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Update

Storms hit Mid-America, causing nearly $800 million in damage

RAHWAY, N.J.—Severe weather over much of the nation's midsection caused $785 million in insured property damage in mid-June, according to estimates by the Property Claim Services division of the American Insurance Services Group.

Wind, hail and tornadoes that struck Kansas and Oklahoma June 19 and 20 caused an estimated $570 million in insured property damage. The severe weather, assigned Catastrophe No. 19, pelted the Wichita, Kan., area with softball-sized hail.

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Lloyd's to adopt regulatory reform

By STACY SHAPIRO

LONDON—The Council of Lloyd's of London will be restructured for the third time in a decade.

Last week's announcement came at the same time that a special committee criticized how Lloyd's business has been monitored.

However, council members and other "insiders" were cleared by the special committee of any conspiracy, fraud or malpractice in connection with the huge losses recently reported by 10 London market excess-of-loss reinsurance syndicates.

Gooda Walker syndicates issue $583 million cash call. Page 23.

U.S. risk managers, brokers still standing by Lloyd's. Page 29.

LMX losses contributed a large share of Lloyd's record 2.063 billion ($3.85 billion loss in 1989 (*BI*, June 29).

Lloyd's announced Thursday that by Jan. 1 it will implement recommendations from a committee chaired by Sir Jeremy Morse, chairman of Lloyds Bank. The committee's report, titled "A New Structure of Governance for Lloyd's," outlines a new tripartite regulatory structure that will separate supervision of Lloyd's business development from regulation of market conduct.

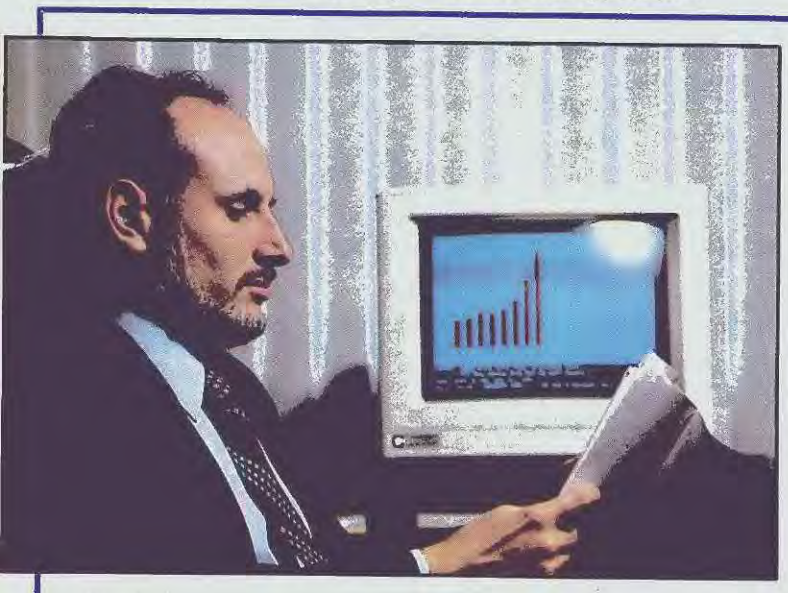
"It's not tinkering, but it's not radical," said Sir Jeremy about the changes. "It's progressive . . .and evolutionary."

The new structure is in line with recommendations made by a Lloyd's task force in January that the Council of Lloyd's originally rejected. An uproar followed that action, and Sir Jeremy's committee was subsequently appointed to review how Lloyd's is governed. The committee received more than 1,000 letters, most supporting a change in Lloyd's governance.

Under the new structure, Lloyd's will continue to be led by a chairman, who must be a working member of the market under the Lloyd's Act of 1982.

But the chairman should be remunerated "on a basis which properly reflects his status and

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Martin D. Weiss' ratings are based on a computer model.

Weiss' ratings called simplistic by firm's critics

Weiss defends work as 'objective'

By DEBORAH SHALOWITZ

WEST PALM BEACH, Fla.—As a newcomer to the insurance company rating business, Martin D. Weiss might have expected to be criticized and not trusted.

Those expectations are now reality.

Critics of Weiss Research Inc.—which uses a computer model to rate life, health and annuity insurance companies—say the rating process it uses is simplistic and flawed, in large part because the organization does not talk with insurance companies' management and consider their responses before formulating ratings.

Consumers seem to disagree, though. Some 70,000 personal lines and group insurance buyers have bought the ratings, and some observers credit Mr. Weiss with adding much-needed balance to the entire insurance company rating process.

Weiss ratings are popular with these consumers because they are presented in an easy-to-understand report card format. Furthermore, the Weiss ratings tend to be lower than those issued by other rating agencies.

However, Weiss Research "goes overboard in pessimism the same way Best goes overboard in optimism," commented Kim McCarrel, a consultant with Wyatt Asset Services Inc. in

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Policyholders' documents can be privileged: Court

By EILEEN P. GUNN

ROCHESTER, N.Y.—Policyholders involved in coverage litigation with insurers do not necessarily have to turn over attorney documents generated in underlying litigation, a New York state appellate court has ruled.

The decision will help risk managers who may sometimes withhold documents from their attorneys for fear they could be used against them to deny coverage, policyholder attorneys say.

The ruling runs contrary to a groundbreaking May 1991 ruling by the Illinois Supreme Court that gave insurers blanket access to a policyholder's attorney documents when a "commonality of interest" exists (*BI*, June 3, 1991). Several similar decisions followed the Illinois ruling.

However, the New York appeals court on June 5 ruled that attorney-client privilege and the work-product doctrine apply only on a document-by-document basis in coverage litigation. A trial court judge or discovery referee should decide whether a given document is protected or should be handed over to the policyholder's insurer, the court said.

Under attorney-client privilege, documents that are viewed only by the client and his or her attorney cannot be discovered by adversaries. The work-product doctrine generally protects from discovery documents made in preparation for a lawsuit.

The New York ruling stemmed from a dispute between Occiden-

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Health plan redesign

Firms embrace managed care despite doubts

By MARK A. HOFMANN

The nation's largest employers increasingly are turning to managed care plans to deliver health care benefits, a new survey finds.

Yet, more than half of the employee benefit decision-makers surveyed say managed care alone cannot control health care costs in the next five years.

"The pessimism in that reaction has to do with actions taken in the past that had a limited effect over any period of time," says Joseph W. Duva, a partner in the New York office of Ernst & Young.

By adopting managed care plans, companies gain the tools to make adjustments on their health care programs on an ongoing basis, he said.

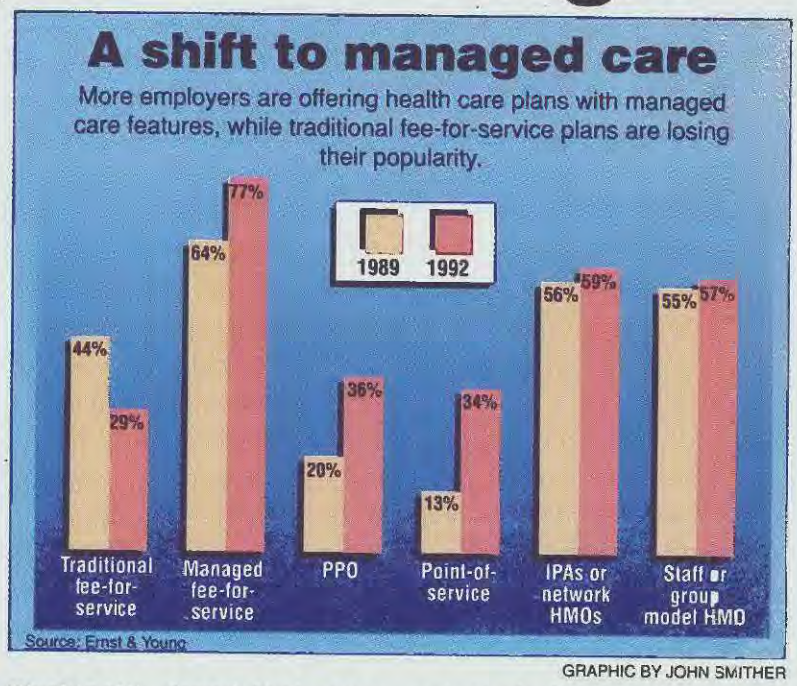
"So basically, you have in place what you will need in the future," he added.

The survey—"Is Managed Care Working?"—found that more than 40% of surveyed employers that in 1989 had offered a traditional fee-for-service health care plan have since dropped it.

The movement has been "to 'gentler,' that is, more option-oriented, forms of managed care," according to the survey's authors.

In fact, the form of managed care plan that is growing most rapidly is point-of-service plans,

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GRAPHIC BY JOHN SMITHER

Update

Storm toll put at $785 million

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Including this storm, State Farm Mutual Insurance Co. says it has paid more than 250,000 hail claims valued at more than $500 million so far this year. Based on its experience, State Farm estimates 1 million hail claims totaling $2 billion have been filed with insurers this year.

Wind, hail, tornadoes and flooding, assigned Catastrophe No. 18, caused an estimated $215 million in insured property damage from June 14-19. Affected were parts of Alabama, Colorado, Illinois, Indiana, Iowa, Kansas, Kentucky, Michigan, Minnesota, Mississippi, Nebraska, Ohio, Oklahoma, South Dakota, Texas and Wisconsin.

AT&T pact improves benefits

NEW YORK—American Telephone & Telegraph Co. will set up a new stock plan and improve work and family benefits under a proposed three-year contract with the Communications Workers of America and the International Brotherhood of Electrical Workers.

Under the agreement announced last week, AT&T will provide each union employee with $1,500 worth of stock on Oct. 15 and $1,800 worth of stock two years later.

AT&T will finance health care benefits for 12 months, up from the current six months, for employees on unpaid leave to take care of a newborn or newly adopted child.

The reimbursement for adoption expenses increases to $2,500 from $2,000 and will now cover costs of adopting stepchildren.

AT&T also will add $2.5 million to an existing $7.5 million fund which, among other things, makes grants available to outside agencies to improve day care for employees' children.

The company will boost pension benefits by 13% for workers retiring after May 31, 1992. A profit-sharing plan will be phased out, but negotiations will begin to set up a new plan.

Dental and vision care benefits will be improved. No major changes will be made to the company medical program.

Federal offshore insurer rules

WASHINGTON—The Senate Permanent Subcommittee on Investigations wants Congress to "establish federal certification as a prerequisite" before an offshore insurer or reinsurer can write business in the United States.

"It is not the intention of this proposal to pre-empt state regulation" of domestic companies, stressed a report by the subcommittee. Rather, the subcommittee "is suggesting that this provision will augment the current state regulatory scheme."

The report also recommends that Congress review the Risk Retention Act of 1986 to determine whether it is being used to perpetrate fraud; that the Justice Department create joint federal and state law enforcement task forces to combat fraud; that the State Department negotiate with foreign governments on sharing data on insurance fraud; and that a national insurance fraud data base be created.

The subcommittee also wants Congress to pass a law making insurance fraud a federal crime. Such a provision was contained in a crime bill that died in the Senate last year (*BI*, Feb. 3).

FBI hits pharmacy scam

WASHINGTON—The arrest last week of more than 100 people—including 82 pharmacists—in a nationwide crackdown on health care fraud is the first in a series of actions against health care crime, says FBI Director William S. Sessions.

A two-year FBI investigation, "Operation Goldpill," uncovered two major types of scams, Mr. Sessions said.

In one, a doctor prescribes medicine for a Medicaid beneficiary who is not sick and is aware of the scam. The doctor then sends the bill to Medicaid while the prescription is filled. The medicine is then resold for a fraction of its value to another pharmacy or person, who then sells it to the public.

In the second scam, pharmacies file false or inflated claims to government programs or insurers. For example, prescriptions are filled with generics, then billed as if name-brand drugs had been used.

California ballot initiatives

SACRAMENTO, Calif.—The California Medical Assn. has collected enough signatures to put an employer health care coverage mandate on the state's Nov. 3 general election ballot.

Also qualifying was a measure to protect public employees' pension funds against raids by the governor or the Legislature.

Among other things, the CMA initiative would phase in over a four-year period a mandate requiring employers to pay at least 75% of the cost of health insurance for employees who work more than 17.5 hours per week and their dependents.

The minimum benefit package that employers would be required to offer is designed to promote preventive care and provide catastrophic coverage, according to the Sacramento-based CMA. Health plans that meet the minimum requirements would be exempt from all other state benefit mandates.

The measure also would regulate excessive provider fees and make it easier for small employers to find affordable coverage.

In addition, the initiative calls for establishment of a commission that would develop guidelines on physician self-referrals, adopt practice parameters and monitor the development of medical technology.

The pension initiative was sparked by the Legislature's recent decision to siphon $1.9 billion from the state employee pension plan to help reduce a $6.4 billion budget deficit. The California Public Employees Retirement System had $64.7 billion in assets at year-end.

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Benefit managers blast AMA's self-referral shift

By MICHAEL SCHACHNER

CHICAGO—The American Medical Assn.'s decision to drop its policy of dissuading doctors from referring patients to facilities in which they have a financial stake is a step in the wrong direction, according to employee benefit managers and consultants.

By giving physicians tacit approval to refer patients to laboratories, X-ray centers and other outpatient clinics in which they have an investment, the AMA is fostering a health care system that is volume-driven and ripe for abuse, critics charge.

Last month, the AMA's policy-setting House of Delegates voted to soften its longstanding opposition to self-referrals based on two beliefs: that physicians and patients are harmed by blanket policies against self-referral and that very few doctors actually abuse the referral process.

The AMA contends physicians should be allowed to continue referring patients to facilities in which they have a stake, provided the patient is first informed of the physician's financial interest and is made aware of other facilities.

However, benefit managers argue and several recent studies support that physicians with a financial interest in an outpatient facility are much more likely to make referrals than doctors with no financial interests in outpatient facilities.

At a time when health care costs are increasing by about 20% annually—with an esti-

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Bad faith backlash

Law firm plans appeal of $8.2 million malpractice award

By JUDY GREENWALD

LOS ANGELES—A Los Angeles law firm, Cummins & White, plans to appeal an $8.2 million jury award in a malpractice suit brought by an insurance company client.

The June 24 jury verdict stems from a business interruption claim submitted in 1983 to Fremont General Indemnity Corp., a unit of Fremont General Corp. Fremont was sued for bad faith for allegedly delaying payment of the claim, and eventually settled the dispute for $8.5 million.

Fremont then sued Cummins & White—which had advised the insurer on adjusting the claim and also represented it in the suit—for professional negligence, breach of fiduciary duties, constructive fraud and negligent misrepresentation.

One of the key issues in the malpractice case was whether the attorney who represented Fremont in adjusting the claim should have served as a witness, rather than as counsel, in the subsequent bad faith litigation, says attorney Paul Richler of Morgan, Lewis & Bocklus in Los Angeles, who represented Fremont in the suit against the law firm.

"Insurance companies should

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On some days, litigants agree to just reach out and settle

By EILEEN P. GUNN

NEW YORK—Insurers and attorneys are taking advantage of informal face-to-face meetings around the country to break the impasse of endless claims negotiations, to spontaneously settle cases or simply to meet each other on neutral ground.

These gatherings, called "Settlement Days," bring together insurer claims representatives and policyholder attorneys to hammer out dozens of settlements in one cost-efficient sitting.

Each year, there are about 100 Settlement Days nationwide organized by the Claims Settlement Services division of American Insurance Services Group Inc. in New York. First organized on a test basis in 1987, Settlement Days began in earnest in 1989 and have grown in number ever since. For the remainder of 1992, there are 45 Settlement Days scheduled around the country.

Insurers use the day to meet face to face

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Trucking execs plead not guilty to insurance scam charges

By JOANNE WOJCIK

LOS ANGELES—Four trucking company executives have pleaded not guilty to charges related to an alleged liability and cargo insurance scam that bilked hundreds of Southern California truck owners out of $1.3 million.

The four were indicted by a federal grand jury on June 15. The grand jury also accused them of bilking at least one insurer out of an as-yet-unknown amount of claims payments when they tricked it into believing it had covered some of the truck owners when in fact it hadn't.

The alleged scam was discovered after the Interstate Commerce Commission received complaints that numerous truckers were operating without insurance, according to a spokeswoman for the U.S. Attorney's office in Los Angeles.

Named in the indictment are: William "Shorty" Akin, 59, of Hemet, Calif., and Searcy, Ark.; Melvin Robinson, 43, of Springdale, Ark.; Everett Cleghorn, 56, of Hemet, Calif.; and Douglas Carpa, 47,

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Inside

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AP/Wide World Photo

A devastated restaurant in Big Bear City, Calif., which was near the epicenter of the second of two major June 28 earthquakes.

Twin quakes' damage toll tops $90 million

By JOANNE WOJCIK

LOS ANGELES—The twin temblors that rattled Southern California last Sunday and the numerous strong aftershocks caused more than $92 million in property damage, most of which is likely uninsured.

Slight damage also was reported in Las Vegas following last Monday's earthquake near the state line, but damage there will probably not hit $1 million, officials say.

Earthquake damage in California could siphon up to $14 million from the state's dwindling Residential Earthquake Recovery Fund, which lawmakers are on the verge of repealing.

Of the fund's $34.7 million, $12.4 million already has been set aside to pay claims from two earlier quakes, according to the state Insurance Department, which administers the program.

Lawmakers are seeking to repeal the program because it is inadequately funded, according to a spokesman for Sen. Art Torres, D-Los Angeles, chairman of the Senate Insurance Committee.

In fact, Sunday's quakes have "underscored the importance of repealing the program," the spokesman said. "This shaky earthquake program has the potential to deep-pocket the state to death."

Meanwhile, risk managers throughout Southern California were inspecting their property and re-checking their commercial insurance policies to make sure they are covered should another major temblor hit, as some seismologists were predicting last week.

The two separate earthquakes, centered 20 miles apart in rural San Bernardino County, resulted in the most strongly worded earthquake advisory ever issued by the state. The advisory declared that "a major earthquake sequence" had begun and was expected to continue.

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Civil procedure reform

Federal courts may follow Arizona's lead

By JUDY GREENWALD

PHOENIX—An overhaul of Arizona's civil justice system that is designed to cut procedural costs and increase efficiency could be a precursor to comparable changes in the federal court system.

But while Arizona's overhaul has many enthusiastic advocates, some attorneys contend the amendments to the state's civil justice rules could increase costs and also create serious ethical problems for attorneys.

There is no clear-cut division of opinion on the changes among attorneys: There are supporters and detractors from both the plaintiff and defense bars.

The rules, which generally took effect last Wednesday, had been approved by the state Supreme Court in December. They are commonly referred to as the "Zlaket Rules" after Tom Zlaket, previously head of the Arizona Bar Assn. and now an Arizona Supreme Court justice, who spearheaded the changes.

The new rules:

- Eliminate the traditional discovery process and require attorneys to exchange all relevant information within 40 days after a response to a suit has been filed, unless the court approves additional time or both parties agree to it.
- Generally limit depositions to the plaintiff, the defendant and one expert witness per issue. More experts could be added only if the court gives its approval.

Another major reform provision, which requires arbitration in cases involving $30,000 or $50,000, or less, depending on the individual county, was introduced in August.

Also among the approximately 20 amendments are provisions that generally limit depositions to four hours and written interrogatories to 40 questions.

Arizona observers note that the Arizona changes are compatible with civil justice reforms proposed by the Bush administration (*BI*, Aug. 19, 1991).

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Tobacco ruling's impact may be felt by other firms

By STACY GORDON

WASHINGTON—Both plaintiffs and defendants in a wide variety of industries will look to the U.S. Supreme Court's recent ruling that allows certain damage claims against cigarette manufacturers.

Specifically, the high court held that plaintiffs could sue tobacco companies for hiding or misrepresenting the dangers of cigarette smoking (*BI*, June 29).

The impact of the ruling on other industries was best described by Justice Antonin Scalia: "Questions raised by (the) decision will fill the law books for years to come."

Indeed, the decision offers something for both sides in product liability litigation.

Defense attorneys take heart in the fact the court reaffirmed that the doctrine of pre-emption is still valid. Under that doctrine, a federal statute regulating industry behavior displaces state tort law claims over the same issues to prevent conflicts with federal law.

For plaintiffs' attorneys, there is the portion of the high court's decision that holds pre-emption clauses must be read narrowly, based on the express statutory language and with a presumption against pre-emption.

The opinion, which was written by Justice John Paul Stevens, says courts should narrowly interpret language that pre-empts state law and should not infer that Congress meant to go further.

In essence, the Supreme Court ruling in *Thomas Cipollone vs. Liggett Group* will mean attorneys for both plaintiffs and defendants have to study federal statutes that pre-empt state law and try to determine to what extent state laws and lawsuits based on them are pre-empted.

The decision stemmed from a lawsuit brought by the family of Rose Cipollone, a longtime smoker who died of lung cancer. Named as defendants were Liggett Group Inc. of Durham, N.C., Philip Morris Inc. of New York and the Lorillard Inc. unit of New York-based Loews Corp.

The family accused the manufacturers of concealing the dangers of smoking.

The Supreme Court held that neither a 1965 nor a revised 1969 law requiring warning labels on cigarette packages and advertisements pre-empts state law claims against the manufacturers for breach of warranty of smoking's safety, intentional misrepresentation, fraud or conspiracy.

But the court found that the

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Better life/health results?

Best sees fewer troubled insurers in wake of record impairments in '91

By LOUISE KERTESZ

A.M. Best Co. predicts that the number of financially impaired life/health insurers will decline over the next several years but still will remain at historically high levels.

Some 58 U.S. life/health insurance companies—or 2.3% of the total—became "financially impaired" in 1991, Best found in an insolvency study covering 1976 to 1991.

Their assets represent 3.2% of the total assets of the life/health industry. That is far and away the highest percentage in the years covered; in only one other year had that figure exceeded even 0.25%.

Impaired insurers include those that are insolvent, those with capital and surplus below state minimums and those against which state regulators have taken action, such as seizing an insurer to forestall a "run on the bank."

Best forecasts that by 1993 or 1994, the number of impaired life/health insurers will drop to about 35 annually, or about 1.3% of the total. And those companies are expected to represent a much smaller portion of industry assets: "well below 0.5%, perhaps reaching 0.2% over this time frame."

Those 1993 and 1994 projections, though, still would be historically high.

Between 1976 and 1989, the number of insurers becoming impaired had never exceeded 20 in one year. From 1976 through 1988, only 0.5% of life/health insurers on average became impaired. And those impaired companies represented only 0.09% of industry assets on average.

But the projections, Best says, "clearly. . .do not suggest that the industry is on the verge of a financial crisis equivalent to that of the savings and loan industry."

Life insurers welcomed the Best study. "It obviously is good news and a reflection of positive (results) of regulators' efforts to strengthen solvency protection and prevention mechanisms," said a spokesman for the American Council of Life Insurance in Washington.

A total of 290 life/health insurers domiciled in the United States and Puerto Rico became insolvent or otherwise impaired over the past 16 years, according to Best.

Best says its forecast for a de-

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Vets bill to allow retroactive 401(k) payments

By JERRY GEISEL

WASHINGTON—Legislation approved by the House last week would allow employees who return to work after military service to make retroactive contributions to 401(k) plans while their employers—if they offered a matching feature—would have to match the veterans' contributions.

The legislation, H.R. 11, includes a wide range of pension simplification and other benefit provisions as well as provisions to boost investment in inner cities. It modifies a bill earlier passed by the House to protect the employment rights and benefits of employees who join the military.

Unlike the bill passed earlier, H.R. 11 generally would not require employers to retroactively give employees returning to work after military service the same profit-sharing benefits provided to other workers during the time the returning employees were in the military (*BI*, June 29; May 25).

Earlier, employers complained that requiring retroactive profit-sharing contributions could lead to abuse by returning veterans. A veteran could return, receive contributions and then quit after a few weeks.

While the new House bill would not require retroactive profit-sharing contributions, it would let veterans make retroactive contributions to their 401(k) plans. And, if the employer matched deferrals for employees during the time a worker was in the military, it would have to make retroactive matching contributions for the returning veterans.

Since most companies now match employees' 401(k) plan salary deferrals—a typical company match is 50% of employees' contributions, up to 6% of pay—companies would face new

Continued on next page

Veterans' bill

Continued from previous page

401(k) plan costs for returning veterans. The provision itself would be retroactive to August 1990. That would give employees who were called up from the reserves to active duty in the Persian Gulf War the opportunity to make retroactive 401(k) plan contributions.

Benefit experts aren't sure how many returning veterans—if given the opportunity—would make retroactive 401(k) plan contributions.

"A lot would depend on how long an employee was away on military duty and the generosity of the employer match," said Gerald Uslander, a principal in the Washington office of William M. Mercer Inc.

The new House bill also makes clear that 401(k) plans would not have to credit interest for retroactive salary deferrals and matching employer contributions.

Under the bill, a returning veteran could retroactively contribute the same amount he would have been able to had he been working instead of serving in the military.

The compensation of the returning veteran would be set at the amount he was earning immediately before service.

Also included in H.R. 11 are many pension simplification provisions that were part of a tax bill the House passed in February (*BI*, March 2). President Bush later vetoed the bill for reasons unrelated to the pension provisions.

Those provisions would:

- Make it easier for employers to run the 401(k) plan non-discrimination tests.

They would be allowed to compare salary deferrals made by low-paid employees during the previous year with the contributions made by high-paid employees in the current year.

By contrast, current IRS regulations require employers to compare the current year contributions of the two groups.

By using low-paid employees' prior year contributions, employers could know at the start of a plan year how much high-paid employees could contribute to the plan without failing the non-discrimination tests.

- Simplify the definition of "highly compensated employee" for pension non-discrimination testing purposes.
- Require the IRS to round to the nearest $100 and $1,000 the annual inflation adjustments in the maximum employee deferral to a 401(k) plan and the maximum benefit that can be funded through a defined benefit plan.

The IRS also would have to give employers more advance notice on the amount of these inflation-related adjustments.

- Require multiemployer pension plans to adopt more rapid vesting schedules.

The plans could adopt a schedule in which employees were first and fully vested after five years, or a schedule in which employees were 20% vested after three years with vesting continuing at the rate of 20% annually until an employee was fully vested after seven years of service.

Multiemployer plans now typically offer 10-year cliff vesting.

These changes will not significantly simplify pension plan administration, but they are a reversal from recent laws that made administration more complicated.

"The simplification provisions are a welcome change in direction. It displays that Congress has become more sensitive to employer needs," said Frank McArdle, a consultant in the Washington office of Hewitt Associates.

For employees, on the other hand, at least one proposed change will not be welcome. The bill would increase employees' taxes by eliminating favorable tax treatment—known as five-year averaging—of lump-sum pension distributions.

The measure, though, does not include another provision—which had been part of the House-passed tax bill—that would have taxed employees receiving pension plan distributions composed of company stock on any unrealized appreciation on the stock since it was purchased by the employee.

Such appreciation now is taxed only when an employee actually sells the stock, not when the stock is distributed from the plan.

The House bill would also allow non-governmental, tax-exempt employers, like trade associations, to set up 401(k) plans. The 1986 tax law barred tax-exempt employers from setting up 401(k) plans, though it allowed plans that already had been established to remain in place.

In addition, the bill would extend the tax-favored status of employer-provided educational assistance benefits through Dec. 31, 1993. The tax-favored status of educational assistance benefits, allowed under Section 127 of the tax code, expired last week. ■

Provider appeals non-PPO penalty upheld by court

RALEIGH, N.C.—A North Carolina hospital system is appealing a state appellate court's action that will allow the state's self-funded health care plan to continue penalizing plan participants who use a hospital system that is not part of the plan's preferred provider network.

The North Carolina Court of Appeals last week permanently stayed a lower-court injunction that barred the state health plan from imposing the penalties. Carolina Medicorp Inc., which operates two non-network hospitals in Winston-Salem, N.C., is appealing the ruling to the North Carolina Supreme Court.

Carolina Medicorp claims its undiscounted charges already are lower than the discounted charges at the network hospital and that patients should not be penalized for using its facilities.

The state plan requires patients using a network hospital to pay a 20% copayment of all charges up to $1,000 above a $250 deductible. Patients who use a non-network hospital are responsible for a 40% copayment up to $6,000 above a $250 deductible. The plan covers 438,325 state employees, teachers, retirees and their dependents (*BI*, June 22).

Carolina Medicorp filed suit against the state health care system after negotiations concerning the plan's requirements reached an impasse. On June 9, a Superior Court judge granted a temporary injunction barring the state health plan from imposing the additional copayment requirements against plan participants who seek care from Carolina Medicorp. The state's attorney general appealed and the appeals court granted a temporary stay later that week until it could rule on the state's appeal of lower court's order.

The state's high court has not decided whether to hear Carolina Medicorp's appeal.

—By Sally Roberts



Paul Verkouten, Account Executive, Chicago Sales
Derek Serbe, Underwriter, Evanston, IL

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GM sets up educational child care center

General Motors Corp. and the United Auto Workers are joining together with a child care management firm in developing an educational child-care program for UAW employees of the automaker in the Flint, Mich., area.

The UAW-GM Child Development Program, established as a pilot project under the 1990 national collective bargaining agreement between the Detroit-based union and automaker, opened its doors June 15 to provide high-quality care for children of UAW-GM workers.

