance Co. of Fort Wayne, Ind., underwrites specific and aggregate stop-loss insurance for EFP. The coverages attach at $25,000 and $340,000, respectively.

The switch alone to a self-insured plan generated some savings for EFP for a couple of years, even though the plan covered nearly 100% of employees' and dependents' health care costs after a $100 per-person annual deductible. Employees had to pay some small copayments for a few services and the plan capped employees' annual out-of-pocket expenses at $1,000.

"But, then inflation in excess of 10% to 12% caused our claims costs to grow," Mr. Speas said.

Health care claims costs under the plan, which totaled $235,000 in 1984-85 plan year, were steadily rising. Halfway through the 1985-86 plan year, claims costs totaled about $170,000 and were headed toward $300,000, a 27.7% increase from the year before, he said.

"Self-insurance gave us more control over the plan, but we wanted to take a different approach," Mr. Speas said.

But, merely increasing employees' annual deductibles under the plan was not an answer. And, requiring employees to contribute to the premium—which EFP had never done—would not work, he said.

In addition, implementing a mandatory utilization review program would not be palatable to both EFP and its employees. "The thing that bothered me about mandatory cost containment was that it creates a lot of friction" between employees, the company and physicians, Mr. Speas explained.

However, EFP wanted employees to share in the health care costs. This was necessary not only to contain costs, but also to force employees to think about the cost of health care and how they utilize health care, Mr. Speas said.

In November 1986, EFP introduced several changes in the health plan to achieve these goals.

EFP eliminated both the annual deductible of $100 per person and 100% coverage after the deductible. Instead, the company began requiring employees to pay a 25% copayment on each claim, up to a annual out-of-pocket cap of $2,000 per person or family.

"Deductibles can keep people from going to a doctor until they really have a serious illness. So, we thought that if we offer some financial assistance up front, this might prevent a $5,000 claim from happening," he said. "Plus, if employees started picking up some of their claims costs, I thought they would start using their heads about receiving health care."

EFP still does not require employees to make monthly contributions toward the cost of their health care coverage for either individual or family coverage.

The plan does not include a utilization review program. But, when catastrophic cases involve costs that exceed the attachment point of EFP's specific stop-loss insurance, the cases are subject to case management by Lincoln National.

The plan generated immediate, dramatic savings.

In the 1986-87 plan year, the first year the new plan was in effect, health care claims costs dropped 30.3% to $209,000 for 214 employees from $300,000 in 1985-86, when the company employed 187 workers. The average health care claims cost per employee dropped 39.1% to $977 in 1986-87 from $1,604.

Health care claims costs increased only 0.5% to $210,000 in 1987-88 for 230 employees, meaning that health care claims costs per employee dropped 6.5% to $913.

The plan design changes are not the only contributors to EFP's savings, Mr. Speas pointed out.

Since 1987, the company has had preferred provider arrangements with three area clinics, he said.

"This is not a formalized PPO. But, we wanted to recruit some clinics to offer us discounts. This way, we could encourage employees to stay away from hospitals unless really necessary," he said.

The clinics offer EFP 10% to 15% fee discounts.

To encourage employees to use the clinics, EFP has worked out a billing arrangement with the clinics under which employees pay only their 25% copayment at the clinic. Then, the clinic bills EFP for the remaining charges, eliminating the need for employees to file claim forms.

EFP's savings prove that employees are using the preferred clinics, he said. "In 1987, which was the first year we offered this, we saved $5,000 on health care costs" related to physicians' fees.

"In 1988, the program saved us $17,000."

Mr. Speas disputed the theory that small employers usually cannot negotiate their own PPO arrangements. EFP is "in a position to negotiate," he said, pointing out that the company has 750 lives—including employees and dependents—"that can be encouraged to use these clinics."

Two years after its introduction, both EFP and its employees are pleased with health care plan, Mr. Speas said, attributing its success to several factors.

"First of all, we had confidence in our people and communicated well our objectives under the new plan. We instilled in employees the fact that they still had a good, healthy plan that provided them with financial assistance," he explained.

EFP communicated to employees through a detailed memo that pointed out that both the company and its employees would have to control health care costs to ensure the future profitability and success of EFP.

The memo included examples of expenses employees would pay under the new cost-sharing arrangement, as well as an explanation of the company's increased health care expenditures.

The simplicity of the new plan also contributed to employees' acceptance, he said.

Indeed, one employee benefit consultant notes that the plan's simplicity is a great advantage.

"This is a nice, simple plan that is easily understood and easily communicated to employees," said David P. Rahill, a vp with A. Foster Higgins & Co. in Princeton, N.J.

"I think it's to this company's credit that they did something innovative on their own like this. Small employers usually buy specialty products from insurers," he noted.

More employers are interested in increasing employee copayments while eliminating deductibles, pointed out Joseph Rosmann, a partner in the actuarial, benefits and compensation practice of Coopers & Lybrand in Chicago.

"From an actuary's standpoint, if you go back to what the concept of a deductible is all about, it's that if you can get employees to pay for small things on their own, you reduce the number of claims. And, that reduces administration," he explained.

But, "if you put this plan design in the context of what HMOs have always done, it's not that different," he said. Health maintenance organizations do not typically impose an annual deductible, but many require some copayments.

"I think, in terms of cost containment, the idea of having a strong coinsurance feature with a big annual out-of-pocket expense is a good one. But, I wouldn't advise small employers to self-insure their plans," said Lance Tane, chairman of the group and flexible benefits practice for The Wyatt Co. in New York.

"One big claim in a group this small could really expose the employer to a big risk," he explained, adding that adequate limits for stop-loss coverage are essential for small self-insured employers. ■

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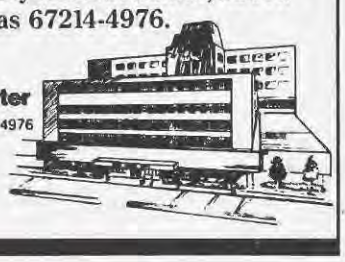
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Bond dispute

Continued from page 1

the bonds, and the State Supreme Court last month refused to grant INA a stay while the injunction is being appealed.

Meanwhile, the U.S. Attorney for the District of Rhode Island in Providence is investigating Mr. Reilly for allegedly pocketing the Navy bond premium and making false statements to the U.S. government, confirmed U.S. Attorney Lincoln C. Almond.

The investigation, which began last November, could involve violations of federal mail fraud statutes, Mr. Almond said.

Mr. Reilly could not be reached for comment on this story. His attorney, Marc DeSisto of the Providence firm of Carroll, Kelly & Murphy, declined to comment.

In his answer to Derecktor's complaint, Mr. Reilly charged that Derecktor "had full knowledge" of his actions.

Mr. Reilly, a former Rhode Island Democratic Party chairman, was a top producer for Frank B. Hall and was featured last fall in Hall advertisements that pointed out his selection by Inc. magazine to serve on the magazine's insurance advisory panel.

The ads, headed, "National Spotlight on Our Mr. Reilly," praised him for "personal, technical and creative leadership."

However, court papers filed by Derecktor and cross-claims filed by Hall and INA paint a different picture of Mr. Reilly, who was fired by Hall after the bond problems came to light.

Derecktor says in its complaint, filed last September, that it entered a contract with the Navy in January 1988 to build two tugboats, with the Navy holding options to order 10 additional boats. The contract required Derecktor to maintain performance and payment bonds naming the Navy as obligee.

Derecktor—which also placed its general liability, workers compensation and other insurance coverages through Hall—subsequently received INA performance and payment bonds in the amount of $2.5 million, apparently signed by Marilyn Spooner, a Hall employee who had been granted power of attorney by INA.

After receiving an invoice, Derecktor issued a check for $82,736 to "Charles T. Reilly (Attorney-in-Fact), INA, Bond Escrow Account," according to Derecktor's complaint. Mr. Reilly, who acted as Derecktor's broker, endorsed the check as "Attorney-in-Fact (INA)" and deposited it in an account at Fleet National Bank in Providence, the complaint and attached documents show.

Though the complaint does not elaborate on this charge, lawyers involved in the case say the bank account into which the premium was deposited was not an escrow account but a personal account of Mr. Reilly's. After questions about the bonds surfaced, Mr. Reilly returned the money to Hall, which then tried unsuccessfully to tender it to INA, lawyers say.

Meanwhile, Derecktor was negotiating with Lockheed to take over the company's shipyard in Savannah, Ga., along with a contract to build 39 landing craft utility boats for the Army. As a prerequisite to accepting a bid from Derecktor, Lockheed required a bid bond, the complaint notes.

In May 1988, Derecktor obtained an INA bid bond from Hall in the amount of $8.7 million, apparently signed by David H. Chase, another Hall employee with power of attorney for the insurer, the complaint indicates.

No premium was necessary because surety companies often do not charge a premium for bid bonds, assuming they will write the subsequent bonds after the contract is awarded.

Derecktor also obtained a "letter of commitment"—also apparently signed by Mr. Chase—agreeing that INA would issue performance and payment bonds if Derecktor succeeded in taking over the Lockheed shipyard and its Army business, the complaint says.

However, INA was not aware of any of the bonds until June 1988, when a Navy contracting officer wrote to the insurer directly to notify it that the Navy was exercising an option for additional tugboats and wanted to increase the amount of the bond, court papers say.