What makes this daycare facility distinctive, though, is its emphasis on early childhood education and development activities. All of the teachers have college degrees in early childhood education or a related field of study and each classroom is broken up according to children's ages, bringing the child/teacher ratio down to as low as 3-to-1.

The center accommodates as many as 200 children at a time, with ages ranging from 6 weeks to 13 years. The center is open Monday through Friday from 5 a.m. to 1 a.m. to accommodate the needs of workers on both day and afternoon work shifts, said Howard Erickson, a UAW-GM spokesman.

A potential 400 children can use the center each day if employees on each shift send the maximum of 200 children per shift to the facility, he said.

UAW-GM workers pay between $65 and $90 per week depending on their child's age, the length of time the child spends in the center and the number of days used, Mr. Erickson said.

While joint UAW-GM funds were used to construct the facility, Mr. Erickson would not comment on the cost to build the two-story, 16,000-square-foot center. The building is set on five acres of land and includes 10 classrooms, indoor and outdoor activity areas, parent/teacher conference rooms, offices, storage facilities and a kitchen.

The center is managed and operated by Prodigy Consulting of Flint Inc., a consulting and management firm that specializes in child care, he said.

The Flint location was chosen as the site for the child development center because that area is the largest UAW-GM plant community in the United States. Fourteen GM manufacturing plants and warehouse facilities are located within the area, ranging from three to eight miles from the child care center, Mr. Erickson said.

According to a company survey, there are almost 19,500 children age 12 or younger who are dependents of UAW-GM workers in the Flint area. Of these children, 6,400 are age 6 or younger.

According to employee surveys conducted before the center was constructed, quality and affordable child care were two of the most important needs expressed by the workers, Mr. Erickson said.

"Workers are much more productive when they know their children are being taken good care of," he said.

—By Sally Roberts

Health plan survey

Employers that offer health insurance also tend to offer some type of managed health care plan, according to a recent survey of Colorado employers.

Benefit beat

While these employers saw their premium rates increase at last renewal, generally the increase was less than 20%.

And, on the whole, the employers are satisfied with their health insurer or third-party administrator and tend to think that their employees are satisfied as well, according to the survey.

The "1992 Health Benefits Survey" was compiled by Sandbak & Co., a consultant based in Evergreen, Colo., and focused on various types of health plans that Colorado employers provide to employees. A total of 238 Colorado-based employers responded to the survey, which was sent to 1,649 employers.

Nearly half of the responding employers, 46%, are in the manufacturing industry, including construction, printing and publishing; 32% are in professional and technical businesses, including communications, education and insurance; 22% are in other industries like consumer products, farm services, petroleum and energy, utilities and health-related services.

Almost all of the employers, 99%, offer some type of health plan, whether medical indemnity, health maintenance organization, preferred provider organization or a combination; 77% offer some type of managed care plan, such as an HMO or PPO; 42% offer only a PPO option with the medical plan; 17% offer both an HMO and a PPO option; 10% offer only an HMO; and 8% offer an indemnity plan with an HMO, but no PPO option.

Businesses that do not offer a health plan probably tended not to respond to the survey, the authors noted.

More than half of the employers, 55%, fully insure their health care benefits; 36% are partially self-insured, meaning they purchase stop-loss coverage; 7% have a minimum premium indemnity plan; and 2% are completely self-insured.

For companies with medical indemnity plans, the survey found that at last renewal, rates increased:

- 1% to 9% for 21% of the firms with fewer than 100 workers and for 29% of the companies with 100 or more employees.
- 10% to 19% for 40% of smaller employers and 41% of the larger employers.
- 20% to 29% for 26% of the smaller employers and 18% of the larger employers.
- 30% to 50% for 6% of the small employers and 8% of large employers.
- More than 50% for 1% of small employers and none of the larger employers.

Rates actually decreased on renewal for 6% of the small employers and 4% of the larger em-

Continued on next page



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Continued from previous page
ployers.

None of the employers with HMO plans reported rate hikes greater than 30%. Thirty-one percent said HMO rates rose 1% to 9%; 62% reported HMO rate increases of 10% to 19%; and 6% reported rate hikes of 20% to 29%. HMO rates decreased for only 1% of the employers.

Employees and employers are generally satisfied with the service they receive from group health insurers and third-party administrators, the survey said.

Sixty percent of employers said their employees are satisfied with the service provided, surveyed employers reported, while 38% said employees were somewhat satisfied and 2% reported employees were dissatisfied.

Satisfaction is even higher among the employers themselves: 77% are satisfied with their insurers and TPAs, 22% are somewhat satisfied and only 1% are dissatisfied.

Half of the employers report that their employees contribute nothing toward coverage costs; 12% require employees to pay from 1% to 10% of costs; 20% of employees pay 11% to 25%; 17% of employees pay 26% to 49%; and 1% of employees pay 50% or more of costs.

For more information, contact Peggy Sandbak, principal, Sandbak & Co., 1153 Evergreen Park Way, Suite M131, Evergreen, Colo. 80349; 303-670-3482.

—By Sara J. Harty

Investment survey

Pension plan administrators believe employees need more education so that they will not invest their 401(k) funds too conservatively, a recent survey says.

At the same time, about one-third of plan administrators believe that guaranteed investment contracts are no longer automatically considered a safe investment, the survey found.

The survey, conducted by benefit consultant Noble Lowndes, was sent to 200 pension plan managers and others with responsibility for retirement plan investment.

More than two-thirds of the respondents, 69%, said they believe employees tend to invest their 401(k) funds too conservatively.

However, 91% said that improved investment communications about basic investment principles, like balancing risk, would help employees to better manage their 401(k) savings.

Guaranteed investment contracts were considered too risky an investment for 401(k) plan assets by 36% of the respondents. The other 64% did not find the contracts too risky an investment.

One-third of the respondents said that they did not currently have any funds invested in GICs.

The other executives were asked what they would do with their GIC investments once they matured. Of those, 28% said they would consider moving the funds to other fixed-income vehicles; 22% said they would reinvest the same amount into GICs; 16% said they would decrease the funds that are invested in GICs, while 1% said they would increase the funds that are invested in GICs.

For more information on the survey, contact Joan E. Flanagan, Manager of Public Relations, Noble Lowndes, 1635 Market St., 10th Floor, Philadelphia, Pa. 19103; 215-563-1000.

—By Sara J. Harty

Trucking suit

Continued from page 2
of Tempe, Ariz.

The four, who were arraigned separately, are charged with 33 counts of conspiracy, mail fraud, wire fraud and tax crimes committed between July 1987 and December 1990. All but Mr. Akin have been released on bond.

According to the indictment, the defendants duped truck owners into believing they would have liability and cargo insurance if they entered into a lease agreement with the West Coast Truckers Assn., a Nevada company that the defendants ran.

"(Mr. Akin) falsely represented and caused to be represented to trucking companies that their trucks would be covered by WCTA's insurance if they paid WCTA a fee per truck every month and signed a 'lease' with WCTA each month that purported to lease the trucking companies' trucks to WCTA," the indictment states.

To further mislead the trucking companies, the defendants issued false certificates of insurance to the fee-paying trucking companies, the indictment charges.

WCTA, which had obtained coverage for its own fleet of trucks through the Nevada Assigned Risk Plan, allegedly never added any of the other truckers to its policy.

Rather, WCTA told its insurer, Industrial Indemnity Co. of San Francisco, that it was actually operating with fewer trucks in order to reduce its premium payments, the indictment asserts.

But when the trucks that were

Defendants face a maximum five years in prison and a $250,000 fine for each non-tax offense.

supposedly "leased" to WCTA were involved in traffic accidents, defendants Akin, Robinson and Cleghorn allegedly encouraged the truck owners to "make material representations to the insurance company as to the nature of the trucking company's relationship" with WCTA to obtain coverage, the indictment charges.

This was intended to dupe the insurer into thinking the claimant was covered under WCTA's policy even though it wasn't.

Authorities are still investigating how much Industrial Indemnity paid out in claims payments for uninsured trucks.

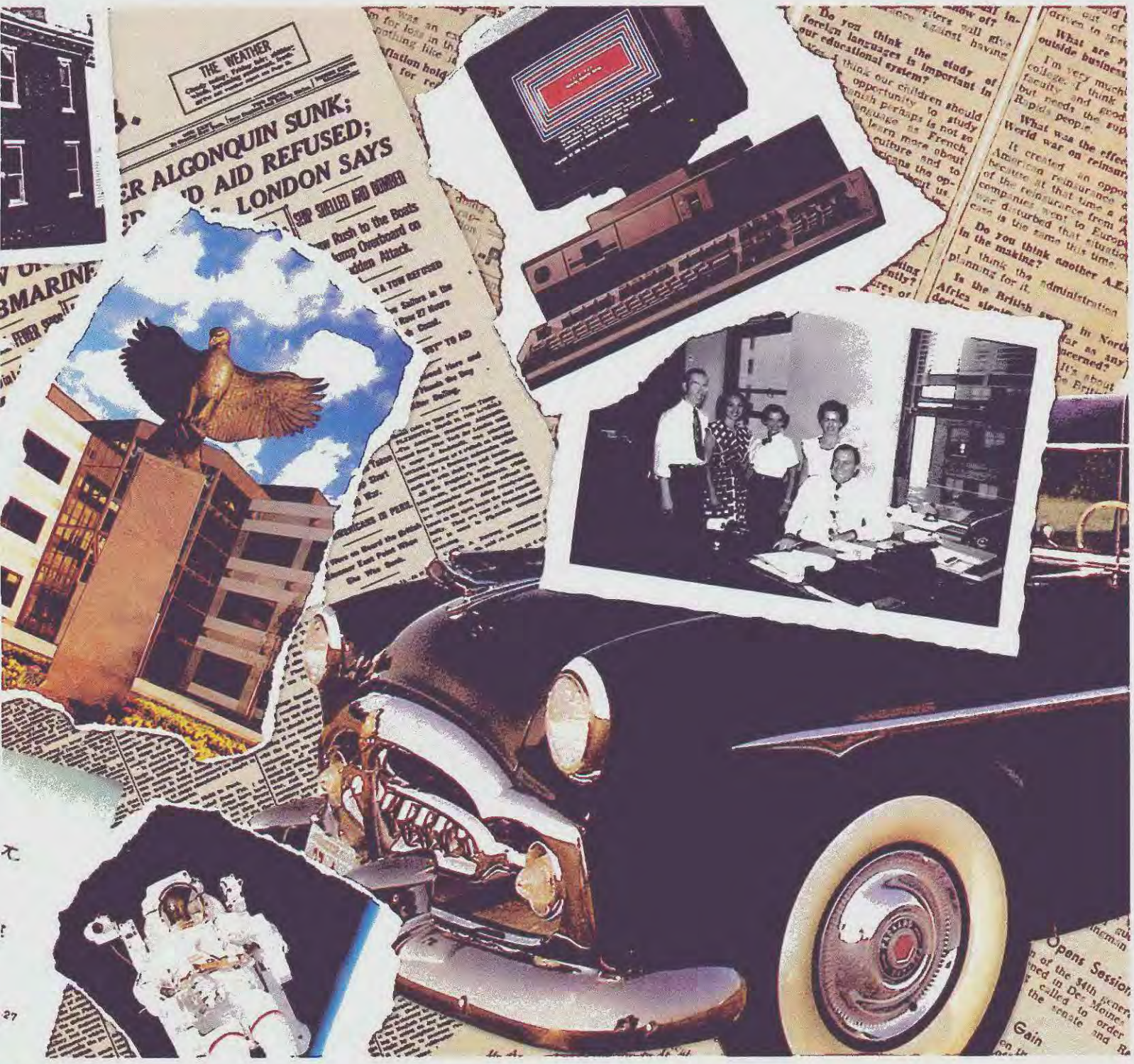
The indictments are the product of a joint investigation by the ICC, the U.S. Postal Inspection Service, the Internal Revenue Service and the U.S. Department of Transportation.

Industrial Indemnity also cooperated with investigators and will serve as a witness during trial, confirmed a spokeswoman for the Crum & Forster Inc. unit.

If convicted, the defendants face a maximum penalty of five years imprisonment and a $250,000 fine for each non-tax offense. The tax counts have a maximum penalty of one year imprisonment and a $100,000 fine.

A trial is set for Oct. 13 in federal court in Los Angeles.

None of the defendants' attorneys would comment on the case. ■



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Opinions

Act now on product bill

RISK MANAGERS: PICK UP your pen and write to your U.S. senators to urge passage of S. 640, the Product Liability Fairness Act.

The full Senate is scheduled on Sept. 8 to consider the legislation. If you support a uniform federal product liability reform law, it is vital to let your senators know—now, not when it is too late—the importance of this legislation.

There's no doubt the plaintiffs' bar will be out in force blasting the bill—introduced by Sen. Robert Kasten Jr., R-Wis.—as pro-business and anti-consumer.

While such a charge may have had some validity a decade ago when the first federal product liability reform bills were introduced in Congress, that's no longer is the case. For example, the current bill would not cap damage awards or shield companies from liability if their products were manufactured in accordance with the prevailing state of the art. Earlier product liability reform proposals included such provisions.

Instead, the reforms included in S. 640 are fair and reasonable.

For example, the legislation would eliminate joint and several liability for non-economic damages in product liability suits.

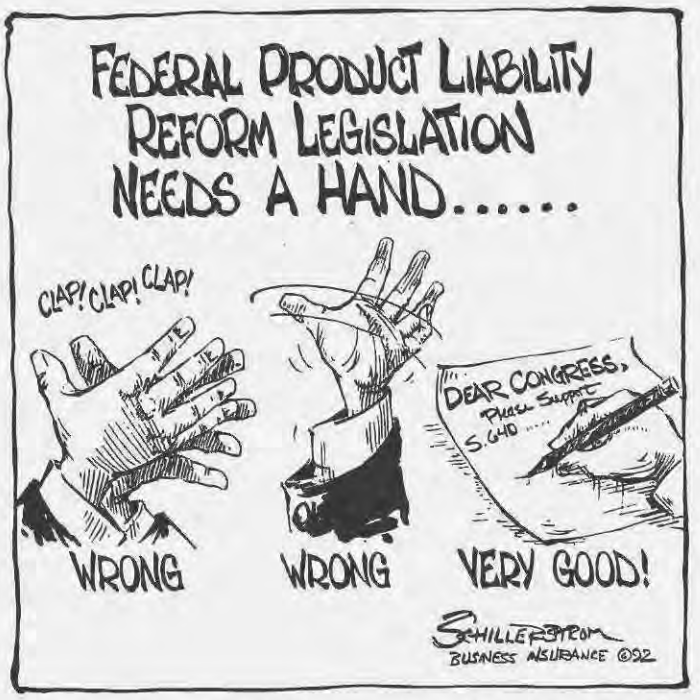
Business, insurers and consumers all are victims of the system now used in many states in which a manufacturer can be held totally liable for an entire pain-and-suffering award, even if it is only slightly at fault. How can an insurer accurately price product liability coverage if policyholders can be held liable for damages they didn't cause? The specter of joint and several liability inflates insurance costs and ultimately leads to higher prices for products brought to market.

In addition, the legislation generally would shield manufacturers from lawsuits involving capital goods products more than 25 years old.

With technology changing so quickly, it isn't reasonable to expect old products to have been manufactured to comply with today's standards or not to have been altered by users without the consent of the manufacturers.

The legislation also creates a uniform standard for punitive damages. An accident victim would have to prove through "clear and convincing evidence" that a defendant exhibited "conscious, flagrant indifference" to public safety.

Too often punitive damages are awarded by juries without rhyme or reason. And while the U.S. Supreme Court has called for stepped-up judicial review of punitive damages awarded by juries, ridiculous awards can still result.



Also under the bill, punitive damage awards generally could note be assessed against pharmaceutical and aircraft manufacturers whose products were approved by the Federal Drug Administration or the Federal Aviation Administration. Only if the manufacturer withheld information or bribed federal officials to win certification could punitive damages be awarded.

That's eminently fair and reasonable because the federal approval process establishes a fair standard of care.

It also is fair and reasonable, as the bill proposes, to eliminate liability for wholesalers and retailers except when they are negligent or when the product manufacturer is broke. A wholesaler currently can be sued for handling a defective product because it is in the distribution chain.

Even if the Senate approves S. 640, it is very unlikely the House of Representatives will consider the legislation before it adjourns this fall. But Senate approval would give tremendous momentum to the drive to pass the bill during the next congressional session.

While low liability insurance rates have put the drive for tort reform on many companies' back burners compared with six or seven years ago, business must not give up the fight for product liability reform, especially on the federal level. Only with continued pressure on lawmakers in Washington can a reasonable, fair and uniform federal product liability law finally become reality.

At issue

What are you doing to monitor your insurers' solvency?



David W. Eaton
Manager-Risk, Insurance and Benefits Financing
Bandag Inc.
Muscatine, Iowa

We rely heavily on our broker's solvency watchdog committee. We also follow the media for information on the larger carriers. We have a long-term relationship with a major property/casualty carrier and go directly to its senior management with any concerns. We don't subscribe to a rating service but may request that information from our broker.



Myrnie Daut
Risk Manager
City of Eugene
Eugene, Ore.

We rely on our broker. When we go through renewals, we always ask what the A.M. Best Co. ratings are for the companies we are considering. Also, our broker monitors the solvency of carriers within its own organization and maintains a list of approved carriers.



L.W. Hollensbe
Director-Risk Management Department
Kerr-McGee Corp.,
Oklahoma City, Okla.

We're relying heavily on our broker, as well as A.M. Best Co. and Standard & Poor's Corp.

Compiled by Sara Harty

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Weiss ratings

Continued from page 1

Portland, Ore.

"Weiss's methods are primitive," asserted Russell Miller, chairman of Russell Miller Inc., a San Francisco investment banking and consulting firm that specializes in the insurance industry.

Mr. Weiss, president of Weiss Research, counters that his organization "uses a much more complex statistical model than any of the other" rating agencies use.

Weiss Research uses a "full-blown econometric model," while "the statistical work of the other rating agencies is far more primitive," he said.

In addition, "Our information is not biased" because it is based strictly on objective data, he said.

Weiss Research's Insurance Analysis Division includes seven analysts, including Mr. Weiss, and two support staffers.

The West Palm Beach, Fla., firm has been rating life insurance companies since 1989. Individual insurance company ratings are available instantly over the telephone, in a one-page summary, in an 18-page report or by subscribing to a quarterly publication.

Insurance companies do not pay Weiss Research to receive a rating, and the ratings are not voluntary—they are published, even if the insurer disagrees.

The ratings are generated by a computer analysis of data pertaining to life insurance companies. The data comes from four sources:

- The data base of the National Assn. of Insurance Commissioners.
- Statutory state insurance department filings.
- Quarterly surveys of the insurance companies.
- Other publicly available data, like reports from the American Council of Life Insurance and the New York Insurance Department.

There are five components to the rating system:

- A risk-adjusted capital index, which analyzes what risks a company is underwriting and compares it to the company's capital and surplus.
- A five-year profitability index, which encompasses gains or losses on operations by line of business, consistency of operating results, the impact of operating results on surplus, the adequacy of investment income compared to policy reserves and expenses as a percent of revenues. Data from current and prior years are weighted so that more recent data have greater impact on the index.
- A policy leverage index, which evaluates how much coverage a company has written in proportion to its capital resources.
- An investment safety index, which analyzes a company's exposure to bond and mortgage defaults, market value declines and changes in interest rates.
- A stability index, which compares a company's current and historical operations to determine if there are significant differences. The index also assesses any protective measures—like capital additions or special investments that are very secure—that a company has taken against adverse experience or economic developments.

While Mr. Weiss touts his ratings as "objective," critics say that Weiss Research's statistical-based ratings are faulty, not fair.

Much of the controversy over the organization's methods surrounds its sole reliance on the computer model. Other rating agencies incorporate discussions with management.

"You just can't evaluate a company just by going through numbers," said Fred Cue, senior vp of finance for the Blue Cross & Blue Shield Assn. in Chicago. Equally important are discussions with managers about their business plans and their sense of their place in the marketplace, he said.

"There might be many things that aren't disclosed by balance sheets," like the current efforts by a company to increase surplus, noted Merle Mattenson, an agent for Prudential Insurance Co. of America in Chicago.

It is "absolutely, unequivocally critical" to communicate with management during the ratings process, agreed Myron M. Picoult, managing director and senior insurance analyst with Oppenheimer & Co. in New York.

These communications often reveal factors and explanations about an insurer's operations that should be considered in issuing a rating, said Mr. Picoult. "You can't go just by the numbers alone."

"You are always looking backwards when you're looking at numbers only," observed Ms. McCarrel of Wyatt Asset Services.

It is a "classic analysts' fallacy" to "project forward past history and extrapolate into the future," she said. "The only thing you can definitively get a handle on with numbers alone is what has happened in the past."

Other rating agencies, though not critical of Weiss Research's methodology, say they find talking with insurer managers invaluable in developing ratings.

And, they say that charging insurers for their ratings, which Weiss Research does not do, is the standard way the bond rating business is conducted. Furthermore, it establishes a contractual relationship with insurers that opens doors to valuable information.

Chicago-based Duff & Phelps Credit Rating Co. charges firms a basic fee of $17,000 annually for its ratings.

"When you have a full, contractual relationship with a client, you become an insider," said Executive Vp Milton Meigs.

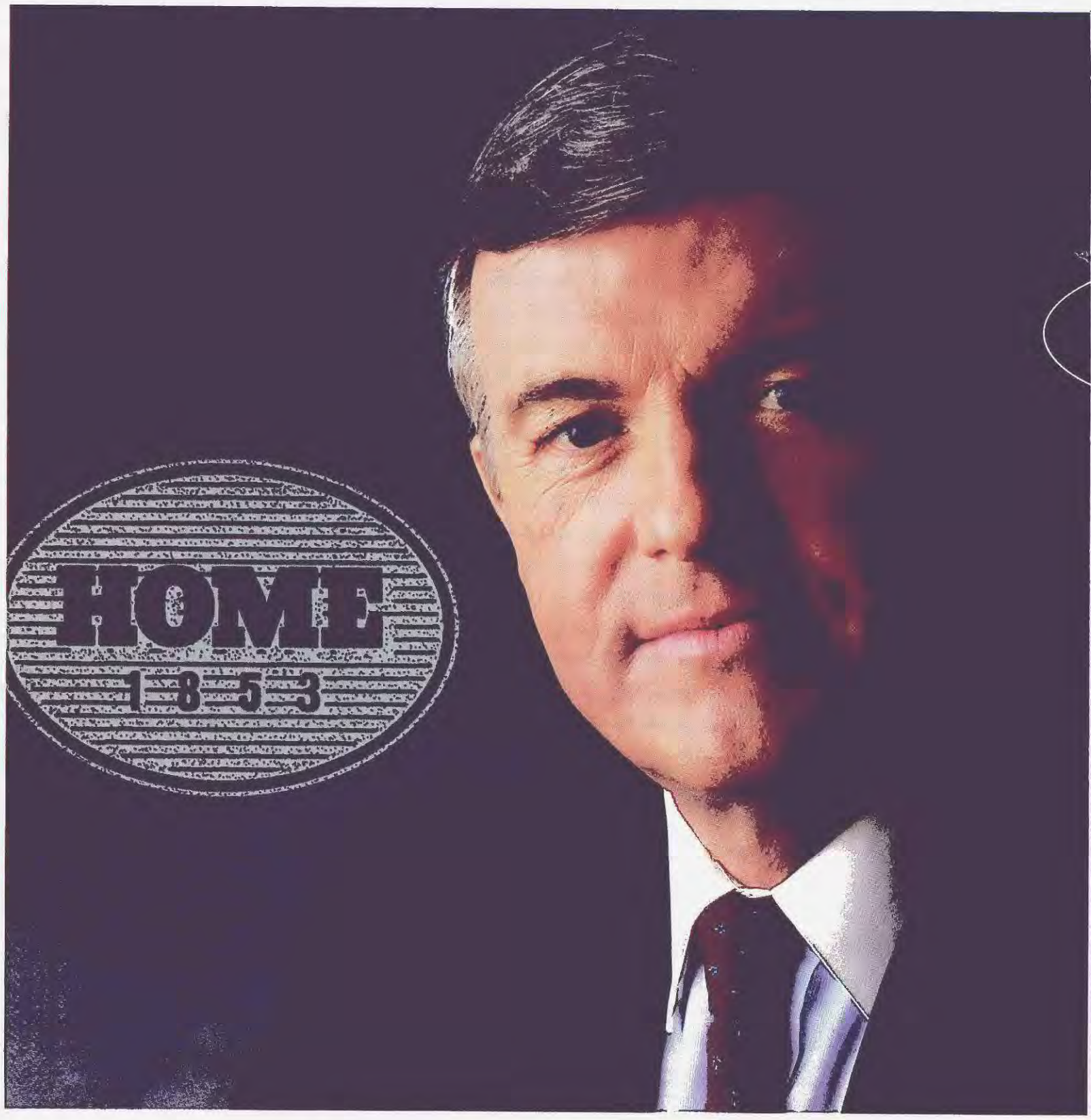
Management shares its projections and expectations with analysts, so that "over time, you get a sense of how good management is at projecting," he said.

"You get a confidence level in the management team, not just a statistical measure at a point in time," he said.

"Insurance, like other financial businesses, is a people-intensive business," Mr. Meigs noted. "The

Continued on next page

THE HOM



OLD PROS ON

Continued from previous page
people that are involved are really the critical element ultimately."

Duff & Phelps has 10 full-time insurance analysts, plus specialists in other areas of the company that are called in when necessary.

"Any financial analyst will tell you ratio analysis is a good starting point—but it shouldn't be the ending point," said Chester Murray, associate director for New York-based Moody's Investors' Service Inc., which has been rating the financial strength of insurance companies since 1986. "I've never run into a case where qualitative assessments are not essential to drawing the right conclusion."

For example, a holding company could own both a life insurance company, which owns some questionable real estate and junk bonds, and a property/casualty company, which is financially solid, he said. "You have to make a judgment on whether the holding company will stand by the life company. If you look at the (numbers of the) life company alone, you're missing this."

"We're trying to look into the future," he said. "Ratio analysis is not predictive. It's really a point-in-time, historical perspective."

Moody's charges insurers $25,000 annually for a claims-paying ability rating.

Ten analysts plus support staff work full-time analyzing the claims-paying ability of insurers while other Moody's professionals are called in when necessary, said Mr. Murray.

The analysts perform statistical analysis and make qualitative judgments, Mr. Murray said.

Another rating agency, New York-based Standard & Poor's Insurance Rating Service, publishes a qualified solvency rating, which insurers do not pay for. The ratings are not voluntary and are based solely on data from the NAIC data base and company financial statements.

"Broadly speaking, this approach can be successful in classifying companies in broad risk categories," said Roy Taub, managing director of the Standard & Poor's Corp. unit. However, "we do feel that an approach based just on statistical information is not as comprehensive a way of analyzing companies," he said.

S&P's also issues claims-paying ability ratings, which cost insurers $25,000 annually on average. These involve extensive discussions with management, said Mr. Taub.

More than 80 people work in S&P's life/health insurer ratings division, 40 of whom are analysts.

Oldwick, N.J.-based A.M. Best Co., which has been rating insurance companies since 1906, charges companies an annual fee of $500.

Insurers can block publication of their ratings. But those that do so are assigned a rating of NA-9 to inform readers that a Best rating is being withheld at the insurer's request, said Larry Mayewski, vp in Best's life/health division.

The NA-9 ratings stay on the books for three years before a company can be rated again.

Best's life/health ratings are developed with a staff of 210 people, 100 of whom are analysts.

Mr. Weiss defends his methodology, noting that some observers have made misleading statements.

"It's been said that we are strictly using numbers and nothing else" to generate ratings, but that is not true, Mr. Weiss asserted.

Weiss Research converts qualitative information—like the quality of reinsurance, the quality of asset/liability matching and the quality of management performance—into a measurable quantity, Mr. Weiss said.

Then the various "scores" are computer analyzed along with the other data, he said. "That's the only way you can really be fair."

Several critics also complained that Weiss Research uses worst-case economic assumptions when evaluating insurers' financial strength.

"Rather than focusing primarily on current claims-paying ability, we place heavier emphasis on a firm's ability to cover claims in the future or in the face of economic adversity," a Weiss Research brochure explains.

The organization develops two risk-adjusted capital ratios. One is a measure of a company's ability to withstand a moderate economic decline, the other a measure of ability to withstand a severe decline. Both are used in rating a company.

But, the organization's computer model "is predicated on everything in the American economy going bad at the same time," said an ACLI spokesman in Washington.

And, although Mr. Weiss claims every possible circumstance and contingency can be built into the computer model, others doubt a computer can properly recognize the nuances of individual companies.

"There's a concern that we have with the Weiss methodology," said Joseph B. Bellerson, president of the New York GIC Exchange, an investment contract consultant in Cincinnati. "We're concerned with the lack of evaluation of the individual characteristics of each life insurance company."

With Weiss, "you get people who are model-builders, not analysts," Ms. McCarrel said.