INA then conducted an internal investigation and wrote to Derecktor on Aug. 25, 1988, that the Navy bonds were unauthorized and would not be honored.

In a separate Aug. 25 letter to the shipbuilder, INA said it also would disclaim liability on the Lockheed bonds.

In addition to seeking an injunction barring INA from refusing to honor the bonds, Derecktor's lawsuit charges INA with breach of contract and negligence and Hall with breach of its obligations, negligence and fraud.

The complaint also charges Mr. Reilly with fraud for allegedly misappropriating the $82,736 Navy bond premium.

INA, Hall and Mr. Reilly have each denied Derecktor's allegations, and INA and Hall each have filed cross-claims against the other defendants.

In a cross-claim against Hall and Mr. Reilly, INA charges that Mr. Reilly "fraudulently forged or procured the forgery of the signatures" of Ms. Spooner and Mr. Chase on the Navy and Lockheed bonds.

Ms. Spooner and Mr. Chase—who were dropped from Derecktor's lawsuit after being named as defendants—testified in depositions they did not sign the bonds and did not know how their purported signatures ended up on the documents, according to court papers filed by INA.

Mr. Reilly once had held power of attorney for INA on bond business, but INA revoked this power in 1984 after Mr. Reilly allegedly exceeded his authority, court papers say. Mr. Reilly did not have power of attorney for the insurer at the time the Derecktor bonds were issued, court papers indicate.

Mr. Reilly refused to answer questions in a deposition.

But, others testified that Mr. Reilly claimed to have signed Mr. Chase's name because of "stress" and "pressure" he was experiencing, INA court papers say.

Mr. Reilly claimed that he received "threatening phone calls from third parties" relating to issuance of the bonds, INA court papers say.

In his answer to Derecktor's complaint, Mr. Reilly claimed "duress" as a bar to the allegations against him, without providing any more specifics.

Separately, Hall has filed cross claims against Mr. Reilly and INA, charging Mr. Reilly with "willful, intentional and unauthorized breach" of his employment contract with Hall and seeking indemnification from Mr. Reilly and INA if Hall is found liable to Derecktor for any damages.

Hall does not state in the cross claim why INA should be liable for any damages.

Hall has notified its fidelity and its errors and omissions insurers about the Derecktor claims, according to Blair C. Fensterstock, senior vp and general counsel for Hall. Mr. Fensterstock said that the company's fidelity and E&O limits are more than adequate to cover any potential liability.

The various charges and countercharges have remained pending while Derecktor and INA have battled over Derecktor's request for an injunction against the insurer.

In court papers filed in support of the injunction, Derecktor argued that Hall was indisputably an INA agent with power to bind the insurer and that the bonds should therefore be honored.

Even if Ms. Spooner's and Mr. Chase's signatures were forgeries and Mr. Reilly did not actually have a power of attorney for INA, the bonds are still valid because Mr. Reilly had "apparent authority" to bind the insurer, Derecktor argued.

Revoking Mr. Reilly's power of attorney did not prevent him from issuing bonds, Derecktor claims. INA continued to provide Hall with bonding instruments to which Mr. Reilly had unrestricted access despite his "past indiscretions," Derecktor argued.

Thus, "INA knowingly permitted Reilly to assume the exercise of authority as an agent of INA," the shipbuilder said.

Sloppy administrative controls at INA allowed the Derecktor bonds to be issued in the first place, Derecktor charged. Until last summer, when INA revised its procedures, the insurer had no system in place for keeping track of hundreds of powers of attorney issued to Hall and other bond producers, "a system more akin to issuing hundreds of signed blank checks," Derecktor observed.

If INA had monitored the use of these forms more carefully, the damages to Derecktor would have been prevented. Thus, INA should be barred from disputing the bonds' validity, Derecktor argues.

"INA has made its bed and it should sleep in it," the company said.

But, INA denies that Mr. Reilly had any actual or apparent authority to issue the bonds or that INA had done anything to ratify the bonds' validity.

INA contends that Hall did not submit the bonds for approval before issuing them as required.

Superior Court Judge John E. Orton III ruled in Derecktor's favor on Nov. 2, 1988, issuing a preliminary injunction barring INA from disclaiming liability on the Navy and Lockheed bonds.

On Dec. 1, the State Supreme Court refused to stay the injunction pending an appeal, though the court noted that the issue of an injunction relating to the Lockheed bonds was moot because the Lockheed business destined for Derecktor had recently been awarded to another shipbuilder.

Derecktor lost the business to New Orleans-based Halter Marine Inc. because of questions about the INA bonds.

The injunction has allowed Derecktor to go forward with construction of two Navy tugboats, according to the shipbuilder's lawyer, Christopher H. Little, of the Providence firm of Tillinghast, Collins & Graham.

However, it is unclear whether the Navy will exercise its options for additional boats, he said.

The failure of the Lockheed deal, meanwhile, has resulted in about $15.8 million in lost profits and $400,000 in other costs for Derecktor, Mr. Little said.

Lockheed itself also has suffered "substantial losses" because of the failure of Derecktor's bid and is now considering options for recovering those losses, including filing lawsuits against INA and Hall, according to a Lockheed official.

•

Associate Editor Michael Schachner in New York also contributed to this story.

Georgia must release IRIS data: Court

ATLANTA—The Georgia Insurance Department must turn over 1987 Insurance Regulatory Information System data to an Indiana insurance professor and newsletter publisher, a Fulton County Superior Court judge ruled.

The department is reviewing the Jan. 10 decision and has 30 days to decide whether to appeal, said Kirkland McGhee, an assistant attorney general representing the Insurance Department.

The ruling is part of a continuing legal dispute involving the efforts of Joseph Belth, a professor at Indiana University in Bloomington, to obtain current IRIS data from the National Assn. of Insurance Commissioners (*BI*, Nov. 23, 1987; July 20, 1987).

Mr. Belth first received IRIS information in 1987, when a District of Columbia Superior Court judge ordered it released.

Last spring, Mr. Belth requested IRIS information from nearly all states under their public information laws. While nearly all other states refused, Georgia filed suit last summer, asking the court to issue an order protecting the information.

The state argued that if the information were not protected, the department would be cut off from receiving future IRIS information, in accordance with an NAIC policy.

For the first time last fall, the NAIC voluntarily released its statistical analysis of insurer finances (*BI*, Sept. 19, 1988). However, because the NAIC released only limited analytical information, critics have questioned its usefulness.

—By Meg Fletcher

Around the states

Florida MET fails

TALLAHASSEE, Fla.—A self-insured multiple employer trust in Florida that provided health care insurance for around 3,000 workers is the eighth such plan in the state to fail in the last two years.

A spokeswoman for the Florida Department of Insurance said the Florida Customs Brokers & Forwarders Assn. Inc. Health Trust was declared insolvent last month. Figures released by the Insurance Department showed the trust with a $605,972 deficit.

According to the department spokeswoman, the trust was the latest victim of the rising cost of health care. "They weren't able to keep premiums up with escalating health care costs," she said.

Inadequate management also contributed to the trust's demise, the spokeswoman remarked.

"Many times the multiple employer welfare arrangements are not run by insurance people, so they don't have the ability to judge when they are getting into trouble" and do not raise rates in time, the spokeswoman said.

The trust provided health care benefits for workers at around 180 companies, according to the Insurance Department.

AV-Med Inc., a Miami-based health maintenance organization, now provides coverage for employees previously covered by the trust.

—By Michael Bradford

Illinois high-risk plan

SPRINGFIELD, Ill.—Illinois Gov. James Thompson is expected to sign a supplemental budget bill approved by the Legislature earlier this month that would fund Illinois' medical insurance program for high-risk individuals.

The measure allocates $5.8 million to fund the Comprehensive Health Insurance Plan through June 30.

Of that, $4 million would pay losses and claims expenses that exceed enrollees' premiums.

Coverage should be available by mid-April for at least 2,500 enrollees, said Richard W. Carlson, deputy state insurance director.

The state is expected to continue funding the program, according to Mr. Carlson. A new bill, S.B. 12, requests $12 million in funding for fiscal 1990, Mr. Carlson said.

Although CHIP-enabling legislation was signed in February 1987, its implementation was delayed by funding disputes (*BI*, July 11, 1988).

CHIP is the only one of 15 approved state insurance plans for the uninsured that uses general revenues to finance any shortfall anticipated from participants' premiums. Most states assess health insurers to pay the shortfall and offer those insurers some type of a tax credit (*BI*, Feb. 1, 1988).

—By Meg Fletcher

Illinois claims rules

SPRINGFIELD, Ill.—The Illinois Insurance Department implemented tougher rules to halt improper claims practices earlier this month.

All property/casualty and life/health insurance companies are prohibited from using polygraph tests in claims investigations, under the new rules.

In addition, insurers are required to follow additional minimum standards in the investigation and disposition of consumer claims, including:

- To pay claims in a timely manner, including those portions of any claim not in dispute.
- To report to the Insurance Department if any court has ruled that the insurance company is guilty of "vexatious" or unreasonable delay.

Because this was not previously required, the department sometimes was not informed of such court rulings, said Michael Hessler, the department's chief examiner for market conduct.

"The changes have been made to ensure greater protection for insurance consumers in the settlement of their claims with insurance companies," Insurance Director John Washburn said in a statement.

In addition, the department implemented new procedures that insurers of private passenger vehicles must follow to guarantee that owners' rights are better protected, especially when a car is declared a total loss.

For example, insurance companies are now required to provide each policyholder with a copy of a department guide on consumers' rights within seven days of the insurer's determination that a vehicle is a total loss.

The department has not seen a need to extend the requirements to commercial vehicle insurers, Mr. Hessler said.

—By Meg Fletcher

Underground tanks

Continued from page 3

or marketing must buy EIL insurance with limits of at least $1 million per claim.

Owners or operators of 100 or fewer tanks must buy at least $1 million in aggregate limits, while owners or operators of more than 100 tanks must purchase $2 million in limits.

Owners or operators of underground petroleum tanks with a monthly throughput of less than 10,000 gallons or those not used in petroleum production, refining or marketing must buy EIL insurance limits of $500,000 per claim/$1 million aggregate.

The EPA rules specify that the EIL policies must provide "first-dollar coverage" in the event of a tank leak, meaning an EIL insurer must immediately respond to a claim by a policyholder even if the policyholder has not satisfied its deductible under the terms of the policy. However, an insurer may recover a deductible after cleanup begins.

Also, the rules state insurers must give at least 60 days' notice before cancellation.

The EPA defines petroleum marketing firms as those engaged in petroleum production, refining or marketing. This includes companies that sell or transfer petroleum to other petroleum marketers or to the public, such as automobile service stations, marine service stations, truck stops and convenience stores selling gas.

However, companies that store petroleum products in underground tanks for the sole purpose of refueling their own fleet of vehicles are not considered petroleum marketing facilities. Also, firms that store gasoline for the sole purpose of refueling vehicles rented to the public, such as car rental firms, are not considered petroleum marketing facilities as long as the fuel is not sold to the general public.

Among the EIL markets that write coverage for owners and operators of underground tanks are two new risk retention groups, Petroleum Marketers Mutual Insurance Co., known as Petromark; and Environmental Protection Insurance Co. (*BI*, Aug. 8, 1988).

Petromark, which reported $8.2 million of capital and surplus at year-end 1988 and is managed by The Planning Corp. of Reston, Va., offers a claims-made EIL policy that fulfills all of the EPA's financial responsibility requirements.

The average annual premium is $2,000 per site, with a $5,000 deductible, said Max Clay, president of Planning Corp.

Almost 1,000 petroleum marketers have purchased Petromark EIL policies since it began operations in February 1988, Mr. Clay said.

EPIC, which was capitalized at $10 million in August and is managed by a Chicago office of Dallas-based Berkeley Risk Retention Group Managers Inc., also offers a claims-made EIL policy that fulfills the EPA's financial responsibility requirements if certain endorsements are added.

For example, although the policy limits are $1 million per claim/$2 million aggregate, defense costs are included within the policy limits. However, defense costs can be covered outside of policy limits through an endorsement to comply with EPA requirements, noted Charles LaBarge, president of Berkeley Risk Retention Group Managers. The cost of the endorsement is a based on a percentage of premium that varies with the amount of limits purchased.

Also, the policy is being rewritten to cover on-site cleanup costs. Because of this, Mr. LaBarge declined to estimate an average premium cost. The minimum deductible is $25,000.

Mr. LaBarge said he expects underground tank policies eventually to account for 40% to 50% of EPIC's total business.

Since the risk retention group began writing EIL coverage a few months ago, it has received about 500 inquiries but has written only five policies, Mr. LaBarge said.

Two new stock insurers—both subsidiaries of Front Royal Group Inc. of McLean, Va.—expect to begin writing EIL policies this year for owners and operators of underground petroleum tanks, said Myra Anderson, assistant vp of Environmental Insurance Management Inc., an underwriting management and consulting firm in McLean, Va.

One of the new insurers, Front Royal Insurance Co., will be licensed in Virginia and will write coverage only for owners and operators with underground tank facilities in Virginia. The other new insurer, Front Royal Surplus Lines Insurance Co., will seek approval to write the coverage on a surplus lines basis in other states, Ms. Anderson said.

Front Royal Group expects that the combined capitalization of the two insurers will be between $20 million and $25 million, but Ms. Anderson could not provide details about each company's individual capitalization.

Policy limits of the companies' claims-made coverage, which is designed to fulfill the EPA's requirements, will be $1 million per claim/$2 million aggregate. The minimum deductible will be $25,000.

The annual premium for a petroleum marketer with three to five underground tanks in one location would be approximately $3,800.

Owatonna, Minn.-based Federated Mutual Insurance Co. will write EIL coverage for underground tanks if a policyholder purchases other property/casualty coverage from the insurer, said Jeanne Hankerson, environmental coordinator.

Federated's current EIL policy does not fulfill the EPA's financial responsibility requirements, but the insurer is developing a policy that will, she said.

The limits of Federated's current claims-made policy are $500,000 per claim/$1 million aggregate. In most states, the minimum deductible is $25,000.

EIL coverage for underground tanks from other commercial insurers is far more limited in light of PLIA's demise.

For example, Detroit-based Michigan Mutual Insurance Co., which in the past has insured underground tanks, will not issue new policies without PLIA's backing, said Louis Solomon, vp and underwriting manager.

Houston-based Ranger Insurance Co., a PLIA member that also has insured underground tanks, 'does not currently underwrite pollution liability insurance," said a company spokesman. He declined to elaborate.

And, Boston-based Liberty Mutual Insurance Co., which had been a member of PLIA until a few years ago, writes EIL coverage for underground tanks for existing policyholders but will not write new business, a spokeswoman said.

Also, two companies that write general EIL coverage have decided—for the time being—not to write the coverage for underground tanks.

A spokeswoman for AIG, the largest U.S. EIL insurer, said the company is evaluating "the viability of being a market for underground tanks" but is not now writing the coverage.

And, Environmental Compliance Services Inc. will not write coverage for underground tanks and does not have plans to enter the market, said an official of the Downingtown, Pa., underwriting manager for New York-based Reliance National Risk Specialists, an underwriting division of Reliance Group Holdings Inc.

Concerns over the limited market for EIL coverage for underground tanks are increasing since some companies must comply with the EPA rules this week.

Owners or operators of underground petroleum tanks must comply with the financial responsibility rules over a two-year period, depending on the size and the number of tanks owned or operated.

All petroleum marketing firms that own or operate 1,000 or more underground tanks and other underground tank owners or operators with a net worth exceeding $20 million must comply by Tuesday.

Petroleum marketing firms that own or operate between 100 and 999 underground tanks must comply with the financial responsibility rules by October 1989.

Petroleum marketing firms that own or operate between 13 and 99 underground tanks that are located at more than one facility must comply with the rules by April 1990.

Petroleum marketing firms that own or operate 12 or fewer underground tanks located at more than one facility or firms that own or operate only one facility with fewer than 100 underground tanks must comply with the rules by October 1990.

Owners or operators of underground tanks that are not petroleum marketing firms and that have a net worth of less than $20 million must meet the financial responsibility rules by October 1990.

State and federal government entities that own or operate underground petroleum tanks are exempt from the financial responsibility requirements, but local government entities must comply by October 1990.

Owners or operators of underground petroleum tanks with a capacity of less than 110 gallons are exempt.

The EPA regulation also provides owners and operators of underground tanks with several risk-financing alternatives, including satisfying one of two financial tests; providing a corporate guarantee from a parent company or other affiliated firm; providing a surety bond; providing a letter of credit; and providing a fully funded trust fund.

Also, owners and operators of underground petroleum tanks may satisfy the EPA's rules by participating in a state fund or pool established to pay for the cleanup costs of an underground storage tank leak, if such a fund exists in the state where an owner or operator is located. About 20 states have funds or pools and another five are considering them. ■

D&O cover ruling

Continued from page 2

surance Co. of Northbrook, Ill. However, the insurers denied the claim.

Harbor wrote $15 million in primary D&O coverage for Continental from 1981 to 1984. Allstate wrote $10 million in D&O coverage excess of $15 million.

Harbor and Allstate argued that Continental agreed to the settlement to protect its reputation in the financial community. The insurers said that although the lawsuit named the five directors, it was really the bank that was at risk from the lawsuit, not the directors.

In fact, in his opening argument to the jury, Harbor attorney Thomas W. Conklin of Conklin & Roadhouse in Chicago said: "Continental was the primary beneficiary of this settlement. . . .The five men named in (the lawsuit) paid nothing to the settlement. They were not obligated in any way to make payment to the settlement. They took no part in negotiating the settlement.

"Nothing paid on behalf of the corporation is covered by insurance. The individuals are covered, but the corporations must pay for themselves," he added.

Continental, on the other hand, argued that the entire settlement should be covered by insurance because the directors were jointly and severally liable for the settlement.

The jury, however, found that none of the $17.5 million settlement was insurable.

In making its decision, the jury was instructed to first determine if Continental had met its burden of proving that the settlement is insured.