Acceptance of the Weiss Research ratings has been less than stellar in the commercial insurance community.

For example, only 21% of those responding to a 1991 survey of members of the American Society of Chartered Life Underwriters and Chartered Financial Consultants who use rating agencies reported using Weiss. In contrast, 99% reported using Best's ratings and 89% reported using S&P's.

Only 20% of the 377 people surveyed said they have confidence in the Weiss ratings. For Best and S&P ratings the confidence rate was 93%.

However, several observers say that Weiss Research is a good counterpoint to the other ratings firms.

Continued on next page

E TODAY



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A NEW TEAM

Weiss ratings

Continued from previous page

For example, Wyatt Asset Services' Ms. McCarrel said that the Weiss Research system "may point you in some directions you hadn't thought of with their numbers crunching."

"They can give you some good insights into what are the things you are overlooking," she said.

Weiss Research "adds a dimension" to the ratings field that the other rating agencies do not provide, she concluded.

"What they've done is a good thing, whether or not technically they're perfect," said J. Robert Hunter, president of the National Insurance Consumer Organization in Alexandria, Va.

"Weiss changes the dynamics" of the insurance rating field, Mr. Hunter said.

"The Weiss system may be flawed, but it may be that Weiss is on to something," said Peter Katt, president of Peter Katt & Co., a fee-only life insurance adviser in West Bloomfield, Mich.

"Weiss probably rates companies lower that should be higher, but he probably doesn't rate companies higher that should be lower," Mr. Katt commented. ■

Weiss rating BC/BS plans

By DEBORAH SHALOWITZ

WEST PALM BEACH, Fla.—While several organizations rate life/health insurers, only one has made a strong foray into rating Blue Cross & Blue Shield Assn. plans and other independent health and dental indemnity insurers.

Weiss Research Inc. in May released its ratings of 65 BC/BS and other health plans.

This is "the area where we would be most able to contribute," said Martin D. Weiss, president of Weiss Research Inc., a West Palm Beach, Fla.-based investment research and advisory organization that began rating life/health insurance companies three years ago.

"We have just broken some major new ground in the area of health insurance," Mr. Weiss said.

Only slightly more than 38% of the BC/BS, HMO and DMO plans that Weiss Research has analyzed were assigned report card-type grades of B or better, and nearly 11% were rated E, or "very weak."

Specifically, two of the 65 plans received A ratings, 23 received Bs, 21 received Cs, 12 received Ds and seven received E ratings.

Forty-two of these plans are BC/BS Assn. affiliates.

"It was assumed that these companies would always be there," said Mr. Weiss, but "the failure of the Blue Cross & Blue Shield plan of West Virginia disproves that notion."

'We have just broken some major new ground in the area of health insurance,' Mr. Weiss says.

Blue Cross & Blue Shield of West Virginia in Charleston, insolvent by $37 million, was ordered liquidated in October 1990 (*BI*, Oct. 29, 1990).

Standard & Poor's Insurance Rating Services in New York also has rated the claims-paying abilities of a few of the BC/BS plans which Weiss Research has rated.

Some of their conclusions vary widely.

For example, S&P rated BC/BS of Florida as A+, compared with a C− rating from Weiss. Similarly, S&P gave BC/BS of Texas an A; Weiss gave it only a C.

Referring to Weiss Research, Fred Cue, senior vp of finance for the BC/BS Assn. in Chicago, said: "As they have been for all companies they rate, they are extremely conservative and they have been extremely conservative here."

Differences are not so wide for other BC/BS plans.

For example, S&P rated BC/BS of Alabama AA; Weiss Research gave it a B+.

S&P rated BC/BS of Minnesota AA−, while Weiss Research rated it B.

And, S&P rated BC/BS of Western Pennsylvania AA−, while Weiss Research assigned the plan a B− rating.

Weiss Research assigned its highest ratings to Medical Service Corp., a Spokane, Wash., health insurer, which received an A rating, and to Pierce County Medical BC/BS plan of Tacoma, Wash., which was rated A−.

Weiss assigned E− ratings to four plans: BC/BS of New Hampshire, BC/BS of New Jersey, BC/BS of Vermont and Wholehealth Insurance Network Inc., a New York-based health insurer.

"The problems of these organizations have been well-known," according to Mr. Cue of the BC/BS Assn. However, "while they're not triple A rated, they've made a lot of improvements," he said.

For the most part, the other rating organizations have not pursued this niche.

For example, Moody's Investors Service Inc. in New York primarily serves institutional investors, which are not interested in BC/BS-type plans, explained Diane Jacobosky a senior analyst with Moody's. ■

Following in his father's footsteps

WEST PALM BEACH, Fla.—The acorn didn't fall far from the tree for Martin D. Weiss.

The 45-year-old president of Weiss Research Inc. developed an interest in financial institutions from his father, who analyzed banks, insurers and brokerage firms in the 1920s and 1930s.

The elder Mr. Weiss, 84, also works at Weiss Research in West Palm Beach, Fla.

Martin Weiss graduated from Columbia University in New York in 1971 with a bachelor's degree in liberal arts.

He received a master's degree in cultural anthropology from Columbia in 1973 and is working toward a doctorate, also in cultural anthropology, at Columbia. Mr. Weiss' doctoral dissertation will be on Japanese financial institutions.

Mr. Weiss is married and has a 10-year old son.

—By Deborah Shalowitz

Insurance company ratings only one of several services offered by Weiss Research

WEST PALM BEACH, Fla.—Insurance company ratings is only one of the services offered by Weiss Research Inc., a privately held firm specializing in financial information.

The West Palm Beach, Fla., firm generates revenue from publishing ratings, newsletters, books and references on the financial safety of banks, savings and loans and insurers. Formed in 1971, it employs 85 people.

It is Weiss Research's Insurance Analysis Division that publishes insurer ratings. Seven analysts, including President Martin D. Weiss, and two support staffers work in the insurance analysis division.

The two key staff members in the division are Ted Brownstein, director of insurance safety ratings, and Peter Chapman, a consulting actuary.

About 70,000 people have bought insurer ratings from the company since it began publishing them in 1989, according to Mr. Weiss.

Insurer ratings are available for $15 each by calling 800-289-9222. One-page summaries of a company are available for $25 each, or $55 for three. Full 18-page reports on an insurer are available for $45 each, or $95 for three.

Weiss Research also publishes a quarterly insurer safety directory with information on about 1,700 life and health insurers. The quarterly directory is $189 per issue, or $376 for a one-year subscription.

A corporate subscription service is available for $766 per year and includes a one-year subscription to the quarterly insurer directory, updates to company reports, and other reports, studies and press releases.

Weiss Research also publishes three newsletters: the "Safe Money Letter," which tracks the interest rates for various securities and offers investment advice; "The Holt Advisory," which tracks the price of gold; and "The Silver & Gold Report," which offers advice on investing in precious metals.

Company policy prohibits employees from owning the securities they analyze.

Weiss Research's Financial Safety Division publishes reference directories that detail the financial standing of 12,300 commercial banks and 2,500 S&Ls.

Weiss Money Management Inc., an associated firm, manages a fund investing solely in Treasury bills, notes and bonds for individual investors. Its portfolio is valued at about $35.5 million.

Weiss Publishing & Marketing Inc. is an associated mailing list broker. It handles the financial mailing lists for Weiss Research and other financial newsletter publishers. It also creates and manages direct-mail and media campaigns.

—By Deborah Shalowitz

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Expenses forcing Aetna to take charge in quarter

HARTFORD, Conn.—Aetna Life & Casualty Co. will take nearly a $200 million aftertax charge in the second-quarter for costs related to massive layoffs and to losses on a financial guarantee written for Olympia & York Developments Ltd.

After five years of declining profits, Aetna is trying to cut costs and boost earnings with a business plan that calls for eliminating 4,800 jobs.

The nation's largest publicly traded insurance company announced last week that its 15 business units are eliminating the jobs by the end of 1993 in hopes of producing an annualized pretax savings of about $200 million starting in 1994.

The company is taking a pretax charge of $145 million in the second quarter to cover severance pay, employee benefits and related charges.

In addition, Aetna will take a $45.7 million pretax charge on second-quarter earnings for losses on a financial guarantee it wrote backing interest payments on bonds secured by a 53-story office tower in New York owned by O&Y.

Aetna already paid $20.75 million to bondholders after Toronto-based O&Y was unable to completely fund interest payments on the bonds, an Aetna spokesman said. Aetna took the pretax charge in the full amount of its financial guarantee obligation in anticipation of O&Y's future needs. The guarantee was issued by Aetna Casualty & Surety Co.

Aetna also issued a $140 million guarantee—secured by a 26-story Los Angeles office tower—on commercial paper issued by Olympia & York Capital Inc. In addition, Aetna wrote about $14 million in other guarantees for O&Y, all of which are secured by bank letters of credit, and has a $197 million mortgage loan on an office building in New York (*BI*, May 25).

No losses are expected on these investments, which are "adequately secured," the Aetna spokesman said.

Meanwhile, each Aetna business unit manager is responding to Chairman Ronald Compton's "challenge to run each operation more cost-effectively," a spokeswoman said.

Aetna's net income dropped 18% to $505 million in 1991 from $614 million in 1990. In its annual report, Aetna said that "continued deterioration in the commercial real estate markets led to large capital losses from additions to mortgage loan reserves and write-downs on real estate."

About 17% of loans in Aetna's $20 billion real estate loan portfolio have either stopped paying interest or are in foreclosure, said William Cavanagh, an analyst with Standard & Poor's Corp. in New York.

While Aetna claims there is "no relationship" between its real estate woes and the 10% cut in jobs to increase profits, Mr. Cavanagh said, "It does increase pressure on management to improve profitability in other areas."

Furthermore, Aetna "must make acceptable profits for investors, even in poor insurance markets," he said.

Walter Fitzgerald, an analyst with RAS Securities in New York, adds: "This step had to be taken to produce an adequate level of profitability."

Aetna is expected to eliminate about 3,000 positions in 1992 and 1,800 more in 1993. Aetna currently has about 46,000 employees.

Roughly 40% of the jobs will be eliminated in Connecticut and the remaining 60% from elsewhere.

Nearly all the cuts will occur in four key areas. Hardest hit will be group health insurance, where about 1,300 jobs will be eliminated, said Aetna's spokeswoman. Property/casualty field operations will lose about 1,000 workers, property/casualty claims about 800, and systems and information technology will lose about 700.

This is not the first time Aetna has laid off a sizeable number of workers. In 1990, the company eliminated 2,600 positions as it reorganized its three domestic insurance divisions into the 15 strategic business units (*BI*, Nov. 5, 1990).

—By Sally Roberts

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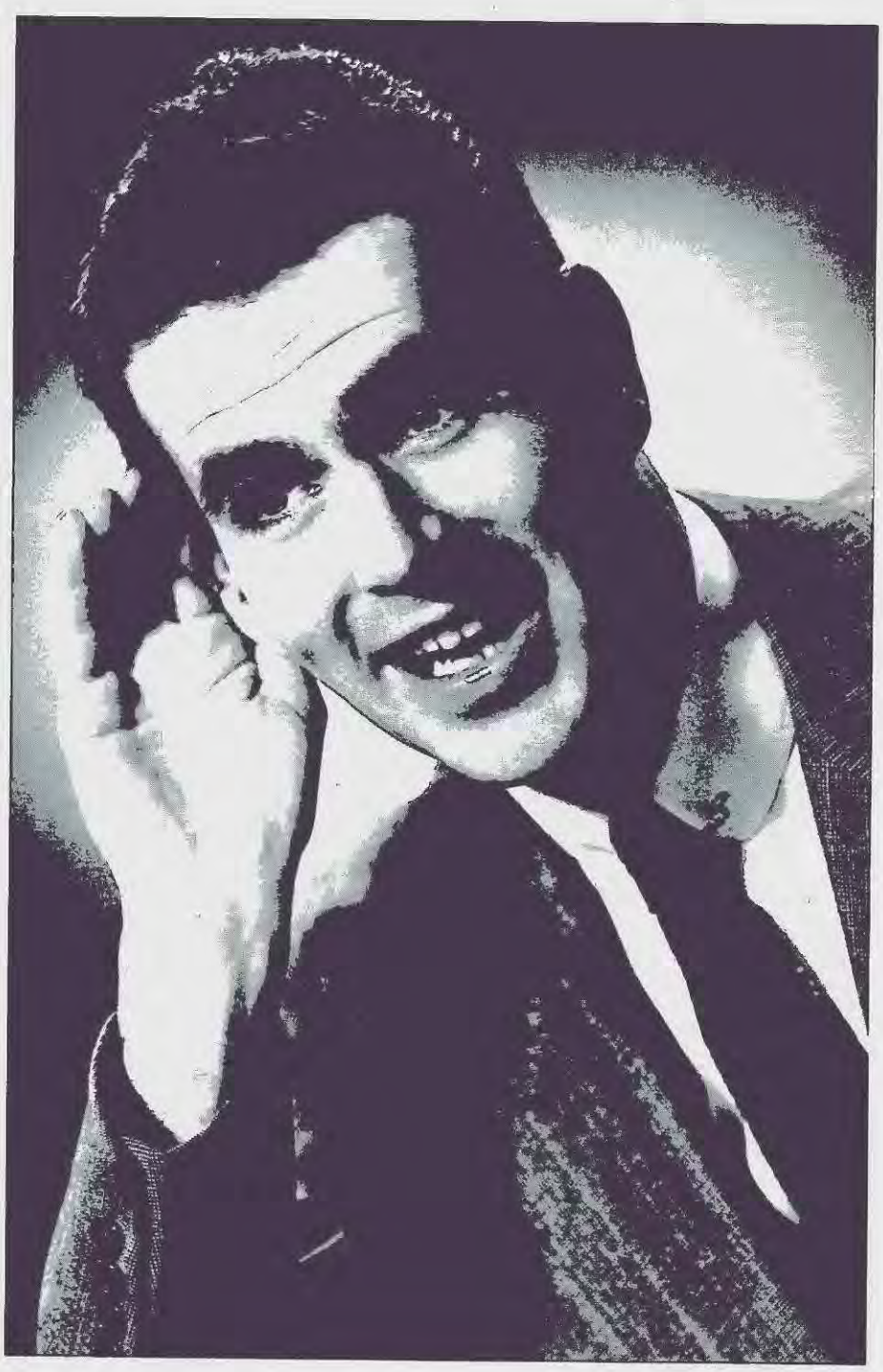
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Referrals

Continued from page 2

mated 20% to 30% of overall costs stemming from unnecessary services—any policy that potentially opens the door to fraud and abuse is inappropriate, benefit managers say.

"This policy decision bothers me. It's a step in the wrong direction," said Fred Hamacher, vp-compensation and benefits with Dayton Hudson Corp. in Minneapolis. "Studies have been pretty conclusive in showing that there's a bias when physicians own labs."

A January study by benefit consultant William M. Mercer Inc. focused on more than 6,500 workers compensation claims in California and found that approximately 76% of all referrals to three common types of outpatient facilities were made by doctors with an ownership stake or investment in those outpatient centers.

The facilities examined by the study included physical therapy centers, magnetic resonance imaging/computerized axial tomography scanning facilities and psychiatric treatment centers.

And, according to the Mercer study, about 31% of the facilities' charges were determined to be excessive and unnecessary.

Another well-publicized study on self-referrals was conducted in 1989 by the Department of Health and Human Services. That study reported that, nationwide, at least 25% of all clinical laboratories, 27% of physical therapy clinics and 8% of medical supply companies are owned in whole or in part by referring physicians.

In addition, the HHS study found that patients of referring physicians who owned or invested money in a clinical lab received 45% more services than other patient. Patients of referring doctors also received 13% more physical therapy sessions than other patients, according to the study.

The study did not quantify how many more medical supplies were used on patients whose doctors had a stake in medical equipment supply companies, but it did report that more supplies were used.

"Self-referral is fraught with peril and conflict, and in my opinion, it needs much more scrutiny than it currently receives," said Arthur Young, employee benefits manager with Hewlett-Packard Co. in Palo Alto, Calif. "Oversight of outpatient referrals is not at the level it should be."

The shift in the AMA's referral policy "flies in the face of political and public opinion and will lead to greater profits for physicians," said Fred Hunt, president of the Society of Professional Benefits Administrators in Chevy Chase, Md., who maintains that third-party administrators are virtually powerless to catch inappropriate referrals.

"It's a very quiet practice that we cannot catch. It's very simple for a doctor to hide his relationship with a radiology center or an MRI unit," said Mr. Hunt.

And, while the recent AMA decision does require a referring doctor to disclose the fact that he or she has a monetary interest in a lab or clinic and also requires a physician to provide patients with information about alternative treatment settings, the effect of this disclosure requirement will be nominal, critics say.

"Disclosure in itself is not going to result in many patients challenging the referrals of their doctors, nor can I envision patients asking for a price list of competing service centers," said Dr. Roger Taylor, national leader of The Wyatt Co.'s health care practice in Washington.

"How am I as a patient to know where to go instead?" asked Mr. Hamacher. "I'd be more comfortable with disclosure if the doctors were willing to also provide exact prices of similar facilities in a region."

Joseph Duva, a principal with Ernst & Young in New York, agreed with these assessments.

"In reality, simply informing a patient of ownership won't do a thing. By and large, patients aren't paying for the services themselves. It's an employer or insurer who pays, so why should the patient care?" he asked.

But physicians say that the situation is not nearly as bad as benefit managers and health care consultants are making it out to be.

They acknowledge that referral abuse does exist in the medical field, but insist that the overwhelming percentage of doctors make referrals based on necessity and not to increase personal profits.

Therefore, a universal policy against self-referral is unfair to ethical doctors and may actually harm patients who live in areas where outpatient services are limited, physicians say.

"Blanket opposition to self-referral is unnecessary," said William E. Ryan, a geriatric specialist in Pennington, N.J., and president of the Medical Society of New Jersey. "The way to police unethical doctors is to give local medical associations wider authority to punish the abusers. This way, not all physicians are punished."

"Every profession has its bad apples, but 95% of physicians are ethical," said an orthopedic surgeon from the Pacific Northwest, who spoke on the condition of anonymity. "I can't deny that an outside lab is a profit center, but doctors should never refer for the express purpose of generating revenues. That's totally unethical."

About the only thing employers can do to insulate themselves from unnecessary self-referrals is to arrange capitated health care plans, in which physicians are paid a flat amount per plan participant, or to require employees to access all care through a gatekeeper, benefit experts say.

"Capitated plans are the only answer," said Hewlett Packard's Mr. Young. "This way, there's absolutely no incentive for a doctor to over-refer."

Dayton Hudson's Mr. Hamacher said employers can attempt to limit employee access to physicians that have investments in outpatient clinics.

"But this is a lot easier to talk about than to do." ■

Settlement Days

Continued from page 2

with policyholder attorneys they call regularly, to clear their desks of lingering files or to reapproach a case that has reached an impasse before turning to litigation.

All types of claims are negotiated at these gatherings, which take place in hotel suites in various cities.

"Face-to-face negotiations sometimes make the difference" in keeping a claim from becoming a lawsuit, said Mary Ann Patrusky, claims supervisor for CIGNA Corp. in Bala Cynwyd, Pa., who went to a recent Settlement Day held in Philadelphia.

Another benefit is that rather than taking a morning out to visit a single attorney's office, "you have 30, 40, 50 lawyers available to you, and they have 10 or 20 insurers there," said Ann Finnegan, supervisor of claims adjusters at Colonial Penn Group in Philadelphia. "The people physically being there is advantageous."

The potential cost savings that result from the efficiency of the claims negotiation program is a big part of its allure.

Attorneys, who come to the meetings at insurers' invitations, pay nothing to attend, "so they have absolutely nothing to lose," according to Jessica Miller, a marketing specialist with Claims Settlement Services. Insurers pay a flat fee of $950 each for a hotel suite that CSS reserves for them to hold meetings with attorneys.

That cost broke down to about $85 per case settled for Ralph Volpe, a claims technical specialist in the Philadelphia office of Aetna Life & Casualty Co. He brought 26 cases to a Settlement Day and walked away with 11 settled and nine pending offers to be finalized.

The cost "is a drop in the bucket when you realize it would cost $5,000 to $10,000 to go to suit, before trial costs," said Mr. Volpe.

Claims Settlement Day is less expensive and more effective than other alternative dispute resolution methods, according to participants.

CIGNA's Ms. Patrusky said she also uses "judge-for-a-day" programs, in which a judge comes to an insurance company to hear claims disputes with policyholders. But costs can run as high as $3,000 for the judge plus $400 for the program organizers, and the judge will hear only eight cases, she said.

Using arbitrators to reach a settlement can be difficult, because the arbitrator can throw out figures that neither party has agreed upon, according to Aetna's Mr. Volpe, who believes person-to-person negotiation is "always a better situation."

"The system feeds on itself, too," said Mr. Volpe. After getting an invitation to a Settlement Day, attorneys will go through their files and suggest additional cases that can be settled with the insurer that invited them, or they will contact other participating insurers.

CSS provides all parties with a list of participants prior to the gatherings, so other contacts can be made.

"The more cases the insurance companies include, the more interested we become," said Morton Slifkin, a partner at Slifkin & Axe in Philadelphia, who initiated contact with several insurers on behalf of claimants and settled about 30% of the cases he brought to the Philadelphia day.



Photo courtesy AISG

Part of Settlement Days' allure stems from the cost savings in bringing 30, 40 or 50 lawyers together with 10 or 20 insurers.

Because the purpose of Settlement Days is to settle, certain conditions, like thorough preparation and a willing attitude, are essential to assure that settlements will happen, participants say.

"The insurance company by participating is indicating a willingness to settle," said Mr. Slifkin.

"If you're reasonable and they're reasonable, (the day) will get you somewhere where you weren't before," agreed Kevin Malloy, an associate with Dashevsky, Horwitz, Kuhn & Disandro in Philadelphia, who represents claimants.

Also, he added, "you're scheduled and prepared ahead of time, rather than calling someone out of the blue when they're not ready for you and have 10 other things going on."

A case should be far enough along that enough information has been gathered to make a fair judgment about it, one claims executive said.

CIGNA's Ms. Patrusky found she was more successful with files four or five years old than with cases she has only had for a year or two, which may contain incomplete information.

Sending people with discretionary authority also is essential, so "you can get rid of the caps (on settlement amounts) adjusters would have and move spontaneously on a settlement," Ms. Patrusky said.

To send claims adjusters without negotiating power can agitate the other party and hurt chances for any settlement, agreed Joe DeSimone, an attorney with Rovner, Allen, Rovner, Zimmerman & Kats in Feasterville, Pa.

Mr. DeSimone complained that the insurer personnel with whom he met in Philadelphia did not come with the money or proper authority to actively deal.

"If all they can do is make an offer, I don't want to go down there and spend half a morning doing what I could do over the phone," he said.

Although settling claims is the point of the gatherings, it is not the only reason participants attend Settlement Days.

"I like to meet the people face to face even if the case doesn't settle," said plaintiffs' attorney Mr. Slifkin. "You have comments, things to refer back to when you talk on the phone again."

Disruptive personality conflicts between insurers and attorneys can be resolved by a personal meeting on neutral territory, clearing the way for easier negotiations in the future, participants said.

And insurers sometimes send trainees to observe experienced negotiators and to gain insight into how attorneys work, according to Mr. Volpe, who has attended three Settlement Days.

Although some parties will come with only one or two cases, most use the day to clear files, bringing 10, 20 or even 30 cases.

Now that it is summertime, said CIGNA's Ms. Patrusky, it is great to get a case closed "and send your client on vacation."

For more information on Settlement Days, contact Jessica Miller, Claims Settlement Services, 85 John St., New York, N.Y. 10038; 212-669-0523. ■

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Litigants sought for city flood suit

By SARA J. HARTY and SARA MARLEY

CHICAGO—A lawsuit filed in a Chicago court seeks class-action status on behalf of Chicago businesses with unpaid business interruption claims stemming from the city's April underground flood.

However, the attorney filing the suit is looking for new plaintiffs and defendants.

The original complaint was filed last month on behalf of Melvin Wolf & Associates, a furniture wholesaler located in the Merchandise Mart—where Chicago River water was first discovered on April 13—against its property insurer, General Accident Insurance Co. of America.

Philadelphia-based General Accident had sent the furniture wholesaler a reservation of rights letter, which prompted the suit. However, the insurer never formally denied Wolf's business interruption claim.

Because a settlement has since been reached between Wolf and General Accident, a motion will be filed to dismiss or amend the suit to reflect new defendants and plaintiffs, said Wolf's attorney, Robert A. Holstein of Holstein, Mack & Klein in Chicago.

The new plaintiffs may include two or more restaurants that incurred business interruption losses due to the flood. The restaurants purchased business interruption coverage from Maryland Casualty Co. of Baltimore and River Forest Insurance Co. of Oak Park, Ill., but their claims were denied, according to Mr. Holstein.

River Forest Insurance Co., which exclusively writes coverage for restaurants, had about 30 policyholders affected by the flood, said Eugene F. Chess, claims manager. While most of the claims were for business interruption, some of its policyholders did have water damage. All of their policies were on a standard Insurance Services Office Inc. property form and the decision was made to deny all the claims, Mr. Chess said.

Companies with "manuscripted policies, like Marshall Field's, were very clearly covered," Mr. Chess said. "That makes us look like bad guys but we are dealing with different policies" and "there was no justification" for coverage in this case, he said.

Representatives of Maryland Casualty Co. could not be reached.

If the restaurants are ready to proceed with their suit prior to August, when the motion to dismiss the Wolf suit will be heard, a new complaint may be filed this month rather than waiting to amend the original complaint, Mr. Holstein said.

Either way, much of the language in the complaint will remain the same.

The original complaint seeks class-action certification of both plaintiffs and defendants under an unusual provision in Illinois law.

The suit defines the class of defendants as insurers doing business in Illinois that issued "business income coverage policies" containing ISO policy language or language substantially similar to that in Wolf's policy.

The lawsuit, filed in Cook County Circuit Court, states that there are at least 50 such insurers.

Besides General Accident, the Wolf suit lists ISO as a respondent in discovery. The plaintiff "is informed and believes that ISO has information essential to the determination of who should be properly named as additional defendants and (has) information regarding interpretation of the contract of insurance," the says.

While the Wolf suit is believed to be the first flood-related action in which an insurer has been a named defendant, at least eight other lawsuits have been filed in connection with the incident (*BI*, June 1). Those suits, which also seek class-action status, seek damages from the city of Chicago and Great Lakes Dredge & Dock Co., the contractor that installed bridge pilings last summer over a section of the city's underground freight tunnel system that collapsed, allegedly triggering the flood. ■

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Malpractice

Continued from page 2

really think long and hard" before having the attorney who is a witness to important events, especially those involving coverage advice, later serve as trial counsel, Mr. Richler said.

Fremont alleged that the lawyer should have removed himself as counsel and served as a witness for the insurer's defense.

"An insurance company is entitled to as many and as much fundamental rights as any client," said Mr. Richler.

But Cummins & White's attorney, Charles C. Wehner of Wehner & Perlman in Los Angeles, says the law firm acted properly in its handling of the case and contends Fremont is attempting to shift its own liability onto the firm. In fact, having the firm's attorneys testify in the bad faith litigation would have harmed Fremont's case, he claims.

Cummins & White plans to appeal the verdict, he said.

The complex dispute began with a July 4, 1983, fire at Callas Meats, a meat market and grocer in Lancaster, Calif.

A son of the market's owners, Harry and Elizabeth Kasparian, admitted to setting the blaze, but at different times contended he had been kidnapped and forced to do so by either the Armenian nationalist movement or the KGB, according to Alan Faigin, associate general counsel for Fremont. No charges were ever filed against the son.

Fremont hired Cummins & White in November 1983 to represent it in adjusting the market's business interruption claim.

Fremont advanced $100,000 in provisional business interruption payments to the Kasparians in both January and February 1984. But on Cummins & White's advice that there was insufficient information available, another $110,000 payment was not made until after an accountants report was prepared in March 1984, according to Mr. Faigin.

By that point, however, the Kasparian family had fallen behind on loan payments and it was too late for them to save their business. In July 1984, the business was returned to the Callas family, the market's original owners and the Kasparians' secured lenders.

In February 1985, the Kasparian family filed a bad faith action against Fremont. The family alleged it had lost its business because of Fremont's delays in paying the business interruption claim.

Fremont, which was represented by Cummins & White in the 1989 trial, was ordered by a jury to pay the Kasparians about $20 million. This was subsequently reduced in post-trial motions to $12.5 million and was eventually settled for $8.5 million in March 1991.

Mr. Faigin charges that several factors led to the verdict:

- Cummins & White failed to raise the defense that Fremont had relied on the advice of counsel in handling the claim.
- In late 1983, a Kasparian family member went to Cummins & White in an unsuccessful attempt to give attorneys business records and was left sitting for three hours before leaving.

Legal ethics guidelines actually forbade Cummins & White from directly accepting the records from Mr. Kasparian. But while the firm could have told Mr. Kasparian to submit it to them indirectly through his own attorney, it never did so.