To be insured, the judge said Continental must prove that the settlement was made in response to claims of "wrongful acts" that were actually made or threatened against the five directors; that Continental was required or permitted to indemnify the directors for the settlement; and that the settlement was made in good faith.

The judge also instructed the jury that if Continental was successful in proving those three points, the insurers must then prove why some or all of the settlement was attributable to entities or individuals that are not insured, such as Continental Illinois Corp.

This last jury instruction is the most significant aspect of the case, said John Morrison, an attorney with Altheimer & Gray in Chicago.

This instruction, which forces the insurers to prove they are not responsible for the entire amount of the settlement, is a departure from existing Illinois law, according to Mr. Morrison, who is regarded as an expert in D&O liability.

He added that allocation disputes between policyholders and insurers are very common and that a subsequent appellate court ruling in this case "could prove to be of assistance to other policyholders embroiled in similar lawsuits."

"A decision by the appellate court should provide a guideline for further administration of directors and officers policies," he said.

Continental attorney Watson Tucker, who will file the appeal, agreed that the appellate court ruling will be very significant.

Mr. Tucker, who is with Mayer, Brown & Platt in Chicago, said Continental is appealing the jury verdict on the basis that several legal questions that were put to the jury should have been answered by the judge, such as whether the bank had the power the indemnify the directors.

Mr. Tucker said the case did not advance the law because it was a jury verdict rather than a judicial opinion.

Insurer attorneys, on the other hand, say the verdict has great value.

Harbor attorney Mr. Conklin said, to the best of his knowledge, this is the first time an insurer has won this type of case by showing that the corporation dominated and controlled the underlying litigation.

"In most cases, corporations run the ship entirely," said Mr. Conklin. "They pay the settlement entirely and then try to pass the check on to the D&O insurers."

"It is a sham," he said. "The intent of D&O insurance is being distorted by making directors the fall guys."

Mr. Conklin also said the verdict could be significant for other D&O policyholders. The verdict "sends a clear message to corporate attorneys that they better make a sincere effort to make fair allocations," he said.

Allstate attorney Samuel Purves of McKenna, Storer, Rowe, White & Farrug, agreed. The verdict "will cause policyholders to focus on allocation issues," he said.

Mr. Purves also noted that disputes between D&O policyholders and their insurers often are settled out of court. As a result, there is very little case law in this area, he said.

"This case for the first time creates a standard in law," said Mr. Purves.

Previously, the only case that dealt with how D&O settlements should be allocated between policyholder defendants and non-policyholder defendants was a 1986 decision by a U.S. District Court in New York.

Judge Charles L. Brieant ruled that when a D&O policyholder settles a lawsuit and other non-policyholder defendants are released from the litigation, the D&O insurer has the right to try to prove that it is not responsible for the entire amount of the settlement (*BI*, July 14, 1986).

The decision involved a dispute between Continental Casualty Co., a unit of Chicago-based CNA Financial Corp., and Pepsico Inc. of Purchase, N.Y.

However, Mr. Purves said the Pepsico decision was "not well-researched or well-argued language."

Mr. Conklin agreed, saying "Pepsico is a bad precedent." ●

Harbor Insurance Co. and Allstate Insurance Co. vs. Continental Illinois Corp., Continental Illinois National Bank & Trust Co. of Chicago et. al.; U.S. District Court for the Northern District of Illinois Eastern Division, No. 85 C 7081.

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Georgia regs

Continued from page 4

istic only of HMOs, said Lynn Dowling, president of the Chicago-based American Assn. of PPOs.

However, increasingly HMOs and PPOs are blending characteristics, observed Richard A. Hinden, a partner with the law firm Altheimer & Gray in Chicago. This may result in increased state legislation to help regulators understand and control them, he said.

In the future, "the lines between and among alternative (health care) systems will blend," Mr. Hinden predicted. As these occur, regulators may "despair" trying to understand and control the risks and step up their regulation of them, said Mr. Hinden, who tracks state legislation for the AAPPO.

"Over the past 10 years there has been a significant increase in the regulation of PPOs, but not in one particular direction," Mr. Hinden said.

Thirty-three states now have some form of PPO laws or regulations, Mr. Hinden said.

The "vast majority" of regulations take a "pretty hands off" approach to regulation.

In a 1986 report, The RAND Corp. concluded that while state PPO laws had the potential to be restrictive, most states were not unduly curbing the development of PPOs.

Most states are concerned with protecting employees from inadequate access to care, incentives for providers to give less than full care and preventing plan insolvencies, he said.

"We do expect to see more legislation in the area of PPOs," said Ms. Dowling of the AAPPO.

Among other things, the legislation is expected to define PPOs so that HMOs do not masquerade as PPOs and thereby avoid the higher level of regulation to which HMOs traditionally are subjected, she explained.

But, if regulators do not perceive that PPOs are the source of potential abuses, they may escape heavier HMO-type regulation, Mr. Hinden said.

Some people would argue that the Georgia department's proposed PPO regulations are an attempt to indirectly define PPOs, Ms. Dowling said.

The Georgia Insurance Department's proposed rules and regulations are designed to implement Georgia's first law allowing the state insurance department to regulate PPOs. The law, H.B. 507, was approved last spring and became effective Jan. 1.

The state attorney general's office is currently reviewing the department's proposals.

Estimates vary greatly about the number of PPO plans in Georgia with capitated arrangements. HealthStream's Ms. Hunnicutt estimated that more than a half-dozen PPOs with capitated arrangements provide dental benefits to 200,000 or more Georgia employees or their dependents.

The proposed rules and regulations, which were released Dec. 7, 1988, were the topic of a Jan. 9 public hearing under the direction of Martin Wilson, deputy insurance commissioner. The period for comment on them was continued until last Thursday, he added.

The department is now reviewing the comments to decide if it should modify the rules and regulations.

"I don't see any great need for changes in them," Mr. Wilson said last week. However, the department is asking the Legislature to clarify its authority over PPOs operated by trusts based in states outside Georgia.

Drafting the proposed rules and regulations "was one of the hardest things to try to do. The act is really restrictive," Mr. Wilson said.

The bill's legislative history yields clues to the problems and the resulting confusion.

The Legislature has been mulling prohibiting capitation since 1986, but a bill introduced that year was not adopted.

Commissioner Evans proposed PPO legislation in 1987 based on the NAIC's model PPO law. His version permitted capitation.

But, physicians opposing capitation were "at loggerheads" with PPO industry representatives who wanted the bill to specifically allow capitation, said David Poythress, executive director of the Georgia Health Network, an independent practice association of physicians.

During negotiations, legislators asked Mr. Evans how he would interpret the bill if any reference to capitation were removed, and he replied that removal of that provision demonstrated a legislative intent to prohibit capitation, according to both Mr. Evans and Rep. Crawford Ware, D-Hogansville, chairman of the House Insurance Committee, who sponsored the bill.

The final version of the law made no mention of capitation and also included new coinsurance restrictions, which the insurance department contends requires it to prohibit capitation arrangements in PPOs.

Rep. Ware said in an interview that employers who support PPOs with capitation arrangements "haven't brought their complaint to me. I would be delighted to discuss that with them."

Spokesmen for dentists, physicians and some PPOs without capitated plan arrangements are happy with the new law and the Insurance Department's proposed rules and regulations to implement it, they said.

They generally disagree with those who contend that employers costs will rise as a result of outlawing capitation. "I don't see the advantages of capitation if it forces providers into risk sharing,

Continued on next page

American Mutual

Continued from page 1

million on net written premiums of $23.9 million. Their combined ratio was 192.7%, after additions to loss reserves of $9.4 million and an expense ratio of 71.8%.

As of Sept. 30, 1988, the policyholder surplus of the two mutuals had dropped to $38.1 million from $55.2 million as of Dec. 31, 1987, which is one of the reasons the department sought receivership.

A third affiliate, American Policyholders Insurance Co., a stock insurer owned by AMLICO through a holding company, was not included in the receivership order and continues to operate.

As of Sept. 30, 1988, APIC reported policyholder surplus of $66.8 million. APIC had $157.6 million in net written premiums and a net loss of $7.1 million as of the third quarter. The insurers' combined ratio was a healthy 99.2% due to a much higher volume of written than earned premiums.

Because APIC was not involved in the pooling arrangement it did not experience the same loss reserve problems as the other two subsidiaries. About 60% of APIC's business is in small to medium-sized commercial business and 40% is personal lines business.

The significant increase in recent company projections of reserves needed for prior accident years was the straw that broke American Mutual.

In a normal review of reserves in December, American Mutual realized that its estimates for workers compensation losses and assumed reinsurance stemming from policies issued between 1964 and 1984 were low by about $50 million, explained Mr. Wortman.

Consultants Tillinghast, a division of Towers, Perrin, Forster & Crosby, and William M. Mercer Meidinger Hansen Inc., a unit of Marsh & McLennan Cos. Inc., confirmed the findings.

In the fall of 1988, the insurer had estimated that it was underreserved by $34 million, according to Deputy Insurance Commissioner Mr. Rice.

"We felt that was a small enough amount compared to the company's total assets that we did not need to take the steps we have now completed," he said.

However, when American Mutual realized that its $34 million reserve estimate was short by another estimated $50 million, the Insurance Department felt it was time to put the company into receivership, explained Mr. Rice.