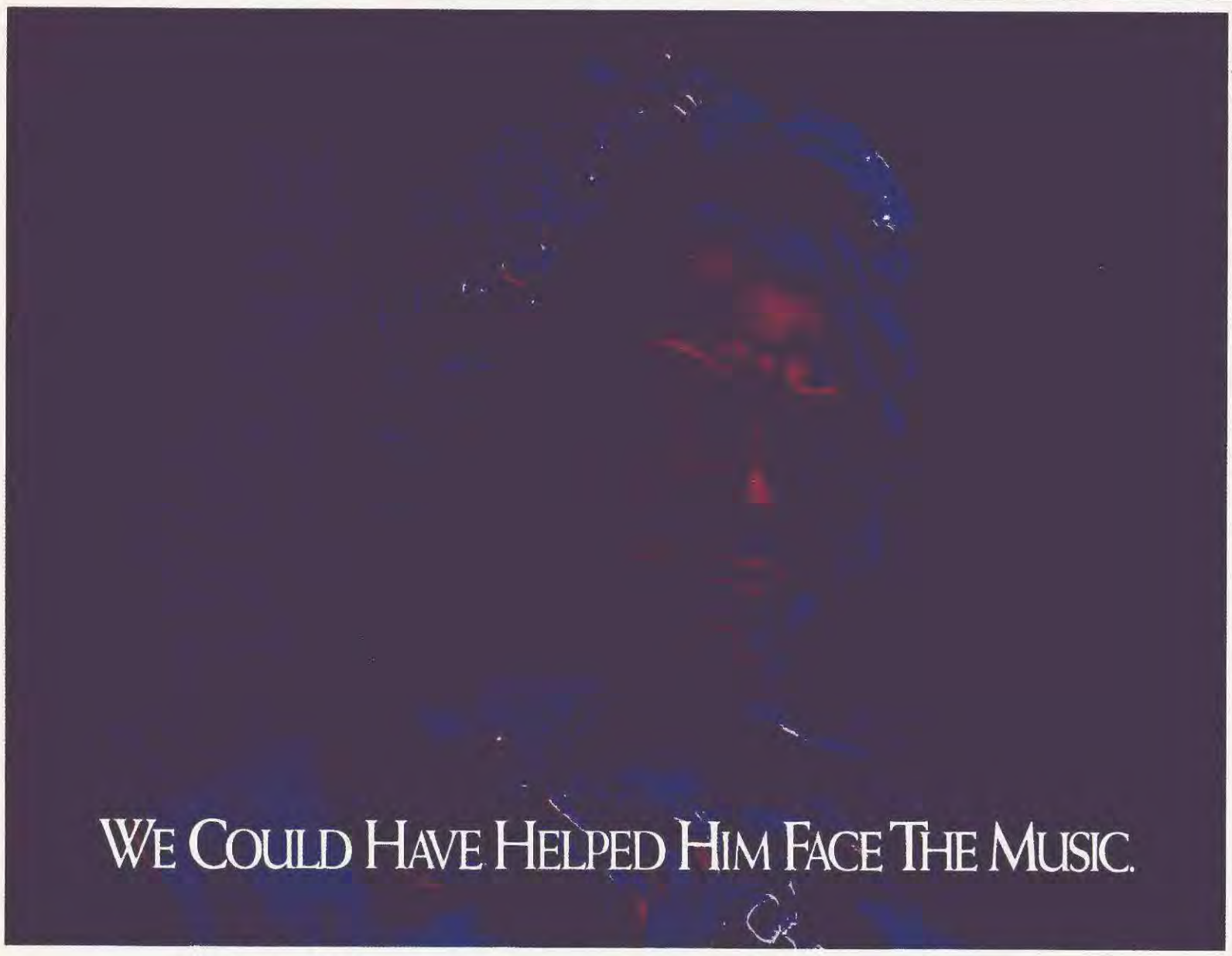
"They just let this poor man sit there for three hours," said Mr. Faigin. The ethical code was never clearly explained to the jury during the trial, he said.

- Particularly damaging was a deposition from an accounting expert who said a Cummins & White attorney handling the case, Gene Weisberg, told him the $110,000 payment made in March was discussed in an oral report as early as a January meeting.

Mr. Faigin, though, said this was not the case. "I think he got confused."

Cummins & White's Mr. Weisberg is to blame for the damage caused by the accounting expert's testimony, according to Mr. Richler. "This is the kind of

Continued on next page



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Agent/Broker Topics

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Slimmer staffs in 30 days

Principals are finding their next cost-cutting target

By LAURA MAZZUCA

THE COMPANY CAR is gone. Country club dues are a thing of the past. Producer compensation has been restructured and reduced as customer service representatives take on more sales responsibility. So where else can an agency or brokerage turn to cut what little fat is left in their business?

More and more, the answer is restructuring support staff compensation.

"Producer compensation is going nowhere," said Diane Cross, a consultant with Business Management Group in Hartford, Conn.

Compensation & Incentives

So agencies and brokerages are restructuring their support staff compensation by replacing across-the-board annual raises with bonuses tied to agency performance, Ms. Cross said.

They are following the lead of Top 20 brokerages like Hilb. Rogal & Hamilton Co., which recently instituted a general salary freeze.

Staff salaries are a fairly new area of concern. For years, producer compensation has been the dominant topic of discussion (*A/BT*, April 1. 1991).

Over the course of the soft market, most agencies and brokerages already have "massively" slashed their "selling-related" expenses, like producer commissions and related perks, said Larry Marsh, president of Marsh, Berry & Co. in Mentor, Ohio.

Now these businesses are getting down to cutting basic payroll expenses—by restructuring compensation methods, adopting across-the-board salary freezes or reductions, and sometimes by laying off employees.

Such cuts are a matter of survival for many agencies and brokerages that have stopped growing in the soft market. But they are difficult to make, especially for small agencies that have only a few support staffers, Mr. Marsh said.

For one thing, performance-based compensation is not easily applied to individual support staff, he said.

With producers, customer service representatives and others involved in getting new business or servicing existing accounts, compensation can easily be tied to the increase in book volume, Mr. Marsh said. Incentives for support staffers, on the other hand, are typically built around an agency's general performance and are therefore less directly tied to an employee's individual performance, he explained.

And making cuts in support staff is difficult because of many agencies' increased reliance on these personnel in the soft market (see story, page 16D).

Despite those difficulties, agencies and brokerages say they are trying to foster a new emphasis on teamwork and accountability as methods of compensation are changed.

At Hilb, for instance, its cost-control strategy includes the restructuring of producer and account

Continued on next page

Agents struggling in the inner cities

Will inadequate access to markets destroy what the riots left standing? Problems not limited to Los Angeles

By LAURA MAZZUCA

LOS ANGELES—Herb Jones was one of the lucky ones.

During the Los Angeles riots in April, elderly neighbors warned vandals that his Crenshaw Boulevard insurance agency was black-owned. That, he believes, saved it from destruction.

"They burned down the market across the street and the building on the corner. But they left my business alone," said Mr. Jones, president of Community Financial Planning, which has operated in the Crenshaw district for 23 years.

And the next day, area gangbangers scared off looters who were looking into Mr. Jones' storefront office for something to steal.

Other agencies in the area weren't as lucky. Some were burned out completely. Others had to close because of water damage. And Mr. Jones' business lost electricity for five days after the riots.

But having escaped ruin during the riots, Mr. Jones and other area agents are losing their lifeblood in another way—by a lack of available insurance markets.

While he has one preferred appointment with a California-based personal and commercial lines insurer, Mr. Jones' appeals to major insurers for appointments have been met with "ridiculous" volume requirements. Or silence.

Even after diversifying into real estate, financial planning and life insurance, Mr. Jones is in trouble.

Annual premium volume dropped 15% last year to $680,000. Business is so bad that he was recently forced to lay off his office manager. He's now at the agency until 10 or 11 at night, handling paperwork she once handled.

"When you let your office manager go, you know that the profit line is getting pretty thin," he said.



Photo by Tim Petros

His own Crenshaw district agency spared, Herb Jones surveys damage nearby.

Inner cities overlooked

Mr. Jones' plight is by no means unusual for independent agents in inner-city areas.

Of course, some of their problems—the recession, the soft market, competition from direct writers—are shared by small agencies everywhere.

But other problems are unique to the inner city. For example, while suburban or rural agencies struggle with greater volume demands from insurers, inner-city agents simply don't have any insurers to make such demands.

"The problem of appointments is no better than it was 20 years ago. In fact, it's worse," said Jim McDowell, secretary/treasurer of Beneficial Insurance Agency, located on Chicago's South Side.

As president of the Professional Insurance Agents & Brokers Assn. of Illinois—a coalition of 65 inner-city firms across the state—Mr. McDowell cites the lack of standard insurer markets as the major concern of inner-city agents.

His own agency, with $4 million in annual premium volume, has contracts with several major insurers—including General Accident Insurance Co.,

Continued on page 16D

Agent/Broker Topics

CSRs moving up the ladder

By LAURA MAZZUCA

As customer service representatives play a bigger role in agencies, principals may face the same problems they face with producers—finding them and paying them.

CSRs service accounts to free up producers. They also handle administrative tasks once done by producers, like preparing submissions for insurance company review, preparing client proposals and rating accounts.

To find CSRs able to handle such tasks, some agencies and brokerages are even using recruiters.

"There's little flexibility on the side of the client; they're willing to wait to find what they want," said Bobbie Stone, a consultant for Robert Murphy Associates, a New York executive recruiting firm.

Demand is rising from larger brokerages for CSRs, especially those well-versed in a specialty area like errors and omissions, she said.

Alphabet houses expect CSRs—or "assistant account executives"—to handle some clerical duties and binder information. Smaller firms are more likely to expect more account servicing, Ms. Stone said.

Salaries are relatively high compared with clerical positions. East and West Coast businesses typically pay $20,000 to $25,000, she said.

Like producers, CSRs that service accounts should have the incentive of "spot bonuses" tied to the size of the book of business they service, said Diane Cross, a consultant with Business Management Group.

Controlling the CSR payroll can prove difficult, cautions Larry Marsh, president of agency consulting firm Marsh, Berry & Co. Inc.

Despite all sorts of talk about hiring "professionals," most CSRs are not professional enough for producers to turn their responsibilities over to them, he said. But well-trained CSRs can handle renewal marketing, freeing producers to sell new business, he said.

Nationwide, salaries average $18,500 for a CSR in personal lines. For commercial business, the figure can range from the mid-teens up to $50,000, with the average salary being "well over" $30,000 at top agencies, Mr. Marsh said.

Ideally, pay should be tied to the volume of business handled. Goals and quotas should be designed around average account size to encourage the weeding out of smaller, labor-intensive accounts, he said.

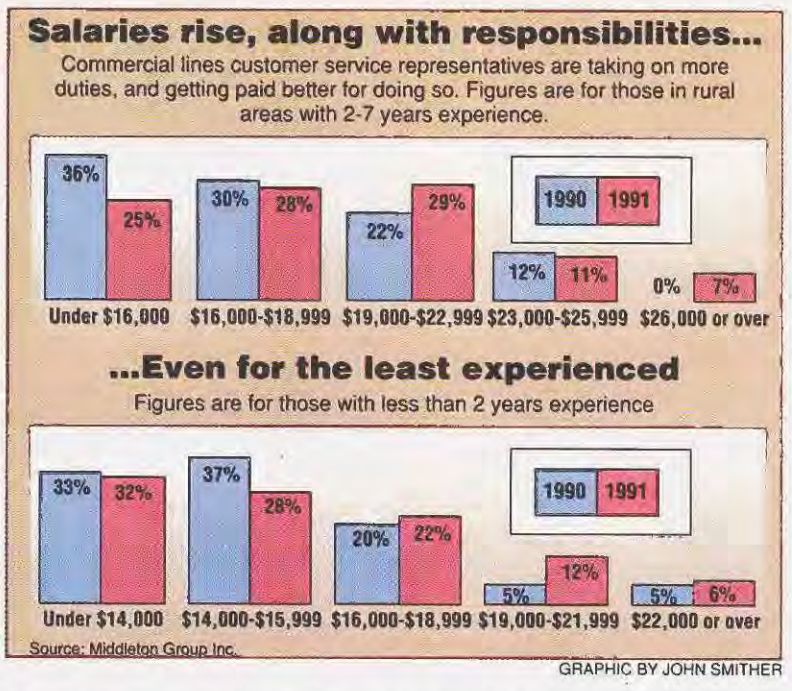
Done right, a CSR program can significantly enhance agency value.

"We have a great staff," boasted Leslie Jacobs, president of the Rosenthal Agency in Metairie, La., with $35 million in annual premium volume. "When we hire, we look for athletes and train them."

Ms. Jacobs credits her staff of 15 "unit support people" for freeing up outside producers to get new business.

Rosenthal Agency recently added a job description for unit support staffers; salaries range from $18,000 to $40,000. The variance reflects the wide range of skills involved, from traditional billing, binding and processing endorsements, to doing everything an outside producer does except leave the office.

Unit support employees are expected to specialize. One, for instance, serves only fuel wholesalers. That's a "big difference from a CSR who's handling 40 accounts," she said. ■



GRAPHIC BY JOHN SMITHER

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Inner-city agents

Continued from page 16A

USF&G Corp., and ITT/Hartford Group Inc. But most association members are smaller and less fortunate, he said.

National agent groups often have little to offer small, inner-city agencies, many of which can't even afford membership dues, added Mr. McDowell, who is also the regional vp of the Independent Insurance Agents of Illinois.

Agents operating in the inner city of Los Angeles and other cities complain that big-name insurers, which demand high premium volume and niche markets, routinely pass the inner-city agent by when making agency appointments.

Even well-known personal lines direct writers have abandoned the area, they say.

It's not that insurers won't underwrite risks in these neighborhoods; rather, they will write the business from agencies elsewhere, sometimes miles from the inner-city businesses seeking coverage.

"Agents experience a lot of discrimination in this area," said Morris Davis, president of Morris Davis Jr. Insurance Agency in Inglewood, a working-class suburb south of Los Angeles. And it's not necessarily racial discrimination, he adds. "Companies just do not want to set up agency plants in this area."

Nowhere else to turn

Passed over by major insurers, inner city businesses are forced to seek coverage elsewhere, often with devastating results.

Inner-city independent agents typically have to place their business through managing general agents—thus giving up a sizable chunk of commission—or turn to non-admitted insurers, which aren't backed by the state guaranty fund.

Because some coverage was placed with unstable, non-admitted insurers, some riot-related claims will not be paid, observed Ted Huntington, vp of public and industry affairs for the Professional Insurance Agents of California.

It was riot claims, in fact, that recently prompted California regulators to bar surplus lines brokers from placing any more business with Pacific Fire & Marine Insurance Co.

The Turks & Caicos Islands insurer faces more than 40 claims totaling $3 million to $4 million. Reviewing Pacific Marine's financial statements, regulators disallowed the insurer's main asset—a $6.3 million certificate of deposit—leaving a statutory surplus of $224,406.

Lack of markets in the area is also why much of the losses arising from the Los Angeles riots were uninsured, said Joe A. Contreras, owner of the Latin Insurance Agency of California in East Los Angeles.

Insurers estimate that they will pay out $775 million in riot-related losses.

However, in an informal phone survey of 1,859 individuals and businesses, the California Insurance Department found that only 38% with riot damage had any coverage, incurring losses of about $465.7 million. Nearly half—48%—lacked coverage and had losses of $87.1 million. The remaining 14% did not respond to the coverage question but reported losses of $43.2 million.

Of those without insurance coverage, 46% said it was too expensive, 17% said it was unavailable, 3% said agents wouldn't quote coverage for their area and 0.5% said they did not qualify for FAIR plan coverage. But 11% said they never sought a coverage quote, and 29% did not respond.

"Insurance companies failed to realize that they must participate in the community," said Mr. Contreras, who is president of the Alliance of Inner City Brokers & Agents, a coalition of about 150 agencies in Los Angeles. His 20-year old agency lacks access to commercial coverage other than through the state Fair Access to Insurance Requirements plan, under which insurers provide property coverage to people and businesses for whom insurance is not easily available or affordable.

After hearings on redlining last month, Insurance Commissioner John Garamendi announced he intends to expand the FAIR plan to include replacement cost and business interruption coverage.

But observers with a national perspective take a broader view of the problem.

"The issue is much bigger than redlining," said Patricia A. Borowski, vp of government and industry affairs for the National Assn. of Professional Insurance Agents in Alexandria, Va. "Problems like deteriorating auto markets, congestion, losses and suppressed rates are issues that apply to all urban areas. They're not just core inner-city issues."

Insurers say their reluctance to appoint agents in the inner city is not discrimination, but rather a function of survival.

Citing Proposition 103, some insurers have been reluctant to make any agency appointments in California, let alone Los Angeles.

SAFECO Corp., for instance, has made no new appointments in the state since Prop. 103 was approved in 1988, said Vance Hickin, resident vp for the Pacific Southwest region. Out of a sense of obligation, SAFECO will continue to write new business for its existing customers and agents, he added. "Our decision has nothing to do with Los Angeles."

Others cite corporate marketing decisions as a reason for avoiding inner cities. At CIGNA Corp., a spokesman said agency appointments are made exclusively on the basis of targeting markets like hospitality and leisure, manufacturers, contractors and yachts.

Not all insurers are reluctant to do business with inner-city agents, contend some agents.

Community Financial Planning's Mr. Jones, for instance, said his preferred agency contract with Monterey, Calif.-based California Insurance Group has been very satisfactory, even in the wake of the riots. California Insurance Group is the marketing name for three small insurers ultimately owned by Kelly-Moore Paint Co.

"They've been very supportive. After the riots, the vp called to see how things were going, and told me it's business as usual—if you send it to us, we'll write it," Mr. Jones said. He has placed area office buildings, preferred auto and homeowners risks with the insurer.

And for personal auto risks, a few insurers, including California Insurance Group and National Auto & Casualty Insurance Co. of Pasadena, Calif., have appointed new agents to the area, "so that's a little ripple in the water," Mr. Jones said.

But such sympathetic exceptions are few and far between, agents say.

"I don't have a single major carrier," said Mr. Davis, who has operated his insurance agency in Inglewood for 32 years.

Dealing with non-admitted companies, "you just cross your fingers

Continued on next page

Continued from previous page

and hope they don't go out of business," he added.

Mr. Davis' agency has $1 million in annual premium volume, but it has grown primarily through the acquisition of the books of business of two other agents, not through new business, he said. Mr. Davis would like to hire more employees, but he can't afford it. Instead, he maintains a five-person staff: himself and four family members.

Mr. Davis also points out that agency errors and omissions coverage is expensive and hard to obtain —again, because of his agency's location.

The agency used to represent CIGNA Corp., but lost that appointment when it was unable to meet volume requirements, he said.

Since then, he has had to look beyond the large insurers for markets—with mixed results.

Crusader Insurance Co. in Woodland Hills, Calif., an insurer with a reputation for doing business in the inner city, "is doing a great job in the area," said Mr. Davis, who uses it to place apartment package, liquor store and other commercial coverage. But Crusader only places business through its general agents, which means Mr. Davis must split the commission.

The FAIR plan is another alternative, but until now it has covered only basic property coverage and does not allow producers to charge added fees on the coverage.

For many commercial risks, an inner-cty agent must piece together coverage by using substandard insurers. And banks, acting as escrow agents in commercial transactions, often will not accept such coverage, Mr. Davis said.

Such piecemeal arrangements are generally more expensive for the buyer, as well.

Take, for example, an area medical center for which Mr. Jones recently found coverage. Securing $1 million in limits for the center required going to three sources: the FAIR plan, a federal crime insurance program for theft coverage, and a non-admitted insurer for liability coverage. Premiums come to $12,000 a year, probably $5,000 more than a business owners policy purchased outside the area from a major insurer, he said.

The only "solid" insurer Mr. Davis' agency represents is Republic Insurance Co. of Dallas, which only writes homeowners coverage. And Republic requires more than $100,000 in annual premium volume in order for him to keep the appointment, he said.

As a last resort, Mr. Davis is forced to place business for "the rejects," like substandard auto and hard-to-place commercial coverage through whatever markets he can find. "The big companies skim off the 10% or so of the best business in the area," he said. "All we can do is take the crumbs off the table."

Insurance companies, which are so concerned about their public image and customer service, should understand that an area agent who knows the community would enhance their image, said Mr. Jones. "If business is being written here—and business *is* written on risks in this area—there's no reason why they can't write it right here."

Trying to deal directly with insurers is useless, charges Mr. Contreras of Latin Insurance Agency. "They don't want to spend the time and the money to build in the inner city." Only "carrots" like state or federal incentives to appoint agencies in the area will work, he said.

Roxani Gillespie, the former California insurance commissioner, had the right idea when she proposed to draw preferred auto insurers into the inner city by offering them credit through assigned risk applications, Mr. Contreras said.

While this plan was never launched, a similar system—like one based on tax credits—could be used to bring property/casualty insurers into the area, Mr. Contreras explained.

However, the issue of inadequate markets for inner city agents has grabbed the attention of California insurance regulators. Mr. Garamendi has announced the formation of an Anti-Discrimination Task Force within the Insurance Department, which will develop anti-redlining regulations that include incentives for insurers and their agents to provide coverage in poor areas.

And, while the Office of Administrative Law recently rejected new emergency rules that would have set stricter reporting standards for non-admitted insurers (*BI*, May 4), state lawmakers are currently considering several other measures to toughen regulation of offshore insurers.

In Illinois, Mr. McDowell's says insurers could be sued for discriminatory practices. "Insurance is quite high in the inner city compared with the rest of the state. It's a form of redlining."

Agents agree that unless the redlining problem is resolved, insurer indifference to inner-city problems will result in more unrest, and possibly violence, Mr. Contreras said. "The destruction that was seen will definitely be repeated, and boundaries won't be confined to the inner city," he warned.

"If not for the riots, the media would not be looking at this," Mr. Davis said. "The last time they looked at it was 25 years ago. I don't think it should be another 25 years before it's looked at again." ■

AUGUST — **Marketing & Sales Promotion**

Issue: August 3
Ad Closing: July 22

The recession and the soft property/casualty insurance market are delivering a two-fisted punch to most agencies' budgets. Yet, now more than ever, agencies need to spread the word about their services. *BI's Agent/Broker Topics* section will look at how agents promote themselves considering the slimmer margins under which they're operating and will examine what types of sales promotion are the most cost-effective.

SEPTEMBER — **Most Productive Agencies**

Issue: September 7
Ad Closing: August 25

What sets the most productive agents and brokers apart from the pack? *BI's Agent/Broker Topics* section will once again rank the most productive U.S. agents and brokers and examine how these agents rose to the top of the class. Agency executives will explain how to use niche marketing, automation and producer incentives to maximize staff productivity.

OCTOBER — **IIAA Conference Report**

Issue: October 5
Ad Closing: September 22

Is there a merger in the works between the Independent Insurance Agents of America and the other large agent trade group, the National Association of Professional Insurance Agents? *BI's Agent/Broker Topics* section will assess the state of the IIAA and analyze the potential for such a union and the impact on independent agents. What's more, *BI* will cover the IIAA conference in New Orleans and report the big stories emerging from that meeting.

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Agent/Broker Topics

Driver passes the reins of his 65-year-old firm

California brokerage launched in Depression as a one-man agency has grown to become 31st-largest in nation

By SALLY ROBERTS

SAN DIEGO—In 1927, 19-year-old Robert F. Driver rented a small corner office from a general agent in San Diego to set up his own insurance agency.

Today, that corner office has grown into a nine-story Fifth Avenue headquarters in downtown San Diego, and the one-man shop has become the nation's 31st-largest insurance brokerage (*BI*, June 29).

Last month, a career that struggled through the Great Depression was capped with a lavish celebration at the grand old Hotel Del Coronado. After more than six decades at the helm of the firm he launched, Robert F. Driver stepped down as chairman of the board.

"I've just had a great life," Mr. Driver said. His nearly 84 years have been filled with travel, politics, family, hobbies, industry leadership and community service.

Mr. Driver traces the spiritedness that has fueled his various endeavors to his grandparents, all of whom traveled across the plains in covered wagons in the mid-1800s. His mother's father, William, traveled to Utah with Mormon prophet Brigham Young.

Mr. Driver's own entrepreneurial talents came through after his family moved to San Diego from Utah when he was not quite 3 years old.

"I've really worked all my life," Mr. Driver recalls. At 6, he had his own magazine route; by 10, he was selling candy door-to-door.

His big break came in 1925 while working at a grocery store during high school. There he met a man who hired him as an insurance salesman for Mutual Finance Corp., a small finance company. After his high school graduation in 1927, he went with a friend to New York to visit his sister. Short of money to get home, he took a job with The Home Insurance Co.

Four months later, he was back in San Diego running his own independent insurance agency and placing coverage with The Home, among other insurance companies.

Mr. Driver's start-up company ran head-on into the Great Depression, but unlike many other businesses, it survived.

By 1933, he had his own suite of offices, and in 1937, Mr. Driver became the exclusive general agent for Pacific Employers Insurance Co., in effect the company's first San Diego-based office. Later that year, he changed the name of his agency to the Robert F. Driver Co.

To help cash-strapped customers during the Depression, particularly those whose insurers were bankrupt, Mr. Driver borrowed $5,000 to finance an idea he had for retaining clients while offering coverage. He offered policyholders credit on the unexpired portions of their policies. If customers, for example, had six months remaining on their old policies, Mr. Driver himself would "underwrite" new one-year policies for half-price.

This was "a blessing in disguise," he said. "I paid a few outstanding claims," but "no clients lost anything," he added.

As his company grew, Mr. Driver formed a four-person partnership and then a corporation. He got out of the general agency business in 1950, he said, and has run a brokerage ever since, with offices today in San Diego, Newport Beach and Escondido, Calif.

In the 1970s, the company was the first in the area to start an employee stock ownership plan, Mr. Driver said. The ESOP now owns 70% of the company.

Today, when driving down Fifth Avenue in San Diego, one can clearly see "Robert F. Driver Co." in huge lighted letters on top of the nine-story building.

Primarily a commercial property/casualty broker, Driver specializes in public entity insurance. It currently employs 220 and generates gross revenues of $22.5 million, making it the largest insurance brokerage in San Diego and among the largest in California.

"I'm very proud," Mr. Driver remarks about the success of his company. "We have the finest group of people in the world."

Selling insurance has changed over the years, he observed.

Back in the beginning, "If you didn't sell anything, you starved," he said. In addition, there were no educational programs, no state licensing regulations, and agents had to figure everything out for themselves. "Everything has changed now."

His business acumen is not limited to insurance.

A frequent backer of young entrepreneurs, Mr. Driver undoubtedly made one of his best investments in surfboard maker Don Hansen in the late 1960s. Homemade surfboards, though, eventually became more popular than manufactured boards and the business declined.

Knowing of Mr. Driver's investment in the surfboard manufacturer, clothing designer Jim Jenks approached Mr. Driver with an idea he had about manufacturing surfwear. "I shared my enthusiasm, and he thought it would be a great idea," Mr. Jenks recalls.

Together, Mr. Driver, Mr. Hansen, Mr. Jenks and Chuck Buttner, a surfboard salesman, each kicked in $5,000 and started Ocean Pacific Sunwear in the early 1970s—now an international clothing and specialty item company that licenses the use of its name to other manufacturers. Its 1990 sales were $25 million.

"Mr. Driver is one of the finest gentleman I have ever met or had the chance to work with," said Mr. Jenks, owner of Ocean Pacific Ltd. in Tustin, Calif. "He has supported us through great times and bad times."

Mr. Driver recently stepped down as chairman at Ocean Pacific. While he is still on the board, he says he just watches the company now. He still owns one-quarter of Ocean Pacific.

In addition to his entrepreneurship, the best thing that ever happened to him was his political career, Mr. Driver says jokingly. "I ran for office three times and was defeated all three times. . .thank goodness."

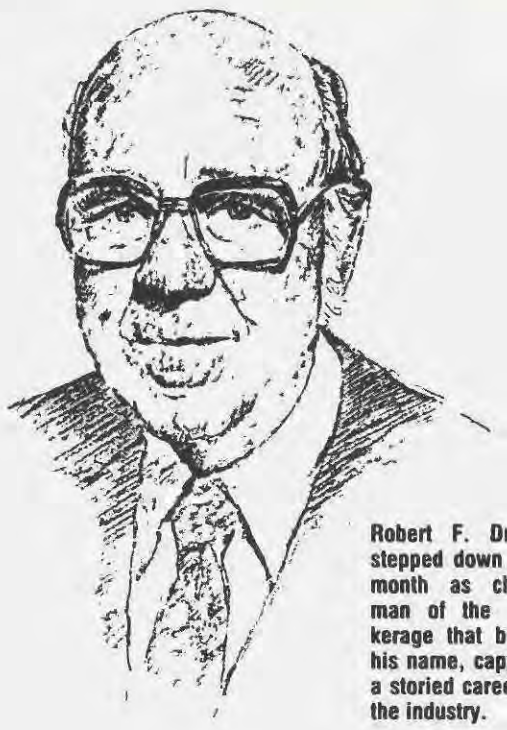
"San Diego is basically a Republican town, and I am a Democrat," he added.

Although Mr. Driver never held public office, he does admit to knowing former presidents Roosevelt and Truman, in addition to his "very close friend," former California Gov. Pat Brown.

And it was Gov. Brown who in 1960 appointed Mr. Driver to the California Horse Racing Board, where he lobbied for better conditions for stable staff and pushed for increased funding for more modern, cleaner housing for track employees.



The Robert F. Driver Co. brokerage is now part of the landscape in San Diego, a far cry from its start in 1927.



Robert F. Driver stepped down this month as chairman of the brokerage that bears his name, capping a storied career in the industry.

That appointment was a good fit for Mr. Driver, a horse racing enthusiast who in the 1950s had turned his hobby into another sideline business. Along with some friends, he bought horses to train and race at Caliente, a racetrack in San Diego.

Mr. Driver later chaired an international horse racing committee responsible for establishing a universal racing code.

Mr. Driver's love for horses is unquestionable, "especially during the Del Mar season," he said, referring to another San Diego-area track. In fact, Mr. Driver's home is strategically located across from Del Mar. Although he used to own quite a few horses, Mr. Driver recently sold his last horses in Australia, he said.

Another pillar in Mr. Driver's life has been community service.

"You can't just take; you've got to put something back in," he says. While Mr. Driver has gotten much out of life, he has put the same amount back in through his community service.

Project Concern is "my No. 1 project on the side," he said. Project Concern is a program that helps Third World communities become medically self-sufficient through training and financial support.

Through the program, Mr. Driver was the key force in raising funds for and then building a children's hospital in Tijuana, Mexico. In addition, he has had the opportunity to travel and assist Project Concern efforts in Guatemala, Hong Kong, Indonesia and Vietnam.

While he is no longer the international chairman of the Project Concern board, he is still active in raising money for the organization.

Another of his favorite causes is a Brigham Young University scholarship program for Native American youth. The scholarship program emphasizes ways to help give young people more self-esteem and support.

"It is a very exciting experience," Mr. Driver said. The scholarship has been in use for 20 years, and he still enjoys receiving and answering mail he receives from the recipients, he said.

Community work "is no big deal" to Mr. Driver; "he feels it's part of his duty," said his son, George Driver. "I wish there were a lot of people that way."

With his father retiring, George is moving up to president of the brokerage from senior vp and chief operating officer. In addition to George, Mr. Driver's son-in-law has been with the company 12 years, and two grandsons currently hold positions in the company.

Together, Mr. Driver and Freddie, his "gorgeous wife of 57 years," have four children, Sandra, Mary Lynn, George and Robert Jr., who died of leukemia in 1971. They also have 14 grandchildren and nine great grandchildren.

Last month, more than 600 of Mr. Driver's friends, family members and employees gathered for a retirement party at the seaside Hotel Del Coronado.

"They had lots of fun kidding me," Mr. Driver recalls. It was definitely "something special."

With no solidified retirement plans at the moment, Mr. Driver said he will keep active by keeping his office but will retire from all other activities.

'I'm a peddler at heart," he said. If he sees a prospective client, he will make an introduction to the company, but that's all, he said.

"My father loves to work," George Driver said. The family would like to see him take it easy, but "we also like to see him do what he wants."

What Robert Driver wants come November is to take it easy on a Caribbean cruise he and his wife have been planning. ■

Study spots agency trends: Fewer, bigger, more efficient

By LAURA MAZZUCA

Continued buyouts have reduced the number of independent agencies nationwide, but agencies today are more efficient and profitable than five years ago, a survey reports.

Since 1987, the number of agencies has fallen 14% to 46,000 from 53,500, according to the 1992 Agency Universe Study by Future One, a joint program between the Independent Insurance Agents of America and 28 insurers.

But these agencies are more productive and more profitable, reporting premium volume increases in both personal and commercial lines of between 1% and 10% with relatively the same number of employees.

"In spite of a very difficult market, the total number of employees is holding, and the agencies are profitable," said Jeffrey M. Yates, executive vp and general counsel for the IIAA.

One surprise in the survey: Ten percent of the extant agencies were started up within the last four years —in the midst of the soft market.

The Future One study, following up on 1983 and 1987 studies, is based on more than 1,500 interviews with agents nationwide in the last quarter of 1991.

Acquisitions, rather than mergers or business failures, are believed to be the main reason for the reduction in the number of agencies. The survey shows that 26% of agencies acquired another agency, compared with 22% in 1987. On the other hand, 5% of the respondents in both 1991 and 1987 said they had merged with another agency.

Even with the declining number of agencies, the total number of people employed by independent agencies decreased only 3% since 1987 to about 450,000.

The number of branch offices remained stable as well. In 1991, 18% of agencies had more than one location, compared with 17% in 1987 and 12% in 1983. Among agencies with multiple locations, two out of three have one branch; only 3% of all agencies have four or more.

This would indicate a trend toward larger agencies. Thirty percent of the agencies surveyed in 1991 reported annual premium volumes of $2.5 million or more, compared wiht 26% in 1987 and only 7% in 1983.

Such growth can be attributed to increases in both personal and commercial lines volume. In 1991, 59% of agencies saw an increase in personal lines business, while 18% suffered a decline. About 53% of agencies said commercial lines business increased; 21% reported a decline.

By contrast, fewer agencies reported growth for either personal or commercial lines in 1987—76% for personal lines and 64% for commercial—and more reported volume decreases—12% for personal lines and 16% for commercial lines.

Customer referrals remain the primary source of new business for both personal and commercial lines. For personal lines, 68% of agencies said they used customer referrals "frequently" to generate new business, compared with 60% for commercial lines. Other methods cited were business associate referrals, which were used frequently by 39% for personal lines and 43% for commercial; business/social acquaintances, used frequently by 33% for personal lines, 34% for commercial; and walk-ins, used frequently by 29% for personal lines, and only 15% for commercial.

The split between personal and commercial lines business is virtually identical to 1987. More than half, or 56%, of the average agency's total volume was in personal lines in 1991 compared with 54% in 1987. The remaining 44% in 1991 came from commercial lines.

This may come as a surprise to those who believe independent agencies primarily place commercial lines business. The average agent still writes more personal than commercial coverage, Mr. Yates said. "It's a core market for them."

While direct writers still get the lion's share of personal lines business, independent agencies place $26 billion in private passenger auto business per year, Mr. Yates noted.

The survey also noted a trend toward hiring more part-time staffers. While the average number of employees per agency grew—to 10 in 1992 from nine in 1987 and six in 1983—the number of full-time employees has not grown. Part-timers are split between sales and support positions, the survey indicates.

Producer compensation, always a hot button for agency principals, is handled by agencies in a variety of ways. According to the survey, 40% of agencies pay only a salary, while 33% pay only commission and 26% use a combination. Other agency employees, like customer service representatives, are more likely to be salaried with no commission: 66% are salaried, 18% are paid salary and commission, and 9% receive only commission.

Advances in agency automation also had an impact on efficiency. The survey indicates that the percentage of agencies that are automated has doubled since 1983. Eighty-eight percent of surveyed agencies now use some type of automation, with 84% having their own in-house system. In 1987, 79% of agencies were automated, up from only 44% in 1983.

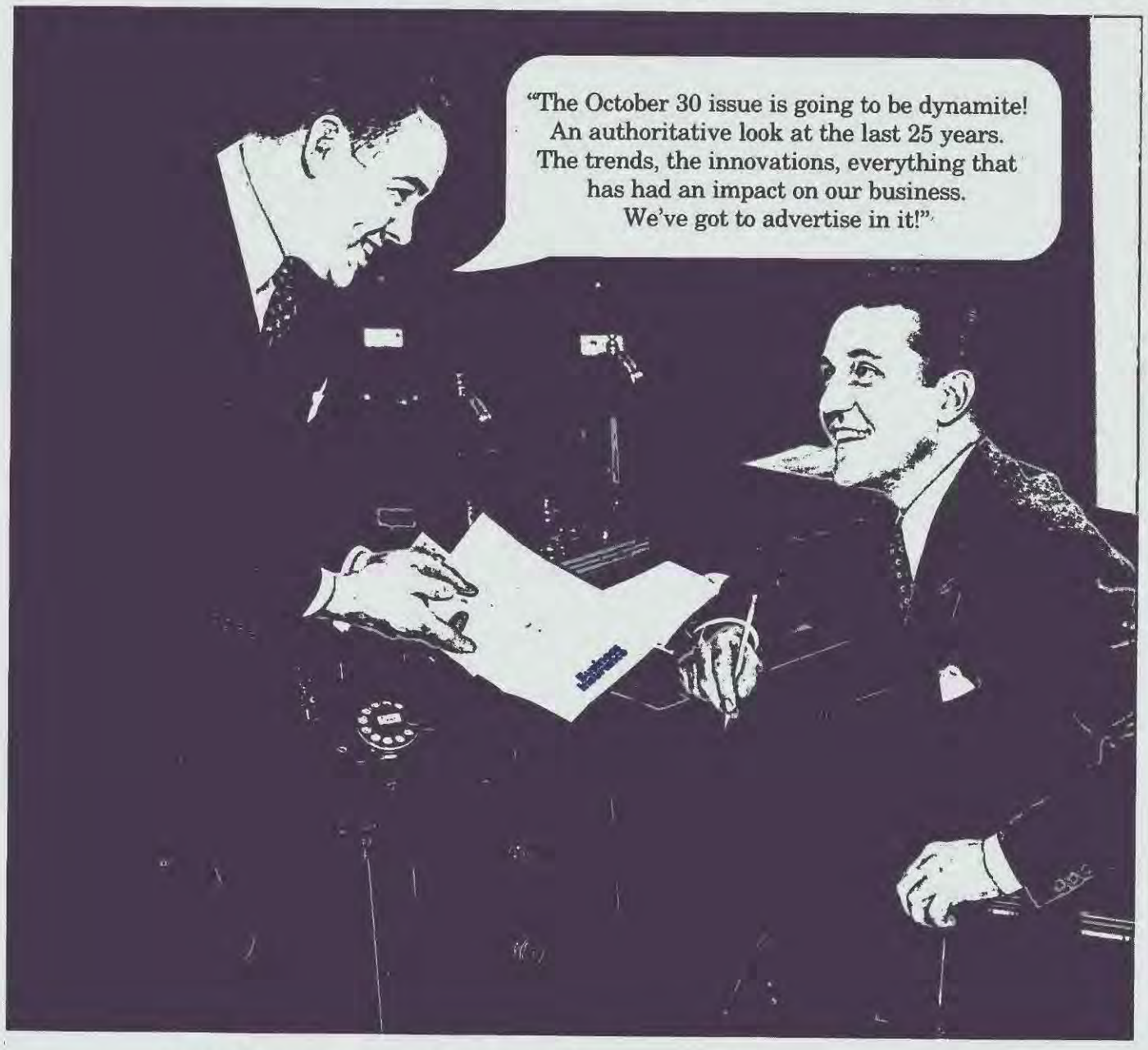
Agencies also are representing more insurers than they have in the

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Agency study

Continued from previous page
past. In both 1983 and 1987, agencies represented an average of seven insurers. In 1991, that number increased to eight. At the same time, agencies representing four or fewer insurers declined to 29% from 35%.

Mr. Yates attributes the increase in insurer representation to a "great uneasiness" on the part of agents about solvency, market withdrawals and niche marketing. By representing more insurers, "they're playing it safe," he said.

Agents are not slighting their best markets, though. The proportion of total business that agencies placed with their major insurers has been stable since 1983. In 1987 and 1991, the average agency placed 46% of its business with its No. 1 insurer, up slightly from 44% in 1983.

In all three years, the average agency placed 22% of its business with its No. 2 insurer. In 1991, the top four insurers accounted for 90% of business placed, compared with 92% in 1987 and 89% in 1983.

When placing both personal and commercial lines business with an insurer, price, financial strength, stability and the ease of doing business are primary considerations.

Price is the driving factor for 31% of agents placing personal lines, and 32% in commercial lines. Beyond price, financial strength is the most important factor for 12% of agents for personal lines business and 11% for commercial lines business. ■

Is honesty the newest thing in sales?

Why not? It sure beats the slick low-probability pitches agents are trained to make

By JACQUES WERTH and NICHOLAS E. RUBEN

SEVERAL YEARS ago, we took a hard look at why so few people like selling or being sold to. We didn't need a Gallup poll to discover that, as a rule, neither salespeople nor their customers like much about the selling process.

The first step, finding the cause, was relatively easy. The inherent conflict between buyer and seller is rooted in the classic characterization of selling as the "Art of Persuasion"—trying to persuade as many people as possible to buy what you're selling, whether they need it or not.

In that kind of environment, most of what a salesperson says or does will be construed as manipulative and insincere, both of which consistently create resistance. Salespeople perceive that resistance and react to it defensively. The war is on. Every contemporary sales technique we have examined has some sort of manipulative base that creates resistance.

In insurance, most companies teach their agents to find prospects whose demographics indicate they might need the seller's product; to persuade the prospect that his or her perceived needs are real and that he or she should satisfy them; to persuade the prospect that the salesperson has the best product or service; to overcome the prospect's objections; and to close the deal.

The current approach to selling insurance, like most other products or services, is to try to get appointments with everyone in your market who will "give" you one. Because agents spend most of their time indiscriminately trying to get appointments, most of these appointments are with low-probability prospects—people who won't buy.

On the other hand, prospects have already heard most, if not all, of the deceptive, vague prospecting pitches agents have been taught. Most prospects already have automatic hardball answers to agents' slick pitches out of sheer defense.

Indiscriminate and deceptive prospecting techniques create two strata of potential buyers: "low-probability prospects," who are unlikely to buy because they never wanted to in the first place; and "high-probability prospects," who are ready, willing and able to buy, but who seldom buy from an agent who approaches them deceptively.

This prevalent approach to prospecting creates an enormous amount of rejection that springs from the process itself. It is an inefficient process that wastes the salesperson's time and his or her company's resources.

The alternative is *honesty*. Tell the prospect what you're selling and ask him or her whether he or she wants it—with no flattery, no convincing, no half-truths.

If you state your offer clearly and concisely, and give prospects a choice—without any convincing, persuading or manipulation—most prospects will usually take a minute to see whether they want what you are offering, instead of resisting you by reflex.

High-probability prospecting is an identification process, not a selling process. Your goal is to identify high-probability prospects, not to sell the appointment. There is no rejection or failure when you are identifying. There is a lot of rejection and failure when you are selling.

If a prospect isn't willing and able, the conversation is over. Stop right there. Then pat yourself on the back because you just saved between $100 and $600, the cost of an average sales call.

When you call on a high-probability prospect, your first priority is to establish a relationship of mutual trust and respect. Most sales trainers teach salespeople to establish the relationship during the sale, while the salesperson is busy being persuasive, convincing, charming, flattering and manipulative. In that sort of environment, would you be willing to enter a relationship?

High-probability prospects are especially careful, *because* they want to buy. Typically, they will not admit their buying intentions to someone they don't trust. And the reason they don't trust the salesperson is simple: What the salesperson is telling them is a transparent manipulation.

The key is to be sincerely interested. Feigned interest doesn't work. Neither does false enthusiasm. If you treat this as just another technique, you are sure to fail. Sincerity, honesty and integrity are the only things that work.

All successful relationships are based on mutual trust and respect. If you develop that kind of relationship with a customer, you have an edge that is almost impossible for a competitor to overcome. If you don't develop that kind of relationship, you will always be just another salesperson.

After you've spent some time asking questions and listening—not talking—then and only then do you begin to "do business." You do that by asking business-related questions as part of your inquiry to determine whether there is a mutually acceptable basis for doing business.

The agent should ask:

"Why do you need this type of insurance? Do you want this type of insurance? It will cost anywhere from (blank) to (blank) to buy the insurance; are you prepared to spend that? If you decided to buy the insurance, when would you want the policy to start? When you're making a major financial decision like this, with whom who do you usually like to talk it over? If you decided to go forward, who else would have to agree?"

These questions are not examples. They are precisely chosen to flush out the stumbling blocks that are sure to surface later on. It's mandatory that you receive complete and satisfactory answers to each question before you move on to the next. If you don't, the unresolved question will come back to haunt you.

During the high-probability selling process, your purpose is to discover whether there is a mutually acceptable basis for doing business. If at any point, your sixth sense tells you that reaching mutually acceptable terms is not a high probability, then the "discovery" turns into "disqualification." There's no rejection, frustration or failure when you disqualify someone, but rather only when you didn't disqualify someone when you should have.

You've taken time to get to know another person. But you haven't wasted time with an elaborate dog-and-pony show, personalized analyses, proposals or computer illustrations. In high-probability selling, you only go the extra mile when the prospect has committed to buy from you if you meet his or her criteria. If the prospect makes that commitment, you can begin an association with a foundation that is stronger than you ever thought possible. ■

Jacques Werth is chairman and Nicholas E. Ruben is executive vp of High Probability Inc., a consulting firm in Langhorne, Pa.



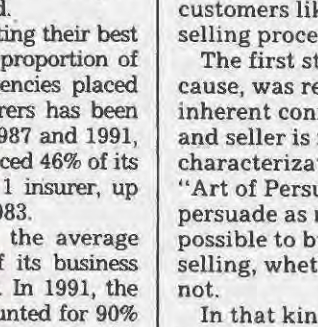
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thing a good lawyer straightens out with a witness" beforehand, added Mr. Richler, who noted that one of several issues in the subsequent malpractice trial was whether Mr. Weisberg had been adequately prepared.

Furthermore, while there was opportunity to subsequently correct the inaccuracy in the deposition, this was never done, said Mr. Richler.

In addition, because he was the counsel, Mr. Weisberg never took the witness stand to deny there was an oral report. There was also a failure to submit notes taken at that January meeting, which would have indicated no such figure was presented.

There was initial confusion about what the business' financial records indicated, said Mr. Richer.

"We alleged that (Mr. Weisberg) should have gotten on the the stand" and testified that he had advised his client there was not enough documentation to pay in December 1983 and January 1984, and that Fremont had acted in good faith, said Mr. Richler.

Fremont became aware of problems in handling the case during post-trial motions, said Messrs. Faigin and Richler. The insurer learned that Judge Bruce R. Geernaert had suggested to Mr. Weisberg at a pre-trial conference that perhaps he should consider withdrawing as counsel because he might want to serve as a witness in the case, according to Mr. Faigin. This suggestion was not discussed with Fremont before the trial ended, he said.

"We probably should have had that thought" of having Mr. Weisberg withdraw as counsel, Mr. Faigin said. But the code of legal ethics requires that the lawyer advise the client on this possibility, he said.

Cummins & White "failed to come forward and say, 'We should be witnesses,' " Mr. Faigin said.

Cummins & White's attorney defends his client's actions.

The jury decision in the underlying litigation "was based upon Fremont's own conduct" in connection with its liability for the claim, Mr. Wehner said.

No business interruption payments or advances were made for a period of nearly seven months after the fire, he said.

Cummins & White was not hired to assist with the claims adjusting until mid-November, "so for nearly five months, Cummins & White had not even been retained," he said.

Mr. Wehner said the law firm was retained to determine whether Fremont was still obligated to pay the claim in light of the arson. Cummins & White advised Fremont to pay the claim as soon as its own experts determined the appropriate amount under the business interruption coverage, he said.

"The trial against Cummins & White dealt with whether or not Cummins & White attorneys who advised Fremont on a limited basis" should have been witnesses, he said. "The answer is 'no,' " said Mr. Wehner.

Had they testified, the attorneys would have waived the traditional attorney-client privilege and would have had to say that they had advised Fremont to pay the claim as soon as the loss was determined, which would have hurt Fremont's case, Mr. Wehner said. Only insurance companies —not lawyers—can be held liable for bad faith insurance practices, he noted.

In the Cummins & White malpractice trial, Fremont incorrectly attempted to shift its own liability for bad faith insurance practices to its own counsel, according to Mr. Wehner.

The $8.2 million malpractice award reflected 100% of the punitive damages Fremont paid in the underlying litigation, or $5.7 million, and 90% of the compensatory damages, or $2.8 million.

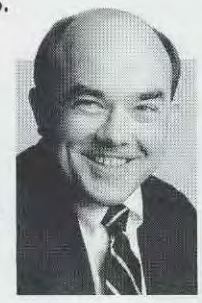
Mr. Wehner said that under the terms of an earlier agreement between the two sides, Fremont would not proceed against the assets of the firm or its lawyers.

He added that the insurer could seek the remainder of a $2 million professional liability insurance policy, whose limits include defense costs, that Cummins & White has with Lawyers Mutual Insurance Co. ■

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As the walls crumble

Upheavals spur demand for political risk coverage

By David D. Avasthi

PRIVATE POLITICAL RISK INSURANCE has blossomed, especially as opportunities in overseas trade have spurred growth in worldwide trade and investment. Corporations must think and act globally in order to remain competitive. Risk managers are therefore increasingly faced with the task of protecting their corporation's risks emanating from foreign governmental, political or legislative actions.

Perhaps among the most prominent changes has been the dissolution of the Soviet Union and the resulting creation of the Commonwealth of Independent States. Elsewhere, the breakup of Yugoslavia has created uncertainty in Croatia and Serbia. Czechoslovakia is showing strain between its citizens. In the Far East, cease-fire and peace accords are taking hold in Kampuchea and Vietnam.

Latin America is not immune to changes either. The debt crisis of the early 1980s has given way to increased stability, leading to the hope of long-term growth. In countries throughout Latin America, freely elected leaders are struggling to carry out free market reforms that last year created modest economic turnarounds with little political instability. These changes are still in their fragile early stages. Even in countries with decades of democratic history, instability rears its head, as just happened in the unsuccessful coup attempt in Venezuela.

Corporate executives, anticipating major profit opportunities in countries heretofore considered unattractive or closed due to governmental restrictions, are moving to take advantage of current conditions and new trading alliances. The risk manager must respond to these actions by embracing a program that will protect the interests of the corporation in new ventures abroad.

In trading abroad, corporations owe it to their stockholders to protect rights, guarantee assets and maintain the corporation's viability in foreign countries. A very good form of protection is political risk insurance—insurance that would indemnify the business in the event that a foreign government cannot or will not abide by the contractual terms of a given export, import or service contract, or does not honor the rights granted to the investor at the time the foreign investment was made.

Political risk insurance protects against financial loss to businesses involved in international trade and investments when these losses are caused by unexpected, discriminatory or arbitrary acts of foreign governments. Examples of such acts run the gamut from sanctions; embargoes; unilateral cancellation or modification of contractual terms and conditions; unavailability or non-supply of foreign exchange for repatriation of profits, dividends or payment of invoices; the capricious calling of letters of credit; advance payments received; or performance by the policyholder.

Exactly what risks are protected by political risk insurance and exactly which policies should be purchased depends on the trade or investment activity being undertaken by the prospective policyholder. Broadly speaking, there are four different types of policies: confiscation, expropriation and nationalization; contract frustration; unfair calling; and contingency.

- **Confiscation, expropriation and nationalization.**

This coverage protects the overseas assets of the policyholder against acts of confiscation, expropriation or nationalization by a foreign government in power, de jure or de facto. These assets can be mobile, like land-moving equipment temporarily based overseas at a construction site, or permanent, like an automobile plant earning profits and dividends for the investor. The basis of valuation of the investment can be either the book value or the replacement cost.

A variety of assets are insurable: inventory, spare parts, bank accounts, retained earnings, prepaid supplies, loans guaranteed by the parent company and receivables. This coverage also has been purchased by private individuals who own vacation homes overseas, and individuals who are posted overseas on temporary assignments may insure their private belongings. This coverage can be purchased for individual investments or can be purchased in a manner wherein the policy lists several of the policyholder's investments worldwide with individual country limits and with a policy aggregate. Such multi-investment policies can be attractive enough to underwriters to warrant a lower overall premium rate.

There are some very useful extensions to the above product. Deprivation indemnifies the policyholder in those situations in which the investment is not actually confiscated but instead made useless to the policyholder by depriving it of certain rights granted at the time the investment was made. For example, a policyholder may be forbidden to import certain vital spare parts without which the investment must halt production.

Another extension involves loss of net income insurance, wherein the policyholder can insure the future stream of earnings it would have earned had the investment not been lost. Normally, the income stream covered is limited to the length of the policy.

Even in countries with decades of democratic history, instability rears its head, as just happened in the unsuccessful coup attempt in Venezuela.

There are two other extensions involving insurance against physical damage to the investment due to strikes, riots and civil commotion and another due to war on land. War risk coverage currently is quite limited both in terms of available capacity and the types of assets insurable. For example, only mobile assets can be covered.

- **Contract frustration.**

Whenever the policyholder is involved in a contract with a foreign government entity or even with a foreign private entity, the policyholder stands the risk that the terms and conditions will not be abided by because of government action or inaction. These policies will indemnify the policyholder in those circumstances.

There are basically three forms of contract frustration policies: exportation; service contract deterioration and repudiation; and importation. The exportation policy protects exporters from losses caused by the buyer not abiding by any term or condition of the export contract, provided that the buyer is a public entity. If the buyer is a private entity, then the reason for the buyer not abiding by the contract must be a result of government action or inaction in order for the policy to respond. The types of risks covered in this policy include non-honoring of letters of credit; protracted payment defaults; unilateral cancellation of the contract or any relevant licenses; and deterioration of any condition in the contract. The policyholder can buy coverage for both pre- and post-shipment exposures, i.e., exposures that develop in anticipation of completion of the contract and exposures occurring when the product has been accepted by the buyer but not yet paid for.

The second form of policy is the service contract deterioration and repudiation policy used to cover businesses involved in selling services, whether or not they export products. Essentially, it covers risks similar to those covered by the exportation policy.

The last form is the importation policy. This is the counter-version of the other two, since the policyholder in this case is the importer. The coverage protects the policyholder against losses caused by non-delivery of products purchased and paid for in advance. The indemnification also can be extended to include cover for consequential losses due to penalties inflicted because of the policyholder's inability to complete performance on other contracts that required delivery of the products purchased.

In all of these policies, it is important to remember that the policyholder usually is not exposed to the full value of the contract; there are usually various debits and credits that affect what the actual exposure is at any given time, like advance payments, multiple deliveries and progress payments. A careful calculation of actual exposures could reduce the effective cost of this insurance as a percentage of the total contract value.

- **Unfair calling of demand bonds policies.**

These policies are used in situations in which the policyholder, which is entering into a contract to export goods or services, is expected to put up guarantees in the form of letters of credit or demand bonds.

These instruments are used so that the exporter or contractor does not put up frivolous bids, or that the contracting party does not abscond with advance payments. It also guarantees performance by the policyholder per the terms and conditions of the underlying contract.

The risk in these situations is that the foreign government entity in whose favor the guarantees are issued would call the guarantees even when the exporter is in total compliance with the underlying contract. This could happen for several reasons. The foreign government may wish to express displeasure with the exporter's government—as happened in Iran after the shah was overthrown and letters of credit issued by U.S. exporters and contractors were called—or the government could require some quick access to foreign exchange or could have the mistaken belief in wrongdoing by the exporter.

- **Contingency insurance.**

This is important if, for example, a company negotiates with a government and, after an agreement is reached, the contract must be ratified by another body of the government or possibly by the congress or parliament of that country.

Sometimes the ratification can take quite some time, even though it may only be a formality. In these cases, the contractor may wish to begin work on the contract to take advantage of certain conditions, including keeping the work force employed and possibly reducing the chances of work delays. The contractor is taking the chance, however minute, that its efforts and expenses may be lost if the contract is not ratified.

With contingency insurance, however, the contractor could be reimbursed for expenses incurred in vain in the event of non-ratification.

Please note that the vital difference between this category of insurance and the others is that under contingency insurance, neither party—the policyholder nor the foreign government—is at fault; in the other categories, the policyholder and the insurer shall retain rights to recourse against the foreign government deemed to be at fault.

For example, this kind of insurance came into

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Political risk insurance

Continued from previous page

play when the tunnel under the English Channel was in the discussion stages. Contractors sought contingency insurance so that they could start mobilizing engineering and design crews without incurring a loss should the governments of France and England not have ratified the contract. As it turned out, the project was ratified and the insurers suffered no losses.

Political risk policies do not normally extend beyond a policy period of three years, and underwriters prefer to have shorter exposures, because premium is earned more quickly and it is easier to forecast macro-geopolitical factors with less margin for error.

Coverage is usually not for 100% of the exposure, except possibly in cases of confiscation and expropriation policies. The indemnity offered usually fluctuates between 80% and 90%, and premiums are usually charged on the indemnified amount. The less-than-total indemnification allows the insurer to reduce the moral hazard and also gives additional comfort as to the willingness of the policyholder to continue cooperating with the insurer toward recoveries in the event there is a loss.

Policies are issued on a declaration basis, as well as on a shipment-by-shipment basis, and in the case of expropriation policies, underwriters offer multi-country policies covering the policyholder's investment in a multitude of countries—predefining the maximum indemnity by country and placing a policy aggregate in the event of multiple losses during the policy period.

Contrary to other insurance lines, the risk manager must know that the policyholder does not get paid on the date of loss. The insurer is liable for payment of the loss only after the expiration of the waiting period, whose length is determined by the underwriter's analysis of its experience in that country, the policyholder's experience there and the normal bureaucratic delays that occur in that country.