The timing of the discovery of the inadequate reserves could not have been worse. Last fall, American Mutual began an intense effort to restructure its operations and shore up its financial condition.

News of the underreserving undermined much of the progress the insurer had made.

For example, as part of its restructuring American Mutual had arranged for a $100 million capital infusion from John Head & Associates in New York. The investment banking firm withdrew its offer when it learned that American Mutual was severely underreserved, said Mr. Wortman.

"The investment was based on the fact that the company could pay off losses in an orderly fashion," explained Mr. Wortman.

At the time American Mutual began its restructuring the three insurers had approximately $140 million in policyholder surplus, which was to be transfered to its loss reserves upon receiving the $100 million capital infusion. Without the $100 million infusion, the entire $140 million was still needed for reserves, leaving the insurers with no surplus against which to write new policies, explained Mr. Wortman.

"Our need for loss reserves has completely eaten our surplus," he said.

As a result, the mutual insurers were forced to stop writing business and go into voluntary receivership.

A quota share reinsurance program arranged last year was terminated Dec. 31, 1988. Last year, APIC reinsured 100% of the business written by AMLICO and AMI. In turn, APIC ceded 50% of its business—except Massachusetts auto business—on a quota share basis to American Re-Insurance Co. of Princeton, N.J., and Aetna Casualty & Surety Co. of Hartford, Conn.

Mr. Rice said one of the options for bringing American Mutual out of receivership is to sell its profitable APIC subsidiary.

Currently National Grange Mutual Insurance Co. of Keene, N.H., is looking at buying APIC, according to Mr. Rice.

Mr. Wortman said additional options include the sale of the insurers' renewal business as well as sale of its claims handling services.

In the meantime, the receivership plan calls for a 250-person reduction in the company's workforce of 1,420 people.

A.M. Best Co. had not assigned the companies ratings since 1986 due to their deteriorating financial condition.

Policyholders can call a toll-free hot line if they currently have questions about the rehabilitation. Commercial policyholders in Massachusetts can call 800-284-3571. Commercial policyholders outside Massachusetts can call 800-225-3646. ■

Update

New toxic exposure limits OK'd

Continued from page 2

Penalties for non-compliance will vary according to the seriousness of the offense but could be as much as $10,000 for each willful violation of the standard, an OSHA spokesman said.

Clarendon to buy back 2 units

NEW YORK—The Hamilton, Bermuda-based Clarendon Group Ltd. plans to repurchase two U.S. insurance operations, Clarendon American Insurance Co. and Clarendon National Insurance Co., from Finland-based Kansa Corp., sometime this year, said Clarendon Chairman Rodrigo Rocha.

Mr. Rocha said the Clarendon Group always intended to exercise a re-purchase option in its purchasing agreement with Kansa last spring (*BI*, May 2, 1988). "We looked at it as a financing," said Mr. Rocha of the deal, which was completed Dec. 20. Kansa purchased the companies to help ease liquidity problems at the two Clarendon units' parent, Atlantic Capital Corp. in Delaware.

Details of the repurchase have not been finalized but will involve Clarendon paying Kansa about $200 million in cash, plus assuming some debt, Mr. Rocha said.

Francis Carter has left Clarendon Insurance Co. (Bermuda) Ltd. as president because Clarendon plans to focus on its U.S. business.

Cover obtained for inauguration

WASHINGTON—The presidential inaugural committee obtained in excess of $10 million in cancellation of events coverage for last week's inauguration in Washington.

The coverage, brokered by Marsh & McLennan Inc., was written through Chubb Custom Market Inc., a unit of Chubb Corp. Chubb also wrote property insurance for the inauguration with limits of about $2 million per occurrence and aggregate.

Gulf Insurance Co. of Irvine, Texas, provided general liability coverage with limits of $1 million per occurrence and $4 million aggregate. Gulf also wrote auto liability and physical damage coverage for the committee with a $1 million per occurrence limit and no aggregate limit.

National Union Fire Insurance Co. of Pittsburgh, Pa., a unit of American International Group Inc., wrote directors and officers liability coverage for the inaugural committee. Limits were not disclosed.

In addition, the inaugural committee obtained more than $30 million in excess umbrella liability insurance. Transamerica Insurance Co. confirmed it wrote some of the excess coverage.

The premiums for the coverages were "extremely competitive," said LeConte Moore, a vp with M&M's Entertainment & Insurance Division in New York.

Super Bowl limits increased

MIAMI—The National Football League purchased liability insurance coverage for Sunday's Super Bowl game with limits exceeding the $5 million in liability coverage the league purchased for the 1987 Super Bowl in Pasadena, Calif.

The coverage was brokered by Corroon & Black Corp. of New York and placed with Transamerica Insurance Co. of Los Angeles through Fort Wayne, Ind.-based K&K Insurance Agency Inc.

The NFL has no cancellation insurance that would respond to an event lost to civil disobedience, such as the Miami riots that erupted last week, said Thomas A. Sullivan, the NFL's acting treasurer. But, the league has a "disaster" policy that can be enacted by Commissioner Pete Rozelle if 12 or more players of a team are injured or killed, he added.

Joe Robbie Stadium, the site of the game between the Cincinnati Bengals and the San Francisco 49ers, is located 22 miles north of where the rioting occurred.

Property coverage for Joe Robbie Stadium, which is valued at more than $100 million, is underwritten by Industrial Risk Insurers of Hartford, Conn. Fred S. James of Fort Lauderdale, Fla., brokered both the property and liability coverage for the stadium and the Miami Dolphins, which play there.

Eight special events including media parties and a Kid's Day also were insured. Nautilus Insurance Co. of Scottsdale, Ariz., part of the Greenwich Conn.-based W.R. Berkley Corp. Group, wrote primary liability coverage with combined single limits of $1 million for the events, said Henry DeMayo of Alexander & Alexander Services Inc. in Miami, which brokered the coverage.

Excess coverage for the special events was written by Interstate Fire & Casualty Co., a unit of Fireman's Fund Insurance Cos.

Briefly noted

A federal district court judge in Los Angeles declared a mistrial in a case in which a woman claimed that she had been rendered sterile from using **G.D. Searle & Co.**'s Copper-7 intrauterine contraceptive device. The judge cited time delays by both defense and plaintiff's attorneys in preparing and presenting their cases. No new trial date has been set. . . .**John A. Kraeutler**, a former managing general agent for American Centennial Insurance Co., on Jan. 12 pleaded not guilty to charges he defrauded the insurer. He was released after posting a $250,000 bond. . . .Travelers Insurance Co. does not have sufficient proof to recover $16 million of defense costs from London market excess insurers for the **Shell Oil Co.** pollution coverage litigation, ruled California Superior Court Judge William Lanam Jan. 11. . . .**Richard Fay**, a former congressional committee staffer who played a key role in drafting the Employee Retirement Income Security Act in the early 1970s, died of cancer last week in Washington. Mr. Fay, 46, was a partner in the Washington, D.C., office of the law firm Reed, Smith, Shaw & McClay. . . .Fortune magazine last week named **Royal Insurance P.L.C.** as one of Europe's top stocks in light of the elimination of trade barriers in 1992.

Georgia PPO proposal

Continued from previous page
when that is the role of insurance carriers," said Larry Madlem, president and chief executive officer of the SouthCare Medical Alliance, PHP Inc. Mr. Madlem described SouthCare as Atlanta's largest PPO, consisting of 11 hospitals and 900 doctors.

A capitation arrangement "injects inappropriate financial concerns into a doctor's professional relationship with his patient," Mr. Poythress said. "It sets up an invitation for an insufficient level of treatment," he added.

There are many other ways to put together a compensation arrangement, including discounting normal charges and hospital per diem arrangements, Mr. Madlem added.

Georgia employers that contract with PPOs that charge on a capitated basis also may face uncertainty about the status of new or renewed contracts that took effect since the beginning of the year.

"I will assume that (the rules and regs) will go back to Jan. 1," said Insurance Commissioner Evans.

Other department proposals for regulating PPOs are not considered controversial, including those that require PPOs to:

- Submit all plan forms for department approval prior to use.
- Charge rates that "shall not be excessive, inadequate or unfairly discriminatory," and submit actuarial certification as to the appropriateness of rates.
- Continuously review costs and the utilization of the PPO's services and facilities.
- Grant group policyholders specified grace periods for the payment of premiums.
- Disclose all approved providers' names to group members.
- Meet advertising guidelines.
- Print a boldface warning on the face page of the group policy reflecting the limitations of the program or benefits.

In addition, the proposed rules prohibit PPOs from:

- Unreasonably restricting availability of plan services. For example, a PPO would not be allowed to deny a plan enrollee services if there is an insufficient number of providers in a service area.
- Issuing policies that provide no reimbursement for services rendered by a non-preferred provider. ■

Texas regulators

Continued from page 1
state Sen. John T. Montford, D-Lubbock, who initiated an investigation of the board by a former FBI agent.

That investigation uncovered regulatory problems that are "an open invitation to those intent on committing fraud to come to Texas and prey on unknowing insurance purchasers and policyholders," Sen. Montford wrote in a letter to the state's top public officials.

In the letter, Sen. Montford urged Gov. Bill Clements to call for the resignation of board Chairman Edwin J. Smith and board members Jim Nelson and David Thornberry.