Political risk underwriters generally are able to quickly issue non-binding indications of terms and conditions that may be offered subject to receipt, review and acceptance of risk details. It is only after final analysis of all information relevant to the risk that the underwriter issues a binding quote. This procedure tends to take longer.

When rates are quoted by an underwriter, they are usually quoted on a per annum percentage of the insurer's maximum liability for the covered investment. In contract-related risks, if the risk exposure fluctuates over the life of the policy, the underwriter quotes on a monthly percentage of the liability outstanding at any one given time, and for declaration-type policies, the quote may be based upon a percentage of turnover.

The risk manager is most likely to receive the best terms and conditions from an insurer if the submission is compete with full documentation. Incomplete presentations lead to slow response and frequent declinations. Each political risk underwriter receives thousands of submissions each year. Detailing the strengths of the contract, like the arbitration provisions, penalty clauses, terms of payment and/or delivery schedules, graphical depictions of exposures over time, and past experiences of the insurance applicant in the host country could play a major role in whether the risk receives a quote and how good the terms are. Similarly, for confiscation insurance, a history of the investment, description of incentives received, illustration of benefits to the host country and divestiture contingency plans could assist the underwriter to give prompt and favorable consideration.

Despite the major demand in the market for political risk coverage, the risk manager is still plagued by a lack of underwriters willing to lend capacity. The number of insurers offering political risk insurance has fluctuated over the past several years, but has always remained small. The lack of interest is due to a number of factors.

For one, the $100 million in gross written political risk premium has not motivated companies that are used to seeing figures in the billions from their property/casualty lines. Also, there is a paucity of underwriting expertise within conventional insurers' staffs. Underwriters tend to come from international financial and economic backgrounds. Lastly, many underwriters have fallen victim to the "morning headline underwriting" syndrome: The few celebrated loss cases have skewed their perspective and perpetuated misconceptions.

It is important for the risk manager to properly ascertain the credentials of the insurer with respect to experience and reputation among other policyholders. If the need for political risk insurance is considerable, he or she may be well-advised to diversify the company's source of insurance among the current political risk writers.

Due to the catastrophic nature of the losses and the lapse of time between when a policy is bound and when losses are paid, an insurer's financial strength and rating play a major role in a risk manager's decision. If the financial strength of the insurer falls short of the corporation's security guidelines, the risk manager should inquire about the structure of the reinsurance program. In some cases, he or she may do well to request a "cut-through clause" which would transfer the liability of a loss to the reinsurers in the case of the financial default of the insurer.

In most instances, unless the risk manager has a direct relationship with an underwriter, it is advantageous to use a broker with political risk expertise to facilitate preparing a complete submission, obtaining competitive quotes and arranging for coinsurance or reinsurance if and when capacity offered by one underwriter is not sufficient to insure the total exposure.

Notwithstanding the above, the risk manager also must attempt to develop a direct rapport with the underwriter. He or she must be aware that while the intent of the coverage may not differ from one underwriter to another, the wordings may, and consequently, so could interpretations. It is vitally important for the risk manager to understand exactly how the underwriter shall interpret the policy conditions at the time of loss.

A comprehensive understanding of policy conditions by the risk manager is essential to avoid disputes with an insurer in the event of a loss. There have been cases in which resolution of claims disputes took years due to insufficient understanding of the policy terms from inception, resulting in loss of time and money, negating all of the benefits that should have been derived from political risk coverage.

Until now, most risk managers have left the purchase of political risk insurance to the financial and treasury officials of the corporation. It is time that this product be brought into the risk manager's area of responsibility, similar to other more conventional lines of insurance. ■



David D. Avasthi is president of Avasthi & Associates Inc., an underwriter and broker specializing in international risks in Coral Gables, Fla.

Tardy marriage voids widow's benefit

A worker's widow was not entitled to spousal benefits under workers compensation law when the worker's injury occurred before their marriage, according to the District Court of Appeal of Florida.

Jimmy Crews, who was employed by the Department of Transportation, sustained a compensable knee injury in October 1986. In the two years following the accident, Mr. Crews underwent six surgeries, but he continued to deteriorate both physically and mentally. He had been living with Rebecca Crews for more than 16 years, including at the time of the initial accident, but they were not legally married until Jan. 16, 1988.

On Nov. 14, 1989, Mr. Crews committed suicide. Mrs. Crews filed for benefits, but the workers compensation judge found that although Mr. Crews' suicide was compensable, she could not receive benefits because they were not married at the time of the initial accident.

On appeal, Mrs. Crews argued that the term "accident" in workers compensation law could refer to both the employee's initial, or work-related accident, and to any subsequent intervening accident—in this case, his gunshot wound to the head—which contributed to his death. But, the court said that a compensable suicide does not constitute an intervening act or accident. Thus, the court concluded that because she was not Mr. Crews' spouse—living with and financially dependent upon him, both at the time of the initial work-related accident and at the time of his death—Mrs. Crews was not entitled to benefits. *Crews vs. Department of Transportation*, District Court of Appeal of Florida, Dec. 19, 1991 (*BI*/01/Au.-$10).

Legal briefs

Severance benefits denied

Employees do not retain any continuing right to severance payments after their workplace is sold by their former employer because such benefits are contingent and unsecured, according to a ruling of the 2nd U.S. Circuit Court of Appeals.

Several former employees of GAF Corp. who had worked in its facility in New York brought this suit. The employees were members of unions whose collective bargaining agreements with GAF included a severance payment policy. GAF sold the facility to BASF Corp. in March 1978, and all of the employees involved in this case continued as employees of BASF. The suit alleged that GAF violated New York labor law by failing to make severance payments after selling the facility. The case was transferred to federal court, and employees also filed complaints alleging violations of the Employee Retirement Income Security Act of 1974. The federal trial court ruled for the employer.

On appeal, GAF argued that none of the employees were laid off because of lack of work; thus, severance pay was not owed. The employees argued that, under the severance payment provision, severance pay should be made even though the employee takes a job with another company. The appellate court said that by its plain language and evident intent, the severance payment policy did not apply because only employees permanently laid off because of lack of work were entitled to severance pay. The court emphasized that where an employee is kept in his or her job because there was no lack of work, despite a change in ownership, that employee cannot accurately be described as "permanently laid off because of lack of work." The court also said that to award severance pay in this situation, where a business is sold and the employees stay on, would give the employees a windfall. The court added that severance benefits are not vested under ERISA. *Bradwell vs. GAF Corp.*, 2nd U.S. Circuit Court of Appeals, Jan. 21, 1992 (*BI*/02/Au.-$10). ■

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

Tobacco ruling

Continued from page 3

1969 law does pre-empt claims that cigarette ads and promotions failed to warn of the health hazards of smoking and that the ads neutralized the effect of required health warnings.

"This is one of those cases that will be cited by both sides in product liability litigation," said Malcolm Wheeler, a product liability attorney with Parcel, Mauro, Hultin & Spaanstra in Denver.

"This case, however, will not be outcome determinative in product liability cases," Mr. Wheeler said.

Whether a manufacturer can successfully defend against a product liability lawsuit by claiming the action is pre-empted by a federal statute will "depend on the language of the statute and the conduct of the industry involved," he said.

Product liability attorney Barbara Wrubel agreed: This ruling alone will not cause "plaintiffs to ultimately be successful" in their claims.

"While the decision does provide a road map for a careful plaintiffs' attorney who wants to avoid pre-emption, plaintiffs must still prove a causal connection between the defendant's breach of duty and the plaintiff's injuries," said Ms. Wrubel of Skadden, Arps, Slate, Meagher & Flom in New York.

For example, a plaintiff suing a pharmaceutical manufacturer must show that his or her injuries were caused by the manufacturer's failure to warn about the product's dangers.

"In the short run, we will see more product liability lawsuits, but in the long run, plaintiffs still have a hard road to go to prove causation," she said.

Among the industries in which manufacturers raise the pre-emption defense are the auto, pharmaceutical, medical devices, chemical and liquor industries.

"The ruling exposes these other industries to claims that would have been destroyed by a looser construction" of the pre-emption doctrine, said Laurence H. Tribe, a Harvard Law School professor.

For example, the Supreme Court's ruling does not bar people injured in auto accidents from suing automobile manufacturers and alleging that they would not have been hurt as severely if their cars had been equipped with airbags.

Manufacturers currently defend against these claims by arguing that these lawsuits are pre-empted by the National Highway Transportation Safety Act, which does not require airbags.

The Supreme Court's narrow interpretation of the pre-emption doctrine does not reveal how tort claims against industries regulated by the National Highway Transportation Safety Act or any of the other federal statutes should be resolved.

Drug companies often rely on the the Food, Drug and Cosmetic Act.

Manufacturers of medical equipment seek pre-emption under the Medical Device Amendments of 1976 to the Food, Drug and Cosmetic Act.

Chemical manufacturers seek pre-emption under the Federal Insecticide, Fungicide and Rodenticide Act.

And, liquor companies seek protection under the Alcoholic Beverage Labeling Act.

Various court rulings interpreting pre-emption under these statutes are mixed, depending on the facts of the case, according to product liability attorneys.

"This is very fact-driven litigation," said John Bell of Johnson & Bell in Chicago.

And, Mr. Wheeler pointed out that these cases are very "statute-specific."

"The Supreme Court has made it clear over and over again that pre-emption decisions turn on the specific language of the statute and the legislative intent," he said.

It is difficult to gauge what impact the Supreme Court's ruling will have on other industries because the statutory language in the cigarette labeling laws differs from the language in other statutes, said product liability attorney Victor Schwartz of Crowell & Moring in Washington.

Further, it is difficult to compare the facts of the cigarette cases to any other type of product liability litigation, said Cynthia Walters, a product liability lawyer with Budd, Larner, Gross, Rosenbaum, Greenberg & Sade in Short Hills, N.J.

"Cigarette manufacturers will be saddled with lawsuits as a result of the Supreme Court's ruling, but I don't think this will make a difference in other industries," she said.

"I wouldn't put any other industry on par with the cigarette industry," Ms. Walters said.

In other types of product liability litigation, "courts will find pre-emption, but they will not paint pre-emption with a broad brush," Mr. Schwartz predicted.

"If courts find pre-emption at all, they will be very surgical and precise in what claims are pre-empted," he explained.

For example, if a statute specifically requires manufacturers to label their products in a certain way and the manufacturer subsequently learns new information about the dangers of its product, this labeling statute would not protect the manufacturer against tort law claims that it had a duty to warn the public.

"Pre-emption will be like an ice sculpture, precise and subject to meltdown," Mr. Schwartz quipped. ●

Thomas Cipollone vs. Liggett Group Inc. et al., U.S. Supreme Court: No. 90-1038.

Earthquake damage

Continued from page 3

While initially seismologists said there was a greater than 50% chance of an aftershock with a magnitude greater than 6.0 on the Richter scale, the chances were reduced to 30% by Wednesday morning.

The early Sunday morning quakes, which served as a wake-up call for most Southern California residents, measured 7.4 and 6.5 on the Richter scale. The 7.4 quake was the strongest to hit California in 40 years.

The stronger quake struck at 4:58 a.m., centered in a desolate area six miles north of the small desert community of Yucca Valley, while the 6.5 temblor that hit at 8:05 a.m. was centered east of the Big Bear Lake resort on a newly discovered fault line (see map).

More than 1,000 aftershocks—including one as strong as 6.0—shook California throughout the week.

The quake and the ensuing aftershocks caused more than $92 million in property damage in two California counties.

San Bernardino County, which includes Big Bear and Yucca Valley, reported total property damage of $91.1 million, including $47.5 million of residential and $17 million of commercial damage.

Damage to public water and sewer facilities, schools, hospitals and government facilities has amounted to $26.6 million, according to officials with the California Office of Emergency Services.

The quakes left about 27,000 residents of Yucca Valley and Landers without water service. More than 400 cracks have been counted in water pipes traversing the desert.

Riverside County experienced slightly less than $1 million in damage, some $813,000 of it in the city of San Jacinto.

The Property Claims Services division of American Insurance Services Group assigned catastrophe No. 22 to the Sunday quakes. Insured damage estimates were not available last week.

State Farm Mutual Insurance Co. of Bloomington, Ill., reported 2,100 claims totaling $6.7 million.

Transamerica Insurance Co. of Woodland Hills, Calif., had only 19 personal lines and one commercial lines claim, together totaling $115,000.

Because fewer than one-third of California home and business owners typically purchase earthquake coverage, insured damage will probably be limited.

Most residential earthquake policies don't cover damage unless it exceeds 10% of the structure's insured value. Commercial policies have somewhat lower deductibles, usually about 5% of insured value.

Because of the high deductibles on policies written by commercial insurers, the state's residential earthquake fund, which provides up to $15,000 in coverage over a deductible ranging from $1,000 to $3,500, will probably be hit with the largest number of claims.

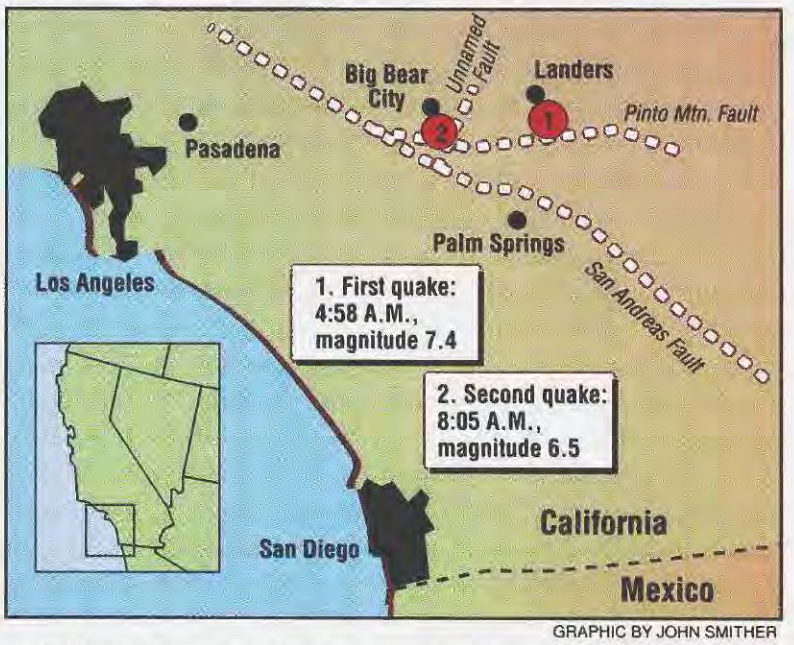
So far more than 1,000 quake victims have called the California Earthquake Recovery Fund.

While adjusters have not yet been dispatched to determine the size of claims, the fund would pay out $14 million if all 1,000 callers have the maximum $14,000 in coverage provided by the fund.

The fund has already paid out or set aside $12.4 million for victims of two earlier quakes (*BI*, May 4).

Financed by premium surcharges ranging from $12 to $60 on each homeowners policy, the fund only has $34.8 million in assets. The fund has been without commercial reinsurance since March 1, when coverage was canceled due to its cost.

Additional premium surcharges collected by insurers but not yet transferred to the fund are "in the pipeline," a spokesman for the department added. But the fund will never be large enough to pay claims from a large earthquake in an urban area, he said.



GRAPHIC BY JOHN SMITHER

"We've just been lucky that these quakes have been confined to rural areas," he said.

The disbanded reinsurance program, which was assembled by Insurance Commissioner John Garamendi last year, provided $144 million in coverage above a $250 million retention. The coverage was led by Lloyd's of London syndicates, but was spread among numerous U.S. and foreign underwriters, according to the Insurance Department.

Recognizing the fund's inadequate financial backing, lawmakers have introduced legislation attempting to repeal the law that created it by Jan. 1, 1993.

The repeal bill, A.B. 2049—introduced by Assemblyman Phil Isenberg, D-Sacramento, and backed by Mr. Garamendi—is expected to come up for a floor vote Monday in the Assembly.

Despite early press reports suggesting widespread damage in Las Vegas, only minor damage was reported in Nevada, said a spokesman for the state Division of Emergency Management.

"The power was out for two hours in some parts of Las Vegas, but that's about all," the spokesman said.

The Las Vegas Hilton lost a window and an engineering inspection showed some superficial cracks, according to Michelle Patton, vp-risk management for Beverly Hills, Calif.-based Hilton Hotels Corp.

Only minor damage was found in Hilton's California properties.

Hilton's Las Vegas and Los Angeles properties are covered for earthquake exposures under a blanket property program that covers all U.S. locations, said Ms. Patton.

Meanwhile, in Burbank, Calif., Stephen Wilder, The Walt Disney Co.'s assistant treasurer-risk management, reported that the company has asked him to look into earthquake coverage in the aftermath of the quakes.

Twice a year Disney runs simulation drills at its Burbank studios. "The makeup department makes up employees as if they are injured or dead," while other employees conduct search and rescue operations, explained Mr. Wilder.

Two years ago, Disney commissioned earthquake engineers EQE International Inc. to determine the maximum possible earthquake loss the company's Anaheim and Burbank properties might experience, said Mr. Wilder.

That estimate can be used to determine the level of insurance desired as well as to help make retrofitting decisions, said Elwood Smietana, vp and regional manager for EQE in Costa Mesa, Calif.

While the switchboard at EQE's regional office in Costa Mesa, Calif., has not yet lighted up with calls from area risk managers seeking information on its services, it expects inquiries.

"Usually we start getting calls two, three or four weeks after a major quake," Mr. Smietana explained. ■

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INTERNATIONAL

Gooda names hit by another cash call

By STACY SHAPIRO

LONDON—The bad news is getting worse for members of the seven Lloyd's of London syndicates formerly managed by Gooda Walker Ltd. as the cash calls hit $1.3 billion.

Gooda Walker members, already devastated by previous cash calls, were asked last week to pay another 307 million pounds ($583.4 million) in cash calls for 1989 and prior years of account. Of this, 223.2 million pounds ($424.1 million) is due at the end of the month. The rest is due Feb. 1.

The members already have faced several cash calls since the middle of last year when the Gooda Walker agency went into liquidation. The previous calls total 375.7 million pounds ($713.8 million) for the years 1983-1988.

This means that to date members on the seven Gooda Walker syndicates have been asked to pay a staggering 682.2 million pounds ($1.3 billion) in cash calls on policies written between 1983 and 1990, including 475.84 million pounds ($904.1 million) for the 1989 underwriting year alone.

Gross paid claims from the syndicates totals nearly 900 million pounds ($1.7 billion) for the 1989 and prior underwriting years of account, said Ralph Sharp, chairman of G.W. Run-Off Ltd., which is managing the syndicates' runoff. And, this estimate does not include any losses in the 1990 and 1991 underwriting years.

Outstanding claims could total near the amount of paid claims, said Mr. Sharp. This would mean that the syndicates' total liabilities before reinsurance recoveries could reach nearly 1.8 billion pounds ($3.42 billion), though Mr. Sharp would not speculate on the total sum.

The Gooda Walker syndicates had total capacity of 640 million pounds ($1.22 billion) in the open years.

The latest cash calls will not be the last for Gooda Walker members.

The recent calls do not include any losses from the syndicates' open 1990 account, although previous calls have included amounts for that year, Mr. Sharp said.

The 1990 account has not yet been closed under Lloyd's three-year accounting system.

The recent calls also were based on the lower end of projections for claims, so more funds may be needed to meet 1989 losses if the projections are wrong, he noted.

The largest portion of the losses stem from two Gooda Walker syndicates that wrote mainly London market excess-of-loss reinsurance and were hit hard by the unprecedented spate of catastrophes in 1989. The two syndicates reported total gross losses of 392.9 million pounds ($734.7 million at applicable exchange rates).

About 50% of the LMX losses to hit the Gooda Walker syndicates came from London insurance companies, not other Lloyd's syndicates, Mr. Sharp said.

The two syndicates are:

- Non-marine syndicate 290, underwritten by Derek Walker, with losses totaling 206.5 million pounds ($386.2 million), roughly three times its capacity of 70.7 million pounds ($133.6 million).

The syndicate's 3,163 members must pay 70.3 million pounds ($133.6 million) by July 31 and an additional 43.4 million pounds ($82.4 million) by Feb. 1. Including previous cash calls, these members have been asked to pay a total of 257.5 million pounds ($489.3 million) for the open 1989 and 1990 years of account.

- Marine syndicate 298, un-

Continued on next page

Australian renewals

Property prices hardening, while casualty rates still flat

By KATE McILWAINE

BRISBANE, Australia—Australian companies are seeing signs that the days of soft insurance rates and competitive market conditions are coming to an end.

Property insurance rates are generally rising 20% to 30% across the board for companies at June 30 renewals.

While most casualty coverages are renewing on an "as-is" basis, companies with substantial losses are seeing rates harden.

And many June 30 renewals are finishing late this year, as underwriters wait to see the rates being achieved elsewhere in the world, brokers say.

Many major accounts are experiencing "extreme difficulties" with renewals, according to John Donnelly, marketing director for the Asia Pacific region with Marsh & McLennan Ltd. in Sydney.

The liability market is "still pretty easy, with no real rate increases unless the loss record is very bad," Mr. Donnelly said. But, he added, there are "no reductions, for a change." In contrast, the property market is hardening considerably, Mr. Donnelly said.

In some industry sectors, rate increases for property and business interruption coverage are "horrendous," Mr. Donnelly said. For example, the mining industry is "a complete disaster," with coal mining risks more difficult than gold mines to place at expiring rates, he said.

Brokers with mining accounts are having "no fun at all," and underwriters with capacity are "holding out to see what the final rate will be," Mr. Donnelly said.

Some underwriters are pulling out of risky markets entirely. "A lot of underwriters are staying away from high-hazard businesses," like mining, Mr. Donnelly said. The plastics and woodworking industries are other hard-to-place risks, he added.

"It's a dramatic change from last year, even from the December renewals," he said. Underwriters are now trying to make profits in all lines, and capacity is decreasing, said Mr. Donnelly. "The collapse of the London property (reinsurance) market is part of the problem."

As a result, many Australian insurance buyers are taking higher deductibles to minimize the effect of rate increases on the costs of their insurance programs. "There's been plenty of doubling, or worse," of deductibles, Mr. Donnelly said.

The current market is being driven by property losses, particularly catastrophe losses in the energy market and claims from natural catastrophes.

"It's the supply and demand principle," Mr. Donnelly said. "Underwriters are pulling out where they have been hurt worst, but those (buyers) who have maintained continuity of insurers are being better looked after."

Noel Pettersen, executive director of the National Insurance Brokers Assn., said commercial property insurance premiums are rising by around 20% at midyear renewals. Rate increases are even higher in classes like directors and officers liability, computer crime and professional liability.

Underwriting losses, lower interest rates and a dramatic increase in claims have caused a shake-

Continued on next page

Industry executives view factors behind delay in market turn

By GAVIN SOUTER

LONDON—Underwriters who think market forces will cause insurance rates to harden are in for a long wait, according to an insurer executive.

Insurers have to bite the bullet and charge the right rate for the given risk, rather than treat insurance as a commodity based on supply and demand, said H. Edward Hanway, president of CIGNA Worldwide Inc., a CIGNA Corp. unit in Philadelphia.

But the deal should rub both ways, said Peter Christie, chief executive of broker Minet Group P.L.C. When the market does finally turn, policyholders should not be charged exorbitant rates simply because there is a lack of capacity.

Low rates are not the only problem for insurers and reinsurers. Greater clarity of the risks that insurers are asking reinsurers to accept is needed, said Patrick Peugeot, chairman of SCOR S.A. in Paris.

Property/casualty rates are under no pressure to harden, and it is up to insurers to impose rate hikes if they wish to return to conducting their business on a more sound financial footing, Mr. Hanway said.

"In many markets around the world, the market practitioners lack the will to do what is right. They've lost the will to establish a rational strategy to meet their customers' needs and generate an acceptable return to their shareholders," he said at the Second World Insurance Congress, sponsored by Lloyd's of London Press in London last month.

However, times must change, as lower interest rates around the world erode insurers' investment income and as reinsurance rates increase, Mr. Hanway said.

"Reinsurers seem to want to return to a rational strategy, but the jury is still out on primary underwriters," he said.

If insurers want to be let off the financial hook, they will have to come to grips with their pricing, Mr. Hanway said.

"We need to address pricing in a holistic sense, understand our risks by class and attribute a price which includes all of our costs, including reinsurance," he said.

This change of approach will

Continued on page 25

Lloyd's does not owe duty of care: Court

By GAVIN SOUTER

LONDON—Lloyd's of London does not have a legal duty of care to look after the interests of its members, a British high court judge ruled late last week.

Ruling on a dispute between Lloyd's and members of loss-riddled syndicates formerly managed by Oakeley Vaughan Underwriting Ltd., Justice Gatehouse ruled that no duty of care by Lloyd's was implied under the Lloyd's Act of 1871, the predecessor to the Lloyd's Act of 1982.

The House of Lords, Britain's highest court, earlier this year ruled that the issue would be decided in a preliminary hearing, rather than a full trial (*BI*, March 2).

If the Oakeley Vaughan members had succeeded in establishing a duty of care, a full trial would have commenced and former chairmen of Lloyd's would have been called on to give evidence.

Justice Gatehouse did, however, grant the members leave to appeal his decision.

LONDON

New Lloyd's broker

A Spanish brokerage has registered its London operation as the first non-British European Lloyd's of London broker.

Gil, Carvajal & Partners Ltd. expects to place 8 million pounds ($15.2 million at current exchange rates) in net premiums at Lloyd's this year.

"I do not believe I exaggerate when I affirm that we are looking at a decision which marks the coming of age of Spanish insurance in the international world," said Santiago Gil de Biedma, president of Grupo Gil y Carvajal, the broker's Spanish parent company.

The broker will place mainly Spanish facultative reinsurance business at Lloyd's, but it has a growing book of treaty reinsurance business that it will place at Lloyd's as well, said David Smith, chief executive of the Lloyd's broker.

Grupo Gil y Carvajal is part of the UNISON network and is 50% owned by Johnson & Higgins. J&H bought 25% of the company in 1989 and another 25% in 1991. The remaining 50% is owned by private shareholders.

Gil, Carvajal & Partners is 82.5% owned by Grupo Gil y Carvajal and 17.5% by Hogg Group P.L.C.

The move by the Spanish broker was welcomed by Lloyd's Chairman David Coleridge.

"We are currently negotiating a license in Spain from the regulatory authorities there, and I see both Lloyd's and the Spanish insurance market benefiting from both moves," he said.

Gil, Carvajal & Partners employs 27 people in offices in London, Madrid, and Barcelona.

Maxwell aftermath

The head of one of the City of London's regulatory bodies has resigned over the Maxwell pension funds scandal.

George Nissen, chairman of the Investment Management Regulatory Organization, said it was his duty to resign because IMRO shared some responsibility for the scandal.

"There is considerable public criticism of IMRO's supervision

Continued on page 25

INTERNATIONAL

Gooda Walker

Continued from previous page
derwritten by Stan Andrews and managed by subsidiary Gooda & Partners Ltd., with 1989 losses totaling 186.4 million pounds ($348.6 million) or more than four times the syndicate's capacity of 38.6 million pounds ($72.2 million). The syndicate's 1,256 members in 1989 must pay 88.7 million pounds ($168.5 million) by July 31 and another 40.5 million pounds ($77 million) by Feb. 1.

Including previous cash calls, syndicate 298 members have so far been asked to pay a total of 187 million pounds ($355.3 million) for the 1989 and 1990 underwriting years.

Many members are fighting vigorously to avoid paying these claims, many of which result from Mr. Walker's role as a leading underwriter for LMX business.

Others simply won't be able to pay.

"I don't wish (Lloyd's) every luck" in getting the latest cash calls paid, said Alfred Doll-Steinberg, chairman of the Gooda Walker Action Group. "I'd like to see them try to get members to pay it."

The Gooda Walker members will continue now-pending litigation to avoid payment of the losses, he said.

About 2,200 members of the Gooda Walker Action Group will go to court July 13 to defend their right to apply for a judicial review of the Lloyd's market. Lloyd's is objecting to an earlier decision by the High Court to allow the application to be heard (*BI*, May 25).

The members have claimed that the LMX spiral, in which catastrophe losses are ceded from underwriter to underwriter and which caused the bulk of the Good Walker losses, was a fraudulent scheme. The members maintain the LMX coverage was devised as a way to redistribute members' premium to brokers and to benefit "insiders" on other syndicates who dumped their losses onto the Gooda Walker syndicate.

Sir David Walker's report on the LMX spiral released last week did not support this view (see story, page 1).

Mr. Doll-Steinberg, who had not read the Walker report last week, noted that Gooda Walker members were awaiting the report before taking any further legal action. If the report's conclusion, however, "is clearly no help to us at all. . .we will continue as if it didn't exist."

If Gooda Walker members cannot—or will not—pay the cash call, G.W. Run-Off will ask Lloyd's to first draw down on members' deposits and then fund any deficiency from the Central Fund, Mr. Sharp said.

So far, G.W. Run-Off has collected 328.7 million pounds ($618 million) of the 375.7 million pounds ($706.3 million) sought in the previous cash calls.

Lloyd's is beefing up the Central Fund in light of the Gooda Walker losses through a special levy of 500 million pounds ($940 million) on members to be paid by July 15. This should bring the total amount in the Central Fund by the end of the month to 1 billion pounds ($1.88 billion).