"They should be replaced with persons who can demonstrate the ability to meet the agency's charge of assuring the financial soundness of the state's insurance industry and protecting the interest of consumers," Sen. Montford said.

The investigation report states that ultimate responsibility for mismanagement at the board "should fall upon the board members themselves. Throughout this inquiry, they appeared to be either misinformed or uninformed of the waste, inefficiency, cronyism and patronage which apparently permeates throughout the agency."

However, all three board members say they will not resign, according to a board spokesman.

Mr. Smith released a statement that said the nature of the report "suggests a witch hunt rather than an objective inquiry." He also expressed "deep disappointment" that Sen. Montford released the report before presenting it to the board, as Mr. Smith said the senator had earlier promised.

Mr. Smith also questioned how investigators could determine that board members were uninformed about activities at the agency since they were not interviewed by former FBI agent Eugene Gee, who conducted the investigation.

Mr. Gee's report, which does not specify when alleged mismanagement at the insurance board began, refers to numerous examples of the agency's "inability or unwillingness to act in the face of overwhelming evidence of troubled insurance companies."

For example, the report states that the board knew about financial problems at National County Mutual in July 1987, but did not take action until October 1988. The report also charges that high-level board employees have reported numerous examples of companies writing "absolutely bogus insurance, some of which were not licensed to do business in Texas. These employees maintain that these companies were improperly placed in conservatorship instead of receivership."

Conservatorship in Texas is equivalent to rehabilitation in other states, whereby regulators step in and take control of an insurer to return it to financial well-being. Receivership in Texas is equivalent to liquidation in other states.

The former employees also gave examples of companies "clearly insolvent" that were placed into conservatorship for periods of more than one year before being converted to receivership and liquidated, according to the report.

The report also alleges questionable personnel practices at the board.

"There has been wholesale hiring of unqualified, untrained individuals following the last legislative session," it states. "In many cases, decisions were based primarily on patronage and cronyism. In some cases, abuses of accepted personnel practices reached all the way to the board level."

Specifically, the report pointed out that former Commissioner Lee hired as board employees his former minister, personal carpenter and numerous friends. "There were also cases where individuals were hired because of their relationship with certain board members."

Mr. Lee last week termed the cronyism charges as "rather bizarre," explaining that he thought the matter had been "fully investigated" and that the hirings had been ruled proper.

To correct some of the problems uncovered by the investigation, Sen. Montford said he will introduce several bills in the current session of the Texas Legislature. Those bills would:

- Permit formation of a Joint House-Senate Oversight Committee on Insurance to be created following the current Legislative session to follow through on recommendations of the report.
- Impose stricter standards on the operation of managing general agents.
- Increase capital and surplus requirements for Texas insurers.
- Repeal the statute that permits confidentiality of information regarding insurers in supervision, conservation or receivership.
- Limit the period of supervision and/or conservation to no more than 90 days each.

Meanwhile, Acting Deputy Insurance Commissioner Lee Powell resigned last week after blasting the board for failing to adequately regulate Texas insurers.

"We ought to put up a sign that just says: 'Insurance isn't regulated in this state.' At least that way, people won't operate under the misconception that somebody is regulating it," Mr. Powell charged in a copyrighted story last week in the Dallas Morning News.

When subsequently contacted by Business Insurance, Mr. Powell would not comment on his decision to resign except to confirm that Friday was his last day in office. He did say, however, that the resignation was merely a "reaffirmation" of a resignation he submitted several months ago, which was effective Dec. 31.

Since the effective date, "I was back only on a day-to-day basis," he said.

Mr. Powell had replaced James Odiorne as head of the board's financial division when Mr. Odiorne was removed from that post late last year (BI, Dec. 12, 1988).

In addition, Texas Attorney General Jim Mattox is calling for a joint House-Senate committee to investigate "the ongoing scandals within the industry and the lack of regulation by the State Board."

"You may think that the National County Mutual situation was an isolated incident, but it most certainly is not," Mr. Mattox said in a statement calling for regulatory changes.

The attorney general also pointed out that Texas legislators in 1986 removed his authority to represent the public in insurance matters before the State Board by creating a public counsel position within the board.

"Unfortunately, the public counsel has no teeth, being without an independent right to appeal bad decisions of the board and being without the staff and funds to adequately investigate industry problems," Mr. Mattox stated.

"I am recommending to the Legislature that either the public counsel office be beefed up, with real authority and resources, or else give back to the attorney general's office the authority to protect the insurance-buying public before the State Board."

Mr. Mattox also recommended that the Legislature:

- Remove from state law the provision that requires a referral from the State Board of Insurance before the attorney general can sue insurance companies for deceptive trade practices.
- Repeal insurers' partial exemptions from state antitrust laws.
- Require that the financial status of insurance companies be made public.
- End "the current void in regulation of the important reinsurance industry. Presently, there is no information available to regulators and law enforcement regarding reinsurance, including even who the principal owners are."

If the Legislature does not act, the state faces the same kind of financial upheaval that has rocked the state's banks and savings and loans, Mr. Mattox charged.

In a response to Mr. Mattox's charges, Messrs. Smith, Thornberry and Nelson said: "Texas clearly is not facing an insurance solvency crisis and Mr. Mattox is not serving the public by suggesting that one is imminent." ■

Insurance services guide

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Nissan captive

Continued from page 3
The stock offering will be limited to Nissan dealers only, and organizers hope to complete the stock sale and have the captive operational by April, said Charles Small, vp with RBH Direct Group in Chicago.

Carson, Calif.-based Nissan U.S.A. is advancing start-up expenses connected with the venture and will be reimbursed from the capital raised in the public offering, Mr. Small said.

The captive will be managed by RBH Management Co. in Chicago.

"The main purpose is to provide stability of rate and coverage" on dealers' insurance policies, said Jim Lanker, vp of the new captive holding company and president of Escondido Nissan in Escondido, Calif.

"Three or four years ago, rates just went through the roof and in some cases coverages were just not available," Mr. Lanker said. "We are looking at (the captive) as a long-range investment in our future."

'The main purpose is to provide stability of rate and coverage' on dealers' insurance, says Jim Lanker.

A survey of Nissan dealers conducted about a year ago found widespread concern over insurance stability, said Mr. Rice.

Questionnaires were mailed to 1,100 dealers, about 600 of which responded within two weeks, he said. The responding dealers overwhelmingly supported the idea of a captive as a solution to insurance pricing and availability problems, and most said they would help capitalize such a company, according to Mr. Rice.

A steering committee of about 14 dealers was formed to pursue the project, according to Mr. Rice, who said nine of the committee members are now members of the United Dealers board of directors.

Under the United Dealers plan, units of Philadelphia-based Reliance Group will issue policies to participating dealers covering general liability, garage keepers legal liability, workers compensation and property risks, Mr. Rice said.

Reliance will provide basic limits of $1 million for each of the coverages except workers comp, where statutory limits will be provided, RBH officials said. Reliance also will offer excess limits of up to $4 million excess of $1 million on the general and garage keepers legal liability and property coverages, he said.

A large proportion of the captive's dealer-shareholders are expected to buy the excess limits, he added.

Assuming United Dealers raises the targeted $12.5 million in capital, the captive will probably reinsure a $125,000 share of the basic $1 million limit, Mr. Rice said.

The captive will not reinsure any part of the excess limits written by Reliance, he noted.

In addition to reinsuring the dealer coverages, the captive will work with Reliance to develop underwriting and loss control guidelines for participating dealers, Nissan announced.

The stock offering, which was registered with the Securities and Exchange Commission last week, will be open to Nissan dealers and their affiliates, as well as franchise owners of Nissan's new Infiniti line.

Mr. Rice added that captive shareholders will be able to buy coverage under the program not only for their Nissan dealerships but for any other auto dealerships they may own.

Nissan and RBH officials will be at the National Automobile Dealers Assn. convention in New Orleans later this month to discuss the program with interested dealers, Mr. Small said.

An RBH sister company, Ryan Insurance Group Inc., has helped form many captives for auto dealerships in the past, though these captives have mainly been designed to write credit life insurance and warranty products sold by dealers rather than the dealers' own property/casualty risks, Mr. Rice noted. ■

Public insurance brokers face flat growth in 1989

By LEONARD M. WILSON

Special to Business Insurance

Our fictional broker is resigned to another year of minuscule growth. . .but flattish results in difficult times are a credible result.

PROFIT PLANNING for the public insurance brokers is usually completed before the end of December. The profit plan lays out prospects for the upcoming year and serves as a disciplined mechanism for coping with the challenges of a soft market. Since we lack access to the financial inner sanctum of insurance brokerage, we have chosen to simulate the budgeting process through the vehicle of Risk Averse Associates, our fictional but perhaps representative insurance broker.



Mr. Wilson

Last year, the Risk Averse budget correctly assessed the dimensions of 1988. It called for rate cuts in the range of 10% across the board, perhaps not sufficiently pessimistic, but quite restrained nonetheless. It also contemplated no growth in reinsurance brokerage, strength in employee benefits, and narrow aftertax earnings gains for the public brokers. The forecast, on balance, was reasonably close to the mark.

This year, the budget incorporates continuing economic expansion, with real GNP growth likely to proceed at 2.5% to 3% for the entire year. Capital spending should rise at a rate double that for the economy as a whole. This assures a brisk level of demand for insurance coverage.

Premium rates on commercial lines evidence not a whit of stability. Prices for 1989 are again likely to soften materially. Caution is the order of the day, and therefore the forecast allows for a decline in premium rates of 10% to 12% for 1989 as a whole. Possibly, the erosion will be more severe in the first half of the year.

Reinsurance rates have not yet followed primary rates downward, but some easing in 1989 seems almost inevitable. Retentions, though, may stabilize, partly mitigating the tendency of prices to drop. Accordingly, reinsurance commissions could be flat for the year, an improvement on 1988 performance.

New business shows no signs of slackening. A hard charging production effort that was honed in 1988 should be able to sustain the influx of new clients. The budget anticipates that incremental production will contribute 11 to 13 percentage points to the revenue stream, despite the negative impact of lower prices on the new business realizations.

Lost business threatens to escalate as price comes to dominate the thinking of the insurance buyer. Particular attention to the needs of the existing client and an absence of complacency about pricing the renewal ought to hold the attrition rate to around 5%.

Compiling the variables that determine the gain in commissions, we arrive at an increase of 1% to 3% in commissions from primary insurance brokerage. This range reflects our assumptions about prices, new and lost business and the demand for additional coverage.

Employee benefits performed in stellar fashion last year. Another gain close to 15% in revenues seems attainable. Complexity and concentration of effort in benefits seem to be the driving elements in this growth.

Lackluster increase in premium throughput promises to dampen the rise in investment income. But higher short-term interest rates should afford a moderate year-over-year gain in this category. No interest rate decline seems likely before late in the year at the earliest, given expectations for a robust economy and the desire of the Federal Reserve to forestall an acceleration in inflation.

Overall, taking into account primary brokerage, reinsurance commissions, benefits, and investment income, Risk Averse expects a 3% to 5% advance in total revenues for the year. This is a rather anemic showing, but would be quite satisfactory in the context of today's insurance markets.

Expenses must be held in restraint to avoid a significant deterioration in profit margins. Inflation, happily, should remain in check at an annualized pace of 4%. Average compensation may have to rise by 4% to 5%, with continuing upgrades in staff as well as the need to keep personnel whole with the inflation rate. Headcount can be contained at a 2% increase without causing any deterioration in service levels, at least for the next 12 months. The growth in new business, though, will necessitate higher levels of productivity.

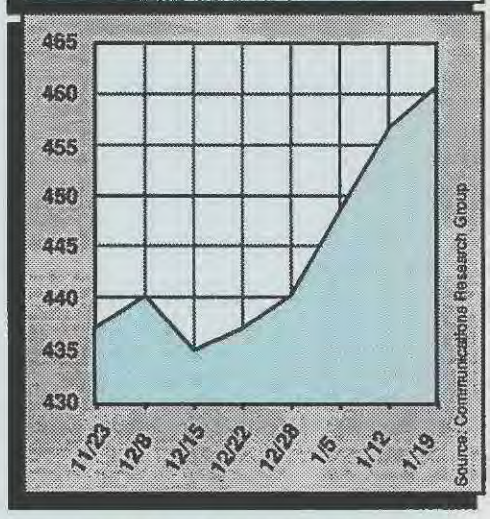
Other operating expenses could creep up faster than employment costs, as was the tendency of recent years. Travel and entertainment reflects the broad-gauge new business effort, and occupancy costs have an almost autonomous momentum.

Based on revenue and expense projections, pretax earnings could rise slightly. If there is any potential shortfall in this forecast, it could be on the revenue side. Net income will not derive any benefit from a lower rate of tax accrual, unlike last year when a tax reduction boosted aftertax comparisons.

Risk Averse is resigned to another year of minuscule growth. This is the burden of a cyclical industry, but flattish results in difficult times are actually a credible result. Given the potential for significant, above-trend line growth in years of rising rates, earnings can grow at 12%-15% over the full insurance cycle, well above most industries. The goal, beyond that of sustaining profit levels, is to avoid penalizing programs that build for the future on the premise that the competition, even in a soft market, is not standing still. ■

Leonard M. Wilson is a senior vp with Lazard Asset Management Inc. He is a member of the New York Society of Security Analysts.

BI Insurance Index



Insurance industry stocks continued their upward trend last week, as the *Business Insurance* Index rose 3.5 points to 461.2 on Jan. 19, from 457.7 on Jan. 12. Advancing issues were led by Orion Capital Corp., up 12.3%; Pacificare Health Systems, up 12%; and Maxicare Health Plans, up 9.5%. Decliners followed Forum Re (Bermuda), down 14.3%; Statesman Group Inc., down 9%; and Western Health Plans Inc., down 7.4%. The most active issue during the period was Sears, Roebuck & Co. (Allstate), 2.5 million shares traded. The *BI* Index gained a slight 0.8% for the period, about even with the leading market indicators: The Dow Jones 30 Industrials also gained 0.8%; the Standard & Poor's 500 was up 1%; and the New York Stock Exchange Composite gained 1.2%.

British Issues

Jan. 19 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence pence
Comml Union	363	11.7	25.3	7.0	363—353
Genl Accident	914	9.0	58.0	6.3	915—890
Gdn Royal Exch	194	10.4	13.1	6.7	195—187
Royal	413	13.6	30.0	7.2	415—403
Sun Alliance	1018	7.8	54.7	5.4	1018-1007
Brokers					
Bradstock	218	12.3	9.0	4.1	218—215
CE Heath	430	13.7	34.5	8.0	430—428
Hogg Robinson	147	13.7	8.0	5.4	147—147
Lloyd Thompson	198	15.6	8.0	4.0	198—197
PWS Holdings	134	19.1	6.0	3.9	134—132
Sedgwick Grp	247	20.6	16.0	6.5	246—240
Steel Brrl Jones	215	19.2	13.3	6.2	215—213
Willis Faber	233	15.9	16.0	6.6	234—230

Source: Philip Olsen/Alan Clifton, Insurance Industry Specialists Kitcat & Aitken Stockbrokers, London