At Lloyd's annual general meeting late last month, Lloyd's Chairman David Coleridge called the Gooda Walker debacle "the greatest disaster since the sinking of the Titanic" (*BI*, June 29). The bulk of the questions directed to the chairman during the six-hour meeting were from Gooda Walker members.

Members asked Mr. Coleridge why Lloyd's didn't stop Gooda Walker from writing the loss-plagued business and stop so many members from joining the syndicates.

Mr. Coleridge said it would have been "wrong and impossible" for Lloyd's as regulators to tell underwriters what they can and cannot write, though the Walker report released last week urged Lloyd's to monitor the risk presented by the business written at Lloyd's.

Mr. Coleridge also pointed out that members would have been outraged in 1987 if Lloyd's refused to allow new members to join the Gooda Walker syndicates. At the time, agents, members and syndicate analyst Chatset Ltd. considered them the most profitable in the market, the chairman said.

When members see big profits reported by Chatset for some syndicates, "it's difficult to tell members not to join those (syndicates) because they are no good," said Mr. Coleridge.

Mr. Coleridge added that Mr. Walker, in his annual syndicate reports, "mentioned categorically that he was in the high-risk business." Mr. Walker's report explained that "if everything went well and catastrophes followed the normal pattern, there was a very good profit to be made. But (he said that) he was in the high-risk business and if there were disasters, heaven help us all."

When answering another Gooda Walker member's question, Mr. Coleridge said that there is no suggestion that Mr. Walker or the underwriters of other loss-plagued LMX syndicates "committed fraud."

If fraud is discovered, then Lloyd's may be able to do more to help members pay their losses, he said. "But you can't put (underwriters) into prison just because you don't like them."

In the meantime, Mr. Coleridge let slip that syndicates managed by Sturge Holdings P.L.C., of which Mr. Coleridge also is chairman, had not purchased LMX coverage from Gooda Walker syndicates for some time following a dispute between the two agencies for non-payment of claims. ■

Australian market

Continued from previous page
out in the Australian industry, said Mr. Pettersen.

"In 1990, there were 129 locally authorized underwriters servicing this market which, on face value, makes it one of the most competitive in the world," he said. "However, major underwriting losses here, as well as a wave of mergers and acquisitions among European-owned insurance companies, are likely to reduce the number of insurers operating in Australia."

One consequence of the current market situation: Senior managers at brokers and underwriters are getting more involved in renewal negotiations.

"A lot of underwriters have reigned in and centralized authority in their head offices," Mr. Donnelly noted.

Ian C. Waters, risk manager for Queensland Fruit & Vegetable Growers, a Brisbane-based cooperative, said underwriters are changing their emphasis from quantity to quality.

"New business departments of the major insurers have had production targets removed and replaced with performance targets," said Mr. Waters, who is also president of the Assn. of Risk & Insurance Managers of Australia. "The emphasis is no longer on premium dollar chasing."

Mr. Waters said one company he knows of is prepared to drop 30% to 40% of its book of business to get back to profitability.

And the major British-owned companies are pushing their Australian offices to write quality business at realistic rates instead of "grabbing any business that comes in the door," he said.

The hardening market represents an opportunity to "preach the virtues of risk management," Mr. Waters said. But it is "a rough time" for risk managers because some misguided managements are reducing staff, including risk management departments, as Australia's economy remains depressed.

"At times when they desperately need risk managers, a lot of chief executive officers are dropping the function in favor of part-time consultants," he noted. "ARIMA needs to highlight the benefits of in-house risk managers so CEOs are aware of what a risk manager can do and what the discipline provides."

Mr. Waters said he anticipated rate reductions because of major changes to the co-operative's operating structure, but rates for the co-op's property and liability coverage have been "on a par with last year's renewals."

Brendan Ryan, risk manager for Sydney-based aluminum producer ALCOA Australia Ltd., said most of ALCOA's insurance renewals are due April 30 and Dec. 31, but he noted there had been "no significant increases" in the April 30 renewals and no change in deductibles.

Next year, though, could be another matter, he said.

Mr. Ryan noted that there had been increases for firms with June 30 renewals.

Yet, while rates have been increasing for property risks and rising a lesser amount for casualty coverage, the market is still "fairly soft," he said.

Mr. Ryan said rate increases in Australia are being driven by global reinsurers taking a harder line and reinsurance increases in the London market.

London market observers have said Australia's property catastrophe reinsurance rates, for example, are skyrocketing 50% to 250% at renewals.

Insurers that had been chasing premium dollars were caught when the market began to swing the other way, Mr. Ryan said.

ALCOA has avoided big increases by developing long-term relationships with insurers that cover highly protected risks. That relationship means ALCOA is able to call on its insurers' expertise and involve them in the planning of new buildings and machinery.

At the Brisbane City Council, Australia's largest local authority, "increases, but not horrendous increases," are expected, said Pat O'Driscoll, risk manager. The council's broker, the Queensland office of Jardine Australia Pty. Ltd., is still preparing its renewal package.

Sid R. Levett, group insurance and risk manager for Melbourne-based packaging and paper manufacturer Amcor Ltd., has just returned from London and Europe where he is placing more of the company's business, most of which is due for renewal Oct. 31. Mr. Levett said he sees a "definite hardening" in the market, as he negotiates those October renewals.

"The Australian market is not a lot of help for big industrial accounts," Mr. Levett said. Australian underwriters "are reluctant to be at the front-end of big industrial accounts, and we can't get the capacity we need."

A "sizable proportion, probably 50%" of Amcor's primary and excess property insurance will be placed offshore this year, he said. Property coverages are predominately placed overseas, with liability coverages being placed with the Australian offices of multinational insurers.

Amcor wants to keep its insurance cost increases to a minimum, but some increases are "inevitable in the current market, even with a clean account," Mr. Levett said.

Since 1988, Amcor has operated a Singapore-based captive, Amcor Insurance Pte., which is managed by Alexander Insurance Managers (Singapore) Pte. Ltd. Alexander Stenhouse, a unit of Alexander & Alexander Services Inc., is Amcor's broker in Australia.

"We'll be using the captive for more risks in the future," said Mr. Levett. But while more coverage will be insured by its captive, the company still will rely on the open market for high-layer catastrophe coverage.

Ross Pullinger, group risk manager for Sydney-based building materials and resource development company Pioneer International Ltd., said his firm anticipated 20% increases for its property, business interruption and marine accounts at June 30 renewals, but was quoted a 300% increase.

As a result, Pioneer switched brokers, Mr. Pullinger pointed out.

"The increase was due to broker problems, not claims," he contends.

The company is now restructuring its insurance program to "get costs back to something reasonable" and will be buying lower limits and increasing deductibles to try to keep its costs in check, Mr. Pullinger said.

Most risk managers now are seeing 20% to 30% increases in property rates and the casualty market will "harden in sympathy," he said.

"It was expected," he added. "We knew the market couldn't stand that, particularly when underwriters are already in a shaky position because of the long, soft market."

Although Australia had too many underwriters for the size of its market, there has been "no big rush of underwriters pulling out," Mr. Pullinger noted. Mergers and acquisitions have reduced the numbers only slightly.

Many underwriters are forcing rate hikes by refusing to compete for market share. National Commercial Union Ltd., for one, has continued the stand it took in previous years to "only write business if we won't lose on it," said Philip R. Clairs, managing director. "We have had rate increases in previous years, therefore renewals this year will not be as great. Percentage increases depend on the base you are coming from." ■

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INTERNATIONAL

Market turn

Continued from page 23

mean a "sea change" for insurers that base their underwriting simply on their judgment of what price the market will bear, Mr. Hanway said.

The market is ripe for a sharp upturn in rates, Mr. Christie said.

When insurance markets have hardened previously, the usual result has been higher profits for insurers and brokers and higher costs for their clients, he said.

This time, however, insurers and brokers will have to be careful not to frighten their clients away from commercial insurance and toward alternative risk financing mechanisms like captives, Mr. Christie said.

"So, like underwriters, we will not look to the coming upturn simply as a way to return to previous profit margins, because our customers won't allow that to happen," he said.

"We should be in the business of providing predictability to our clients. If we continue to see ourselves as a commodity market based on supply and demand, we will show up our inability to meet our customers' basic needs," he said.

Mr. Christie cautioned that without sharp rate hikes, insurers and brokers will have to learn to survive on much thinner margins. As a result, policyholders will start paying much closer attention to insurer security and brokers will have to provide security evaluation services, he said.

Brokers will spend a lot more time searching out secure capacity for their clients, Mr. Christie said. "By the year 2000, one of our primary jobs will be to advise clients on who has the best security. Maybe we should charge for that service."

No recovery in the insurance industry would be complete without greater disclosure of all aspects of transactions between insurers and reinsurers, Mr. Peugeot said.

"The real cause of inadequate underwriting profitability has been the lack of transparency between insurers and reinsurers," he said.

Currently, reinsurers' underwriting commitments are made on the basis of incomplete information concerning the risks covered, because they do not receive or do not request enough information from ceding insurers, Mr. Peugeot said.

In some cases, insurers have withheld information deliberately to mislead reinsurers, he maintained.

For example, the real losses on European property risks have been systematically understated to reinsurers at renewal, Mr. Peugeot charged.

Reinsurers "have been taking positions without knowing the full extent of the risks—worse still, without knowing that they would have to meet claims which already existed," he said.

Mr. Peugeot recommended a series of steps to improve the reinsurance process.

First, reinsurers should more frequently exercise their right to audit the details of insurance policies, he said.

Second, insurers should provide underwriting results more quickly.

"It does seem ridiculous that we can get some information in milliseconds, yet it can take up to three years to have the underwriting results for a given year, and even then only an estimate sometimes," Mr. Peugeot said.

Also, insurers that are not slow to file claims with reinsurers can take more than three months to settle their own outstanding reinsurance premiums, he said.

Mr. Peugeot also recommended replacing the London method of underwriting reinsurance, in which the details concerning the risk are only presented to the lead underwriters.

"It's a method which causes endless problems. It should be replaced, even if this means an increase in underwriting costs," he said. ■

LONDON

Continued from page 23

of two of the Maxwell companies," Mr. Nissen said. "We have freely acknowledged that we are open to a share of reproach for what happened."

The two Maxwell companies responsible for investing the pension funds are Bishopsgate Investment Management and London & Bishopsgate International Investment Management. Both companies were regulated by IMRO.

Robert Maxwell allegedly stole 426 million pounds ($810.9 million) from his companies' pension funds before his death in November 1991 (*BI*, Dec. 16, 1991).

Charles Nunneley, deputy chairman of investment firm Robert Fleming Holdings Ltd. and a director of IMRO, will be acting chairman of IMRO until Mr. Nissen's successor is appointed.

Chancellor runoff

Chancellor Insurance Co. Ltd., the London underwriting subsidiary of Canada's Phoenician Holdings Ltd., has ceased paying claims and is currently seeking to establish a scheme of arrangement.

The company was placed in runoff three weeks ago after suffering large losses from its London market excess-of-loss reinsurance account, which comprised the majority of its underwriting.

In 1990, the company reported a loss of 6 million pounds ($11.4 million). The company suffered another loss in 1991, but figures are not yet available, said Peter Thompson, managing director of Chancellor.

The scheme of arrangement will be presented to the British courts in mid-July.

Reinsurance team

Anglo American Insurance Co. Ltd. has lured an underwriting team from a rival insurer to set up a general North American and international reinsurance account.

The six-member team from London & Edinburgh Insurance Group Ltd. is headed by Duncan Faircloth, who will become director of reinsurance underwriting at Anglo American on Aug. 1.

Anglo American will underwrite between $12 million and $20 million in gross premium on the new reinsurance account, according to Marcus Brown, Anglo American underwriting director.

The treaties written by Anglo American will cover general property and casualty business, catastrophe reinsurance and medical benefits, Mr. Brown said.

"Most people seem to think that we rely on a direct U.S. account, and we have been thinking of ways of becoming a more rounded company," he said.

Now Anglo American will be able to take advantage of the hardening reinsurance market and broaden its client base, he said.

ALM warning

Lloyd's of London will have to adopt stringent new regulations to root out incompetent underwriters if it is to regain members' confidence, says Mark Farrer, chairman of the Assn. of Lloyd's Members.

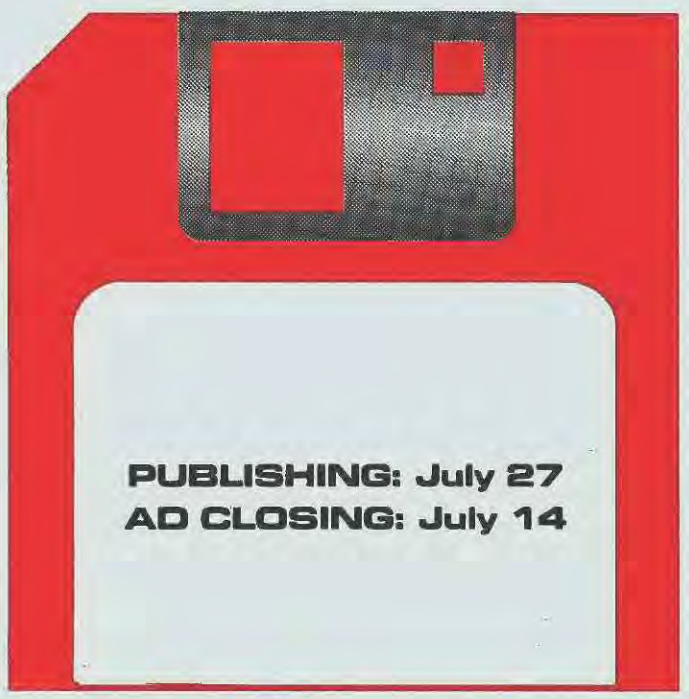
And market authorities must implement the recommendations of the task force that examined ways to increase Lloyd's capital base if they wish to retain the existing members, he said.

"There has been a breakdown of the trust and confidence that have to exist between the market and its capital providers," Mr. Farrer said in the ALM's 1991 report and accounts.

The breakdown stems from Lloyd's failure to introduce wide-ranging changes after the 1982 Lloyd's Act, Mr. Farrer said. "The prevailing mood in the market was to limit the changes as far as possible with the inevitable corollary that clearing up the mess has turned into a collective endeavor." ■

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The Health Care Commission of the State of Kansas intends to issue a request for proposal(s) (RFP) on July 10, 1992 for its insured dental plan.The deadline for receipt of the proposal(s) is Friday, July 31, 1992, 5:00 p.m., C.D.T.

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IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS COUNTY DEPARTMENT, CHANCERY DIVISION
IN THE MATTER OF THE LIQUIDATION OF UNITED DIVERSIFIED CORPORATION
NO. 88 CH 6942
NOTICE

PLEASE TAKE NOTICE that on June 8, 1992 an Order of Liquidation With A Finding of Insolvency was entered against United Diversified Corporation by the Honorable Robert D. Ericsson, Judge of the Circuit Court of Cook County, Illinois. Stephen F. Selcke, Director of Insurance for the State of Illinois is the statutory and court appointed Liquidator of United Diversified Corporation.

TAKE FURTHER NOTICE that pursuant to the order of liquidation, all rights and liabilities of United Diversified Corporation and its creditors, policyholders, if any, and all other persons or entities who may have a claim against its assets are fixed as of June 8, 1992, unless otherwise provided by a subsequent order of the court.

TAKE FURTHER NOTICE that any and all persons, partnerships, corporations, associations, estates, trusts and governmental units having or claiming to have any accounts, debts, claims or demands against United Diversified Corporation or claiming any right, title or interest in or to any funds or property of United Diversified Corporation in the possession of the Liquidator are required to file a Proof of Claim with the Liquidator on or before 4:30 p.m. Chicago Time, December 1, 1992.

TAKE FURTHER NOTICE that the form of and required content of all proofs of claim are described in the Illinois Revised Statutes, 1991, Chapter 73, Paragraph 821. Proofs of claim, together with supporting documents, if any, are to be filed with and may be secured from the Special Deputy Liquidator of the United Diversified Corporation, 222 Merchandise Mart Plaza, Suite 1450, Chicago, Illinois 60654. Filing shall occur upon receipt of Proof of Claim by the Liquidator. The Liquidator further reserves all rights to any and all defenses of United Diversified Corporation concerning such claim. All Proofs of Claim must be duly sworn to before an officer authorized to take oaths.

THE LAST DATE FOR THE FILING OF PROOFS OF CLAIMS WITH THE LIQUIDATOR AT THE ABOVE MENTIONED OFFICE OF HIS SPECIAL DEPUTY LIQUIDATOR IS DECEMBER 1, 1992 AT 4:30 P.M. CHICAGO TIME. NO PERSON HAVING OR CLAIMING TO HAVE ANY CLAIMS AGAINST UNITED DIVERSIFIED CORPORATION SHALL PARTICIPATE IN ANY DISTRIBUTION OF THE ASSETS OF THE COMPANY UNLESS THE CLAIMS ARE FILED WITH THE LIQUIDATOR ON OR BEFORE DECEMBER 1, 1992 AT 4:30 P.M.

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Best study

Continued from page 3

cline in the number of impaired companies is based on six economic and industry assumptions. Four of those indicate fewer impaired companies, with "the last two tempering this optimism," according to the report.

The assumptions are that:

- "Moderate economic growth and relatively stable interest rates should enhance" life/health insurers' operations "and bolster policyholder confidence in the insurance industry."
- Many insurers are selling off their junk bond holdings in favorable market conditions and reinvesting the proceeds in higher-grade securities. Insurers also are curtailing new investment in the commercial mortgage and real estate markets.
- Insurers are refocusing on profitable operations, including "increased efforts to concentrate on the fundamentals of expense control. . .realistic pricing and crediting strategies, asset/liability management and surplus adequacy."
- Regulators, backed by several National Assn. of Insurance Commissioners initiatives, are expected to take "earlier and more decisive actions" in preventing life insurance companies from becoming impaired.
- Commercial mortgages will continue to produce large losses for insurers.
- Health insurers, which accounted for 47% of all impaired companies from 1976 to 1991, will probably enter a down phase in the group health underwriting cycle in the near future. This could produce more impaired companies.

"The industry has gone through some transition, and it's adjusting. It's just that we don't feel that the risk profile will decline to what it's been in the past," explained W. Dolson Smith, senior research editor at Best and an author of the report.

"I think it will take a good deal of time—more than two or three years—to have even the possibility of returning to the exceptionally low levels (of impaired companies) of the past. Just the real estate (exposure) alone is projected to be a long-lasting phenomenon," with "more normal performing (real estate) assets" expected only by the late 1990s, Mr. Smith said.

Changes in life/health insurance products, as well as changes in the marketplace since the mid-1970s, hurt insurers' operating results, Best reports.

Interest rates soared in the late 1970s and early 1980s and financial institutions began offering higher yields. Life/health insurers followed suit. Their new interest-sensitive products included individual and group annuities and guaranteed investment contracts.

Such products raised administrative costs, and, to assure profits, insurers had to find higher-yielding investments. Then, when interest rates fell in the early 1980s, insurers were caught short.

"There is reason to believe, however, that one or more of these companies could have successfully managed their problems, if they had been able to avoid" the large number of surrenders by policyholders who lost faith in the company, Best says in its report.

"Due primarily to the large size of (the impaired companies), the importance of policyholder confidence as a solvency issue became very apparent in 1991," the report notes.

Meanwhile, health insurers, responding to "the dramatic rise in health care costs over the past 16 years," increasingly turned away from marketing traditional indemnity plans. Instead, they offered managed care products, like health maintenance organizations and preferred provider organizations.

But the rapid expansion of managed care and self-insurance resulted in intense competition and pressure on health insurance profit margins, the report says.

The results of these market forces were first seen in 1983, when the number of impaired life/health insurers doubled to 20, or 0.8% of the total number of life/health insurers. The failures were led by the collapse of Baldwin United Corp., with six life/health affiliates.

The number of impaired companies again shot up in 1989 to 42, then 41 in 1990 and 58 last year, Best said.

In many ways, the impaired life/health insurers closely resemble the property/casualty failures Best examined in an earlier study (*BI*, July 22, 1991).

In both the life/health and property/casualty areas, most of the impaired companies had premium growth far exceeding the norm. They also tended to be younger companies and stock companies rather than mutuals.

Also, the impaired insurers tended to have less than $5 million in capital and surplus, Mr. Smith noted.

But he noted one significant difference: "The quality of assets is definitely more of a concern for the life/health companies."

"By the end of 1990, the average life/health insurer had 24% of its assets in mortgage loans, real estate and non-investment grade bonds, compared with only 2% for the property/casualty industry," Mr. Smith said.

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Copies of "Best's Insolvency Study Life/Health Insurers 1976-1991" are available for $15 each from A.M. Best Co.'s customer service department at 908-439-2200, ext. 5742. Quantity discounts are available.

Moody's outlook is mixed for life and health insurers

By LOUISE KERTESZ

Moody's Investors Service Inc. believes mortgage investments and interest-sensitive products like guaranteed investment contracts will spell continued difficulties for life/health insurers.

However, Moody's also sees "renewed conservatism emerging" among life insurance company managers, which bodes well for the industry. And Moody's says it has completed the bulk of its downgrading of life/health companies that was begun last summer (*BI*, July 29, 1991).

"Managements are focusing on financial strength as a primary objective, and they appear to be reducing growth expectations," Moody's said in a recently released report.

"They are divesting non-core operations, looking for ways to enhance efficiency, and they are attempting to improve asset quality and capitalization," particularly by selling off non-investment-grade bonds in a favorable market, according to Moody's "Life Insurance Industry Outlook."

A.M. Best Co. reached similar conclusions in another recently released study on the life insurance industry (see story, page 3).

On average, the 77 life/health insurers analyzed in Moody's report reduced their below-investment-grade bonds as a percentage of capital to 63.5% in 1991 from 95.4% in 1990. And they reduced their mortgage holdings as a percentage of capital to 286.6% in 1991 from 346% in 1990.

But the life insurance industry is not out of the woods yet, Moody's reports. With the seizure last year of six major life insurers by regulators, Moody's says: "We believe that the events of 1991 have fundamentally changed the life insurance industry, and that, as a consequence, the risks associated with life insurance obligations have increased.

"The fact that Mutual Benefit (Life Insurance Co.) was taken over by the state regulators as a result of real estate-related asset quality problems has moved the spotlight of regulatory and media scrutiny from junk bonds to real estate. Unfortunately, the life insurance industry is significantly more exposed to commercial real estate than it is to junk bonds."

A group of 30 to 40 life insurers account for the bulk of the industry's mortgage holdings. "In general, companies with lower real estate exposure will—all things being equal—gain a competitive advantage over those with high exposures," Moody's predicts.

Because of deteriorating real estate holdings and concerns about insurers' asset-accumulation products, Moody's has lowered the ratings of "a significant number of companies," the report says.

Moody's has downgraded about 35 to 40 life/health insurers since last summer, according to Robert L. Riegel, Moody's assistant vp in New York and author of the report.

Moody's sees 'renewed conservatism emerging' among life insurer managers.

But although more rating changes are likely, Mr. Riegel said, "We've done most of the downgrades that needed to be done." Moody's now expects it will need to reduce the ratings of "only a handful of (life/health) companies" because of their real estate exposures and because of concerns about the interest-sensitive products they offer, Mr. Riegel said.

"Commercial rating firms have in the past year taken a different position in rating the financial strength of insurers," said a spokesman for the American Council of Life Insurance in Washington, who said he was not familiar with the Moody's report.

"In particular, they have taken a much shorter-term view, and in many cases, changed or adjusted their grading methods," the spokesman said.

"It's fair to say that the rating firms have reacted to public perceptions about the financial strength of insurers and are now looking at companies from the perspective of financial strength, when many in the industry were under the impression that (the rating firms provided) claims-paying ability ratings.

"There are companies in receivership that continue to pay all of their claims."

"A lot of people say that we've changed the framework" of our ratings, Mr. Riegel responded. "But we say that what has changed is the industry and the factors that contribute to the credit risk in the industry. Our ratings are a response to that environment."

Apart from the "deterioration" in real estate holdings, another change in the environment that now factors into the rating agency's industry evaluations is early intervention by regulators in the event of "runs" by policyholders, Mr. Riegel said.

"Intervention shortens the time frame within which a company has to operate, shortens its flexibility and confines the company. It is viewed as a negative" by Moody's, according to Mr. Riegel.

Moody's also forecasts that group life and health insurers' profits "are expected to decline as the cyclical downturn has begun."

With the increasing popularity of managed care, "all but major service carriers—those with predominantly administrative-services-only and managed care services or strong niche players—should find the group health market unattractive," the report says.

"Companies able to offer integrated experience-rated plans, with quality managed care components, should ultimately emerge as leaders in the large-case sector of the market. Carriers with good cost-control capabilities and superior service on a local basis will have the best competitive positions in the smaller end of the market," according to Moody's.

But, Moody's warns, in the midst of the national turmoil over health care problems, "hostile consumers and businesses" will greet the "inevitable rate increases that follow the downturn."

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Copies of "Life Insurance Industry Outlook" are not available to non-subscribers of Moody's Investors Service.

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Arizona rules

Continued from page 3

In addition, at the same time Arizona gears up for these changes, the federal judiciary is considering similar reforms, said Joseph Spaniol, who is secretary of the Judicial Conference Committee on Rules of Practice & Procedure in Washington. The Judicial Conference represents the federal judiciary.

Among the changes it is now considering, said Mr. Spaniol, are mandated early disclosure of documents and witnesses, and limitations on depositions and interrogatories. The proposed reform of the federal courts was first introduced in August, with public hearings held in November and February.

Modifications to the federal proposals are expected to be completed this week, and in September the proposed reforms will be presented to the Judicial Conference, whose members include Chief Justice William Rehnquist, the chief judge of each appellate court, a district judge from each circuit and the chief judge of the international court of trade.

Upon approval by that body, they are expected to then be presented to the U.S. Supreme Court for final approval next spring. Once the Supreme Court approves them, they automatically become effective unless Congress chooses to take action.

The earliest the rules could become effective is December 1993, said Mr. Spaniol, who noted additional changes may be made during the approval process.

Not only is the federal judiciary likely to introduce similar rules, but so are other states, said William Shattuck, an attorney for Phoenix-based Quarles, Brady & Fanning, who defends insurers and self-insurers.

"I think that other states are likewise contemplating substantial changes in the rules of civil procedure" and once they have seen what Arizona has done, "I would not be at all surprised to find other states adopting rule changes so that their rules basically look like the Arizona rules," said Mr. Shattuck.

Advocates of the Arizona changes say the rules will cut costs, increase efficiency and eliminate frivolous lawsuits.

But opponents say requiring lawyers to turn over information to the other side raises troubling questions about attorney-client confidentiality. Opponents also say the rules could raise the number of motions made and could give plaintiffs an unfair advantage.

Among the advocates is William Jones, of Phoenix-based Jones, Skelton & Hochuli, who served on the Special Bar Committee to Study Civil Litigation Abuse, Cost and Delay, a panel of attorneys and judges that developed the rules.

Mr. Jones said changing the discovery system will cut costs.

Under the traditional system, he said, attorneys must ask the right question in discovery and "God help you" if you don't. This has made discovery into a cottage industry that supports law firms while costing businesses, insurers and others "tons of money unnecessarily," the Phoenix lawyer said. It has also made the system "unnecessarily adversarial," he said.

Requiring both sides to disclose all relevant materials before trial eliminates the "horrible expense" and time of having to request everything in discovery, Mr. Jones said. This is "a little more important than whether the lawyer's bottom line is met."

A pilot program involving 7,000 to 8,000 cases in Arizona courts over an 18-month period cut legal costs an estimated 25% to 30%, he said.

Donald Bisbee, a Scottsdale, Ariz.-based lawyer who primarily represents businesses, said the new rules will "severely reduce" frivolous suits.

With both sides required to disclose information quickly, defendants will no longer have to figure out "what in the world it is (plaintiffs are) suing for," said Mr. Bisbee. Now, the defense attorney can evaluate the case and "if there is nothing there, ask for sanctions," he said.

But among those who object to the Arizona rules is a Phoenix lawyer who sat on the panel that drafted the rules.

Though the rules are intended to reduce the costs and delays associated with commercial litigation, they could have the opposite effect, according to Carol Campbell Cure of O'Connor & Cavanaugh. "I think we're going to see a mass of paperwork that wasn't there before."

Under Arizona rules, parties only have to give a few facts about a case when a suit is filed. As a result, the need to know precisely what information should be offered in discovery will lead to additional motions being filed, she said.

Yet another issue, she said, is how diligently attorneys provide the other side with relevant information. The disclosure standard is "completely subjective," she said. What the lawyer for one side believes is relevant, "may be very different from what the lawyer on the other side interprets as relevant."

Plaintiffs' attorneys who work on a contingency basis have a "pocketbook interest" involved, which could influence what they consider relevant, Ms. Cure said.

As an example, she offers a case of one party in an auto accident suing the other for, among other things, causing emotional distress. The defense attorney may well believe it is relevant that the plaintiff had sued for emotional distress in another case a year earlier. The plaintiff's attorney, however, may not.