BI Industry Stock Report

JANUARY 19, 1989 — 1/13/89 THRU 1/19/89

		Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
BROKERS												
Alexander & Alexander Svcs	NYSE	23.88	3.2	1.6	28.13	17.75	190	1.00	4.2	16.4	3.71	6.44
Corroon & Black Corp	NYSE	31.63	2.0	1.6	34.75	28.00	130	1.08	3.4	4.8	12.40	2.55
Gallagher Arthur J. & Co	NYSE	16.25	0.0	-3.0	19.13	13.88	41	0.48	3.0	11.2	5.16	3.15
Hall Frank B. & Co	NYSE	2.63	0.0	-8.7	5.50	2.50	147	0.00	0.0	-1.4	0.00	N/A
Hilb, Rogal & Hamilton	OTC	14.25	0.0	-6.6	15.50	9.75	9	0.00	0.0	12.0	4.60	3.10
Marsh & McLennan Cos. Inc.	NYSE	57.13	1.6	1.6	59.63	45.25	408	2.50	4.4	14.0	6.74	8.48
Poe & Assoc Inc	OTC	8.25	0.0	0.0	9.25	6.75	0	0.40	4.8	9.3	0.27	30.56
BROKERS	AVERAGE		1.0	-1.9					2.8	9.4		
CONGLOMERATES & HOLDING COMPANIES												
Berkley W R Corp	OTC	31.50	1.6	6.8	31.50	23.50	158	0.36	1.1	6.8	17.63	1.79
Berkshire Hathaway Inc. DEL	NYSE	4675.00	-1.1	33.9	5050.00	2755.00	42	0.00	0.0	18.8	2492.68	1.88
ITT (Hartford Group)	NYSE	53.25	1.7	6.2	54.88	43.25	963	1.48	2.8	7.0	52.23	1.02
Sears Roebuck & Co (Allstate)	NYSE	41.75	-0.3	2.1	46.13	32.25	2499	2.00	4.8	10.9	34.74	1.20
CONGLOMERATES	AVERAGE		0.5	12.3					2.2	10.8		
INSURERS/REINSURERS												
Aetna Life & Cas Co	NYSE	48.50	-0.5	2.6	52.50	39.50	616	2.76	5.7	8.0	53.56	0.91
American General Corp	NYSE	32.50	6.5	8.8	36.38	27.50	740	1.40	4.3	8.2	28.04	1.16
Amer Heritage Life Invt	NYSE	25.00	0.0	-2.9	27.00	24.00	3	1.08	4.3	10.6	20.98	1.19
Amer Indty Fin'l Corp.	OTC	10.75	-2.3	2.4	12.00	8.25	7	0.56	5.2	18.9	15.26	0.70
American Int'l Group	NYSE	71.25	2.5	5.2	70.63	49.00	1251	0.40	0.6	10.5	33.56	2.12
Aon Corp	NYSE	27.88	-2.2	-0.4	29.00	21.88	308	1.28	4.6	9.1	15.13	1.84
Argonaut Group	OTC	48.00	1.1	9.7	49.00	29.50	102	0.00	0.0	7.1	29.19	1.64
AVEMCO Corp	NYSE	24.25	-4.0	-6.3	28.75	17.88	11	0.34	1.4	11.3	7.74	3.13
Baldwin & Lyons Inc	OTC	14.75	0.0	-0.9	16.38	12.13	5	0.20	1.4	6.1	17.57	0.84
Belvedere Corp	AMEX	5.50	4.8	22.2	6.00	4.00	1	0.04	0.7	8.1	7.87	0.70
Chandler Insurance	OTC	10.88	-1.1	17.6	11.25	4.25	92	0.00	0.0	5.3	7.18	1.52
Chubb Corp	NYSE	59.50	0.8	2.6	63.38	51.25	368	2.16	3.6	6.8	46.13	1.29
CIGNA Corp	NYSE	49.75	-1.0	5.6	55.38	42.75	331	2.96	5.9	9.2	49.19	1.01
CNA Fin'l Corp	NYSE	58.75	0.0	-2.9	66.13	51.00	143	0.00	0.0	9.3	46.40	1.27
Continental Corp	NYSE	33.63	2.3	3.9	41.63	31.50	389	2.60	7.7	10.8	42.10	0.80
Durham Corp	OTC	33.00	-0.8	0.0	36.75	21.50	20	0.92	2.8	38.4	26.00	1.27
Farmers Group Inc.	OTC	74.75	0.0	0.0	74.88	40.50	0	1.44	1.9	17.5	22.02	3.39
Fireman's Fund Corp.	NYSE	31.25	4.2	6.8	33.50	25.75	407	0.50	1.6	135.9	26.17	1.19
Forum Re (Bermuda)	OTC	1.50	-14.3	-8.0	4.00	1.13	2	0.00	0.0	4.2	2.58	0.58
Fremont Gen Corp.	OTC	13.50	3.8	0.9	13.50	8.75	111	0.60	4.4	9.1	16.24	0.83
Frontier Insurance Group	OTC	13.25	1.9	6.0	13.50	6.50	28	0.00	0.0	6.6	5.97	2.22
General Re Corp.	NYSE	58.38	2.9	5.2	59.38	45.50	947	1.20	2.1	11.9	26.21	2.23
Home Group Inc	NYSE	12.63	1.0	14.8	14.38	10.50	162	0.20	1.6	1.6	17.76	0.71
Hanover Ins Co	OTC	26.75	1.9	0.0	27.75	20.50	154	0.36	1.3	5.1	25.10	1.07
Harleysville Group Inc	OTC	18.88	2.1	4.9	18.75	13.38	43	0.48	2.5	7.4	16.65	1.13
Hartford Steam Boiler	OTC	36.75	0.0	0.0	37.75	22.50	275	1.40	3.8	12.6	10.65	3.45
Kans City Life Ins	OTC	33.00	-2.2	-4.3	39.50	25.25	30	0.00	0.0	9.5	39.22	0.84
Kemper Corp	OTC	24.00	0.0	0.0	27.50	20.75	763	0.72	3.0	7.6	26.50	0.91
Lawrence Ins. Group	AMEX	8.25	0.0	4.7	11.63	4.50	2	0.24	2.9	18.3	2.90	2.84
Liberty Corp. S.C.	NYSE	37.63	0.3	4.5	47.25	33.88	24	0.80	2.1	13.0	17.40	2.16
Lincoln Nat'l Corp	NYSE	46.25	4.8	5.1	53.50	40.25	329	2.48	5.4	12.0	36.62	1.26
NAC Re Corp	OTC	32.00	-3.8	0.8	33.50	18.50	158	0.00	0.0	14.3	19.92	1.61
Navigators Group	OTC	21.25	3.7	6.3	21.25	14.50	11	0.00	0.0	10.3	12.88	1.65
Nobel Ins Ltd	OTC	4.75	-5.0	0.0	9.50	3.75	11	0.42	8.8	-33.9	7.76	0.61
Northwestern Nat'l Life	OTC	30.88	0.0	-0.8	34.50	22.63	90	1.12	3.6	7.4	35.05	0.88
Ohio Cas Corp	OTC	39.00	2.6	9.1	39.25	32.25	109	1.88	4.8	7.2	27.86	1.40
Old Rep Int'l Corp	OTC	24.63	0.5	2.6	25.88	19.13	150	0.74	3.0	5.8	27.82	0.89
Orion Cap Corp	NYSE	18.25	12.3	18.7	17.63	13.13	165	0.76	4.2	6.2	9.34	1.95
Phoenix Re Corp	OTC	9.75	0.0	2.6	11.00	6.75	73	0.00	0.0	5.3	11.08	0.88
Protective Life Corp.	OTC	13.63	1.9	2.9	15.13	12.25	41	0.70	5.1	16.6	17.25	0.79
Re Capital Corp.	AMEX	9.63	-2.5	5.5	11.75	7.88	3	0.00	0.0	21.4	11.49	0.84
Provident Life & Acc Ins Co	OTC	20.63	1.9	7.2	25.00	15.63	156	0.68	3.3	17.3	21.96	0.94
St. Paul Cos. Inc.	OTC	46.00	2.8	5.7	51.00	38.25	1832	2.00	4.3	6.4	35.83	1.28
SAFECO Corp	OTC	25.63	3.6	8.5	30.00	22.75	1181	1.08	4.2	8.1	21.39	1.20
SCOR U.S. Corp	NYSE	8.75	-1.5	-4.2	9.50	6.63	88	0.20	2.3	6.3	9.39	0.93
Selbels Bruce Group Inc	OTC	11.63	-3.1	2.2	14.25	11.00	89	0.80	6.9	7.8	12.51	0.93
Selective Ins Group Inc	OTC	23.50	2.2	2.2	26.50	19.25	102	1.24	5.3	5.2	19.52	1.20
Statesman Group Inc	OTC	3.13	-9.0	0.0	5.56	2.75	69	0.05	1.6	-313.0	3.48	0.90
Tokio Marine & Fire Ins	OTC	86.50	-4.9	-5.3	98.00	63.25	21	0.22	0.3	52.4	0.00	N/A
Torchmark Corp	NYSE	31.88	2.8	4.5	33.50	24.50	197	1.20	3.8	10.4	12.24	2.60
Transamerica Corp	NYSE	34.00	0.7	0.4	36.75	29.75	354	1.88	5.5	7.8	24.94	1.36
Travelers Corp	NYSE	35.50	-0.4	2.2	40.00	33.00	485	2.40	6.8	13.0	45.28	0.78
Trenwick Group Inc	OTC	15.00	5.3	3.4	15.00	9.75	25	0.24	1.6	14.7	15.41	0.97
United Fire & Cas Co	OTC	30.38	0.0	-0.4	30.50	24.00	5	1.08	3.6	5.0	22.56	1.35
United States Fid & Gty	NYSE	29.75	0.8	4.4	34.38	28.50	429	2.64	8.9	8.0	19.53	1.52
UNUM Corp	NYSE	26.88	0.0	-0.4	28.13	17.88	339	0.48	1.8	11.2	28.53	0.94
USLIFE Corp.	NYSE	37.50	0.0	7.5	40.13	28.00	177	1.36	3.6	9.9	46.77	0.80
Washington Nat'l Corp.	NYSE	25.50	-5.6	-5.6	28.75	24.00	33	1.08	4.2	-7.4	32.33	0.79
Zenith Nat'l Ins Corp.	NYSE	16.88	-3.5	-3.5	23.88	15.00	25	0.80	4.7	7.9	12.53	1.35
INSURERS/REINSURERS	AVERAGE			0.2					3.1	6.4		
HEALTH MAINTENANCE ORGANIZATIONS												
FHP International Corp	OTC	12.88	7.3	6.2	13.13	6.00	110	0.00	0.0	7.8	2.77	4.65
HMO America Inc	OTC	1.00	0.0	6.4	2.75	0.81	125	0.00	0.0	-1.6	1.12	0.89
Maxicare Health Plans	OTC	0.69	9.5	-8.0	4.25	0.50	268	0.00	0.0	0.0	0.00	N/A
Pacificare Health Systems	OTC	14.00	12.0	14.3	13.25	5.75	30	0.00	0.0	12.3	5.51	2.54
Safeguard Health Ent	OTC	5.50	-2.3	0.0	8.25	4.00	41	0.00	0.0	11.0	2.50	2.20
Sierra Health Services	AMEX	1.88	7.4	15.3	3.00	1.25	18	0.00	0.0	14.5	1.59	1.18
United Health Services	OTC	4.50	2.7	0.0	2.69	1.75	164	0.00	0.0	-1.7	2.59	1.74
United Medical Corp.	AMEX	5.75	2.1	9.5	5.75	2.50	53	0.00	0.0	-287.5	3.91	1.47
U.S. Healthcare	OTC	6.00	6.6	3.3	4.44	2.13	1489	0.16	2.7	33.3	2.89	2.08
Western Health Plans Inc.	AMEX	0.75	-7.4	8.7	3.38	0.63	5	0.00	0.0	-0.4	0.82	0.91
HMOs	AVERAGE			3.8	5.6				0.3	-21.2		
ALL COMPANIES	AVERAGE			0.8	3.4				2.7	3.5		

System design: Communications Research Group

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