And lawyers will seek sanctions against opponents for withholding relevant information, she predicted.

Ms. Cure, who frequently defends insurers, said she also sees potential problems with the 40-day limit on when material should be exchanged. Under Arizona's statute of limitations, suits can be filed up to five years after a dispute arises, yet defendants will have only a matter of days in which to respond.

"It may give the plaintiff a little bit of an unfair advantage," she said. "There may be an increased danger to the defendant of getting sanctioned for not disclosing something" in such a short period of time, Ms. Cure said.

Another issue that could arise under the new rules, she predicted, is whether the attorney-client privilege or other privileges apply to certain information, said Ms. Cure.

The new rules "make unnecessary inroads upon the attorney-client privilege," agreed Robert Bruno, of Phoenix-based Teilborg, Sanders & Parks, who primarily represents insurers.

It can create ethical dilemmas for lawyers concerned about their inviolate duty to maintain confidences with their clients. "There's no safe harbor any more" to sit down and talk about a case without the "chilling effect" that it may be his duty to divulge it to the other side, said Mr. Bruno.

The rules also appear to put the onus on an attorney who represents one party to dig out all the relevant facts for the other side, said Mr. Bruno. "I feel like I have an obligation now to work for the other side's case."

Mr. Shattuck of Quarles, Brady & Fanning, said he, too, is concerned about the impact on the attorney-client relationship and on the work-product rule, which protects from discovery most documents developed in preparation for litigation.

Read literally, the law would require counsel to disclose to the opponent everything they know about a case or that could be relevant to it, Mr. Shattuck said. "I am very concerned about what the effect of these new rules will be" on prior protections, he said.

However, a supporter of the rules says this will not be a problem.

"There is nothing in the rules which change any of the customary privileges" between attorneys and their clients, said Judge Robert Myers, presiding judge of the civil department for Maricopa County Superior Court.

The rules would only eliminate the need for lawyers to ask the right questions in obtaining information, he said.

Judge Myers also said that in the pilot program in Maricopa County there were fewer motions and fewer requests for sanctions. "There's the proof of the pudding," he said.

"There isn't a body of case law" yet to clarify the rules, commented Roger Brodman, an attorney with Gallagher & Kennedy in Phoenix. "I think there's going to be a lot of uncertainty in application of the rules because they're so new," he said.

In the long run, however, things will possibly "shake out," Mr. Brodman predicted.

Another concern is that in product liability cases, for instance, which may be filed in 50 states, Arizona will have different rules from the other states. This will be difficult to explain to clients, said Mr. Brodman, who works in this area.

He said he would have preferred it if Arizona had waited for the federal judiciary to change its rules of civil procedure in the interest of maintaining uniformity. "I think maybe Arizona got a step ahead of itself," he said. ■

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demographic section:	Insurer Topics: Marketing/Advertising & Sales Promotion
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closing:	**July 14**
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Business Insurance

Lloyd's reforms

Continued from page 1

the heavy burden of his duties," says Sir Jeremy's report. Currently, the post carries no salary.

The chairman also should serve for a minimum of three years instead of being elected annually, the report suggests.

The chairman will oversee the Council of Lloyd's, whose size will be cut in half to 14 members from 28. The new council will meet every two or three months rather than monthly, as it now does.

The new council will consist of six working members, four non-working Lloyd's members and four non-members, which is in line with the ratio suggested in Sir Patrick Neill's report on Lloyd's self-regulation in 1987. This ratio removed control of the market away from working members as envisaged under the Lloyd's Act of 1982 (*BI*, Jan. 26, 1987).

One of the six working members will be the chairman of Lloyd's.

Two new, separate bodies will report to the council:

- The Market Board, which will oversee Lloyd's business development. The board will be headed by the chairman of Lloyd's and a full-time chief executive officer, who also will be a council member.

The board "would be the driving force in the development of Lloyd's for the foreseeable future," said Sir Jeremy's report.

A strong business-oriented board could curb the disastrous results Lloyd's has reported, Sir Jeremy implied last week. "No regulation will work unless the business driving it has its own sense of goodness and its own sense of compliance," he said.

The market board will consist of 15 or 16 people, including the chairman and the chief executive, as well as members of various associations in the market.

The new CEO—who could be recruited from the insurance market and could be a Lloyd's member who places his interests in trust—should serve five years and be paid properly, the report says.

A new chief executive likely will be selected by year-end.

- The Regulatory Board, to be led by a head of regulation, who would be another council member. This board will consist of 14 people, including the four non-working Lloyd's members and the four outsiders who sit on the council; four working members who are not on the council; the head of regulation; and Lloyd's general counsel. The Chairman of Lloyd's will not be on this committee.

This regulatory board is similar in makeup to the various Self-Regulatory Offices that answer to the U.K. Securities and Investments Board under the Financial Services Act of 1986.

Although the British government has come under criticism for not including Lloyd's under the Financial Services Act, the Neill committee reported in 1987 that it believed Lloyd's should govern itself.

In another report issued last week, Sir David Walker, recently retired chairman of the SIB, agreed that it is not necessary for Lloyd's to be covered under the Financial Services Act as long as Sir Jeremy's recommendations are implemented.

Sir David did concede, though, that Lloyd's regulators may have spotted problems sooner if Lloyd's had been governed by the act.

Meanwhile, the Walker committee strongly criticized the current Council of Lloyd's for lax regulation of the market that resulted in huge LMX losses by 10 syndicates. However, it did not find any fraudulent activity by market insiders.

Two of these syndicates, formerly managed by Gooda Walker Ltd., reported total gross losses of 392.9 million pounds ($734.7 million at applicable exchange rates) in 1989 (see story, page 23).

Sir David added last week that the council was neither negligent nor breached its duty to members by failing to properly monitor the huge expansion of the LMX market in the 1980s.

However, the council used an inadequate premium income monitoring system and failed to monitor and constrain high-risk exposures, which are "very serious criticisms" of Lloyd's, Sir David said.

The Walker committee also believed that the "standards of professionalism, care and diligence on the part of a number of members' and managing agents and active underwriters (fell) materially below best practice," the report says.

The Walker committee has made 18 recommendations. These include:

- A more "pro-active" approach must be taken by Lloyd's regulators to make sure everyone in the market complies with "best practice" standards. There must be "more vigorous enforcement and disciplinary action in respect of regulatory breaches."
- A "volatility analysis" should be conducted on the risks that flow into Lloyd's. Regulators should monitor the "riskiness" of business written by Lloyd's syndicates, and members should be given an indication of the spread of the risks that are written.
- Members' participation on syndicates should be "transparent" so everyone can know which working members are on which syndicates.
- Members agents should not accept new capacity for their members unless it is spread equitably among all of their members, not just a select few.
- Reinsurance between Lloyd's syndicates should be limited to prevent the spiraling of losses through the market.

Lloyd's "needs a change in its regulatory structure," Sir David said. Regulation of members agents, premium income limits and high-risk exposures was "inadequate" in the mid- to late 1980s, mainly because syndicates were profitable, he said.

"The Council of Lloyd's was anesthetized" by the profitable LMX market during that period, Sir David said. "So were the members" who did not take an active role in choosing which syndicate in which to invest and instead relied solely on their members agents for advice.

However, "members should know that they can't rely only on regulation to do everything for them," Sir David warned.

Lloyd's Chairman David Coleridge said last week: "We have yet to consider the (Walker) report in detail. We accept it for what it is, an honest criticism of perceived weaknesses, which we will address with all possible speed."

Peter Nutting, a member of the current Council of Lloyd's and chairman of a group of Lloyd's members who negotiated a settlement over losses from syndicates underwritten by Richard Outhwaite (*BI*, Feb. 17), said the report will give impetus to members who allege that underwriters were negligent.

"David Walker's report will give encouragement to those people that think that they have a case against negligent underwriting," Mr. Nutting said. "The evidence will be there and it should be a relatively simple matter in putting a case together." ■

U.S. market expects Lloyd's to prevail

By EILEEN P. GUNN and SARA MARLEY

U.S. risk managers and brokers aren't ready to bury Lloyd's of London, despite another record loss for the market and anticipated huge losses in the next few years.

But, many predict that Lloyd's will evolve into a smaller market.



Lloyd's reported a record 2.063 billion pound loss ($3.85 billion at applicable exchange rates) for the 1989 underwriting year, which dwarfs its previous record loss of 509.7 million pounds ($983.7 million) for 1988 (*BI*, June 29; July 1, 1991).

And syndicate analyst Chatset Ltd. expects a 1.1 billion pound ($2.05 billion at current exchange rates) loss for the 1990 account, due to close at year-end under the market's three-year accounting system. Chatset also expects a a 750 million pound $1.4 billion) loss for the 1991 account (*BI*, June 8).

Many risk managers and brokers, though, are confident the market can weather these losses.

"Lloyd's is too important a market not to correct itself," said Ron Schneider, manager of property and risk analysis and insurance for Amoco Corp. of Chicago.

"We knew they were giving (coverage) away and it would come back to haunt them," he said. Still, "we think they're viable but shaky, and we have our fingers crossed they can get their act together quickly."

Amoco during recent renewals pulled some coverage out of Lloyd's but plans to maintain its current coverage there.

The expertise associated with Lloyd's is still there and is virtually irreplaceable, another risk manager said. "The basic structure is still there," said James A. Mitchell, corporate insurance manager for Wilmington, Del.-based E.I du Pont de Nemours & Co., which purchases substantial coverage from Lloyd's syndicates.

A risk manager at a utility in the Northeast with a "substantial" amount of insurance placed at Lloyd's believes the market's problems are only slightly worse than the usual turns any marketplace takes over time.

"That type of loss certainly has to be a concern in terms of what it will do to future capacity as well as price in that marketplace," said the risk manager at a large food processor and distributor.

The company, he added, will probably not change its strategies at this point. Portions of the company's excess property program and marine coverages are written by Lloyd's syndicates.

"Lloyd's has some troubles right now, but it is still well positioned for aviation and marine business," said Robert Hilb Sr., president of Hilb, Rogal & Hamilton in Glen Allen, Va.

"Lloyd's will be around for a long time," said David McGurn, president of International Special Risk Services, a subsidiary of Arthur J. Gallagher & Co. Inc.

"They can correct themselves and still be a viable insurance market," he said.

Richard Miller, chief executive of Willis Corroon Group P.L.C., agrees. "There is no question about Lloyd's future: It is too strong, too old and too important to the world market," he said.

"We feel Lloyd's is probably better reserved than any of the U.K. or U.S. markets," said Mr. Miller, who is based in Nashville, Tenn.

"It's still secure financially," said Andrew Marks, president of MLW Services Inc., a regional brokerage in New York.

"Also, there's no way in hell the British government would allow it to collapse. It personifies the London insurance market," he said.

Even some U.S. members of Lloyd's, including those who have sued the market over losses, think Lloyd's will survive.

"Lloyd's stubbed its toe in 1989, but (it) will overcome this temporary situation," said Phil C. Gallagher, regional representative for the Assn. of Lloyd's Members in Miami.

Mr. Gallagher expects to lose about 150,000 pounds ($280,500) for the 1989 underwriting year. It is his second loss since joining Lloyd's in 1977, and he says he is still ahead overall.

In addition, Willis Corroon's Mr. Miller said, "A lot of names feel the worst is behind them."

He also thinks that some members will increase their underwriting in the current year.

Some risk managers question the market's viability but say they simply have nowhere else to turn for coverage.

"I am concerned about the future of Lloyd's," said the risk manager for a U.S. oil company. "I'm concerned because I don't know where else we would go for the types of coverage we need."

The risk manager said the amount of excess liability and marine coverages that his company buys from Lloyd's syndicates is significant.

"It is almost monopolistic," he said of Lloyd's, "because where else do you go?"

Another risk manager, though, sees options.

"I believe something dramatic is going on there," said the risk manager for an East Coast chemical company with significant excess coverage at Lloyd's.

He said his company plans to keep its coverage there but that a dramatic or turbulent downsizing could affect how it renews its coverage with Lloyd's syndicates in 1993.

Some U.S. Lloyd's members suing the market over their losses also are pessimistic about the market's future.

"Lloyd's was a very respected name in the world. It represented stability. That's all out the window," said Lloyd's member Ronald Riley.

"I wouldn't join now. I wouldn't understand why anyone would," Mr. Riley said.

A federal appeals court has issued an injunction prohibiting Lloyd's from drawing on his letter of credit while he appeals a lower court ruling that it does not have jurisdiction to hear Mr. Riley's lawsuit. Mr. Riley charges Lloyd's has violated U.S. securities laws by not registering under the Securities Exchange Act (*BI*, May 25).

The 1989 losses are "another example of the lack of underwriting standards," said John S. Roby, a U.S. member who is suing Lloyd's under securities laws.

Mr. Roby is appealing a federal court ruling last month that any suits brought against Lloyd's syndicates should be governed by English law (*BI*, June 22; Sept. 16, 1991).

Mr. Roby, president of Roby, Foster, Miller & Earick, an independent agency in Mansfield, Ohio, claims that the brunt of the losses will be borne by U.S., Canadian and Australian members, due to the "placement of foreign names on substandard syndicates."

"It's a reactionary, incestuous good-old-boy network," Mr. Roby said. "Insiders profit; outsiders help pay for the losses."

Even those who say they are confident that Lloyd's will survive think that the market will shrink dramatically.

George Nordhaus, a regional representative of the Assn. of Lloyd's Members in Santa Monica, Calif., believes that up to one-third of all Lloyd's names will leave.

Mr. Hilb said: "It is definitely becoming smaller, but it is still viable. For one, members there have been cashing checks for a long time and most can afford to pay now. Second, there just aren't enough stable substitutes to pick up its business. Lloyd's knows what it has."

"To say Lloyd's is in a bit of turmoil right now is nothing new. But we're pretty sure that they'll continue to take aviation and marine risks, albeit with some tougher terms," said Don Weber, chief operating officer of Jardine Insurance Brokers Inc. in San Francisco.

"It's probably the non-traditional business that Lloyd's used to create a market for that may disappear," he said.

"Lloyd's will be a different market than it has been," agreed M. Renwick Severance, vp-specialty services with Hogg Robinson Inc. in Boston.

"Capacity is down, terms are tighter and prices are higher. A few underwriters there are even willing to let business go."

Charles Fiske, group marketing director with Sedgwick James Inc. in Memphis, Tenn., agreed.

"Right now, if you can find similar coverage in the U.S., it's almost definite that the terms and price are better," he said.

"I think we'll see increased attention given each and every risk" by underwriters at Lloyd's, said the risk manager for the food processor and distributor. "We're seeing some of that in the marine market already."

Daniel Batonik, a vp in the property division at New York-based Johnson & Higgins, said underwriters at Lloyd's will no doubt attempt to "firm up the market by offering policies at higher prices and with more restrictive terms."

Lloyd's will be forced to "stick to the business it knows and feels comfortable with," said Lawrence Drake, a managing director with Marsh & McLennan Inc. in New York.

"In order to attract and maintain names, they'll have to be conservative and demonstrably profitable," he said.

Lloyd's also "needs better computerization and actuarial standards and more prompt reporting of results," said Brent LaGere, chairman of LaGere & Walkingstick, a Chandler, Okla.-based brokerage.

However, "I think they have the capacity to do this," he said.

"Downsizing and restructuring are inevitable as the market evolves," said the risk manager from the Northeast utility, who plans to keep his policies with Lloyd's.

"The Lloyd's of 25 years ago is not the same as the Lloyd's of today, and today's Lloyd's will not be the same as the Lloyd's of 25 years from now," he said.

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Associate Editors Michael Schachner in New York and Michael Bradford in Dallas contributed to this report.

Managed care

Continued from page 1

which let employees choose whether to use network providers or pay more to obtain non-network care, the survey found.

The survey, which was prepared for Ernst & Young by Louis Harris & Associates Inc., surveyed the chief or senior employee benefits officers among the nation's 2,500 largest employers.

The survey was conducted in January and February of this year. The researchers conducted 20-minute telephone interviews with 502 executives.

The overwhelming majority of those benefit decision-makers—86%—believe that despite their efforts, health care costs will increase "dramatically" over the next five years.

And while 42% of the respondents felt managed care would be sufficient to solve their health care cost problems during the next five years, 55% said managed care alone would not suffice and 3% ventured no opinion.

The survey found that 43% of the respondents had made great changes to their health care plans since 1989 in an attempt to contain costs, and 44% said they had changed their plans at least somewhat. But among the companies that had made changes, only 21% called the changes "very effective," while 66% judged them only "somewhat effective." Nine percent called the changes "not very effective" and 1% deemed them "not effective at all," while 4% were unsure or refused to answer.

"I think pessimism is a reality because you can only get health care costs down so much," said Mr. Duva.

Even the most aggressive managed care program cannot control factors like demographic changes, he said.

But employers are turning to managed care because "they've seen that everything else they've done doesn't work" after a year or two, said Mr. Duva. "If you do nothing, you pay the trends," he said, referring to 20% or 25% annual increases in health care costs.

Employers that take at least some managed care steps can cut that rate of increase to between 14% and 17% or so, Mr. Duva said. And companies with an aggressive managed care program can cut the rate to the single digits, he said.

The adoption of managed care techniques is an "evolving process," with smaller companies moving more slowly than the largest 100 or so companies, said Mr. Duva.

The survey reported a dramatic drop in the percentage of employers offering traditional fee-for-service plans with no managed care features. Only 22% of the respondents reported offering such a plan in 1992, compared with 39% three years earlier.

But every form of managed care plan listed in the questionnaire is increasing in popularity among employers.

The greatest growth occurred in point-of-service plans, which are becoming increasingly popular among the nation's largest companies, the survey found.

Point-of-service plans offer employees a network of providers similar to a health maintenance organization but allow participants to use non-network providers at a higher out-of-pocket cost. Twenty-two percent of the respondents offered such plans in 1992, compared with only 5% in 1989.

Mr. Duva, who implemented one of the first point-of-service plans while director of employee benefits at Morristown, N.J.-based Allied-Signal Inc., said such plans are attractive because they give corporations flexibility in encouraging employees to opt for managed care while leaving them with freedom of choice to select non-network providers if they desire.

Preferred provider organizations also are increasingly offered by the largest companies. Thirty-four percent of the respondents said that they currently offer a PPO, more than double the 16% that offered PPOs in 1989.

Although they had the most dramatic growth, point-of-service plans and PPOs were not the most popular managed care option among survey respondents.

The most popular was a fee-for-service plan that included some managed care features, such as tying utilization review or case management to a traditional indemnity arrangement.

More than two-thirds—69%—of the respondents said they offered managed fee-for-service plans this year, compared with 57% in 1989.

Health maintenance organizations also gained in popularity between 1989 and 1992. Staff model HMOs, in which physicians and other professionals are employees of the HMO, were offered by 56% of the respondents in 1992, compared with 50% in 1989.

Fifty percent of the respondents said they were offering individual practice association or network HMOs, which are organized around two or more independent group practices and perhaps a few solo practitioners. Forty-seven percent of employers offered such plans three years earlier.

Despite the continued popularity of HMOs, the survey found that nearly half of the 380 respondents who had offered an HMO of any sort during the past three years reported having reduced the number of HMOs offered. But, while 46% have reduced the number of HMOs offered, 53% said they had not reduced their HMO offerings, while 1% did not answer.

Despite the significant shift away from traditional fee-for-service arrangements during the past three years, respondents with those types of plans were the most likely to report that they had their health care cost inflation rates at least somewhat under control, the survey found. Sixty-six percent of respondents with a traditional plan said costs were somewhat under control, with another 4% saying that they were completely under control. Only 28% of the respondents with these plans said their costs were somewhat out of control, while only 3% said they were completely out of control.

However, those responses were not significantly different from those of all survey respondents. Overall, 62% of the survey respondents said that they had their company's health care cost inflation somewhat under control, while an additional 3% claimed to have health care inflation completely under control.

About a third of respondents—31%—judged health care inflation to be somewhat out of control, while only 3% said it is completely out of control.

Employers "think that temporarily they have met their objective. But they realize with the changes in demographics, technology and cost-shifting" they will have to make adjustments in the future, Mr. Duva explained.

Of those companies that had changed their health care plan offerings "a great deal" over the past three years to control costs, 72% said health care costs were at least somewhat under control, the survey found.

"Correspondingly, those companies that have made only marginal changes in their plans to contain health care cost inflation are more likely to feel that health care costs are out of control," notes the survey, which reports that 41% of the executives at companies that made only minor changes thought that costs were somewhat out of control.

"The lesson here is that those who are making larger changes to their plans have more of a sense of control over the inflation of their health care costs than do those who are making smaller changes," says the survey.

Other survey findings include:

- Sixty-seven percent of the respondents said their companies had adopted a corporate strategy plan to manage health care costs, and an additional 8% said such a plan was under development.

In fact, 80% of the respondents reported that their benefit plans are now subject to the same sort of budget review as all corporate capital and operating budgets.

The increased scrutiny, combined with the fact that 87% of the respondents said they felt at least "some pressure" from top management to cut health care costs, demonstrates that employers are no longer willing to be "passive" providers of health care benefits, Mr. Duva said.

- Twenty-eight percent of respondents believed that the changes they had made to their plans since 1989 have affected quality. Eighty-seven percent of those who thought their changes had an effect on quality believed quality had improved. Only 11% thought that the changes had decreased quality, and 3% were unsure.

"People recognize that you don't have to sacrifice quality to manage cost," Mr. Duva said.

In addition, the survey results demonstrate that respondents realize non-managed programs involve unnecessary treatments that raise costs without improving care, he contends.

There was, however, no consensus among respondents as to what type of managed care plan provided the best quality of service.

- Seventy-one percent of the respondents said their company provides retiree health care benefits.

Of those companies, 71% have introduced or plan to introduce a managed care program for current retirees. In addition, 46% of those companies have reduced or plan to reduce benefits for current retirees, while 69% have reduced or plan to reduce benefits for future retirees.

Mr. Duva said that PPOs are not the most aggressive form of managed care plan in holding down costs.

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For further information on "Is Managed Care Working?" contact Joseph W. Duva, Ernst & Young, 277 Park Ave., New York, N.Y. 10172; 212-773-1601.

Update

Health care reform proposals

WASHINGTON—Health care reform proposals are moving along separate tracks on Capitol Hill.

The House Ways and Means Health Subcommittee last week approved a health care reform bill, H.R. 5502, that would give the government power to cap hospital and physician charges. It also would expand the Medicare and Medicaid programs.

In addition, Reps. John Dingell, D-Mich., and Henry Waxman, D-Calif., introduced legislation, H.R. 5514, that would phase in a universal single-payer health care system funded by new payroll taxes on employers and a value-added tax on products.

Meanwhile, the Bush administration sent Congress legislation requiring non-binding arbitration of medical malpractice claims by anyone whose medical care is federally financed or regulated including members of ERISA-regulated plans (*BI,* Feb. 10).

LTV seeks to end labor pact

CLEVELAND—A Federal Bankruptcy Court judge next week will hear LTV Steel Co.'s request for authorization to reject its labor agreement with the United Steelworkers of America.

The Cleveland-based unit of LTV Corp. also wants to void certain pension agreements for hourly union workers. In addition, the company is asking the court to appoint a committee of non-union salaried retirees for the purpose of negotiating modifications in retiree health benefits. If the committee and LTV cannot reach an agreement, the company will ask permission to make changes unilaterally.

Mutual Benefit rehab plan stalls

NEWARK, N.J.—Mutual Benefit Life Insurance Co. rehabilitators last week missed a self-imposed deadline for filing a rescue plan after the New Jersey Legislature failed to pass a bill that would have made policyholders priority creditors.

The state Insurance Department and Mutual Benefit's deputy rehabilitator had vowed to present a plan to state court for approval on June 30. They backed off after lawmakers adjourned Tuesday without passing the Life and Health Insurers Rehabilitation and Liquidation Act, which the Senate passed early last month (*BI,* June 22).

A group of about 20 large life insurers is willing to help pool resources in an effort to bail out Mutual Benefit, but only if policyholders are given priority over general creditors.

If the Legislature does not pass the bill, rehabilitators and Mutual Benefit are prepared to file a stand-alone plan that will not include insurance industry support, said a Mutual Benefit spokeswoman.

Briefly noted

A California judge has approved a final rehabilitation plan for **Executive Life Insurance Co.** that would delay payment to holders of guaranteed investment contracts purchased to back municipal bonds until an appellate court rules on their right to payment. Bondholders will be credited based on the purchase price of the bonds rather than their face value. . . .Standard & Poor's Corp. downgraded the claims-paying ability rating of **CIGNA Corp.'s** intercompany pool to A from A+. S&P expects CIGNA's future earnings and capitalization will be hurt by further loss reserve strengthening and that its mortgage portfolio will deteriorate. . . .A new proposed Internal Revenue Service safe harbor that would enable employers to avoid running complex pension plan non-discrimination tests for so-called **primary insurance amount offset plans** will not be attractive for most employers with the plans, benefit experts say. . . .Pacific Mutual Life Insurance Co. will invest $50 million to recapitalize failed **First Capital Life Insurance Co.** and eventually merge it into its book of business. The recapitalization plan, approved last week by a state judge, calls for Pacific Mutual to finance a new life insurer that will assume First Capital's assets and liabilities. . . .Phoenix Mutual Life Insurance Co. and Home Life Insurance Co. officially completed their merger last week (*BI,* June 22). Standard & Poor's Corp. assigned the new company, **Phoenix Home Life Mutual Insurance Co.,** an AA– claims-paying ability rating. . . .The Massachusetts Workers' Compensation Rating and Inspection Bureau has filed for an **18.9% rate increase.** . . .New York lawmakers last week voted to approve a bill designed to **improve access to health care coverage** by requiring insurers to offer open enrollment and community rating to small employers (*BI,* June 15). The bill, which Gov. Mario Cuomo has pledged to sign, would become effective April 1. . . .The Texas Insurance Department has issued a cease and desist order against **First Assurance & Casualty Co. Ltd.,** a Turks & Caicos insurer that the department says has written trucking liability insurance without being licensed or admitted as a surplus lines insurer in the state. . . .The **Pension Benefit Guaranty Corp.** is taking over three underfunded pension plans sponsored by Munsingwear Inc., a financially troubled apparel manufacturer. The plans, covering about 4,000 participants, are underfunded by about $6 million. The PBGC expects to recover about $2 million as part of an earlier settlement with Munsingwear. . . .Jury trials will be held in two suits by the families of passengers killed when a Soviet fighter shot down **Korean Air Lines Flight 007** in 1983, a federal judge in Manhattan has ruled. Last year, a federal appellate court ruled that the families are not limited by the Warsaw Convention to $75,000 each in compensatory damages (*BI,* May 13, 1991). . . .**Owens-Corning Fiberglas Corp.** has settled approximately 9,000 asbestos bodily injury lawsuits for an undisclosed sum. Some of the lawsuits were part of a Baltimore case involving more than 8,000 asbestos bodily injury claims (*BI,* Aug. 5, 1991). . . .The 2nd U.S. Circuit Court of Appeals has ruled that a federal judge did not properly allocate the portions of a **$30 million asbestos bodily injury award** that Owens-Illinois Inc. and Keene Corp. must pay. The case has been remanded to trial court.

Discovery ruling

Continued from page 1

tal Chemical Corp. and its liability insurers over coverage for claims stemming from the leakage of toxic chemicals at a landfill in the Love Canal section of Niagara Falls, N.Y. Occidental used the site as a dumping ground from 1947 to 1952 (*BI*, Dec. 25, 1978).

The New York ruling marks the first time a state appellate court has found that policyholders have a right to claim attorney-client privilege for documents in coverage disputes, attorneys say. Trial courts throughout the country have split on this issue.

Occidental's insurers say they do not plan to appeal the decision.

Policyholder attorneys laud the ruling, adding that decisions that narrow the attorney-client privilege have a "chilling effect" on policyholder-attorney relationships.

Policyholders who are unsure what their attorney may be asked to turn over to insurers during discovery may withhold information from their attorneys, jeopardizing their chances of success in litigation, they say.

The decision is good for risk managers, who often must decide which documents will be handed over to a company's attorneys, because it recognizes their right to keep some of these documents private, said David Jacoby, an attorney with Phillips, Nizer, Benjamin, Krim & Ballon in New York, which represented Occidental.

"The decision in Occidental is very important in reaffirming the policyholder's constitutional rights to attorney-client privilege," added Irene C. Warshauer, a policyholder attorney at Anderson, Kill, Olick & Oshinsky in New York.

The federal government and New York state are seeking $250 million from Occidental for the cleanup of Love Canal. They are seeking an additional $300 million to $600 million from Occidental for the cleanup of six other hazardous waste sites in the Niagara Falls area.

In addition to the government claims for cleanup costs, some 1,400 plaintiffs injured by the Love Canal pollution have already been awarded $25 million in damages (*BI*, Oct. 17, 1983).

Occidental sued all of its liability insurers in 1978 seeking coverage of pollution-related claims. More than a decade later, it still is not clear how much of the company's costs will be covered by insurance (*BI*, Jan. 21, 1980).

Insurers claim that the pollution exclusion in the comprehensive general liability policy, which excludes coverage for all pollution that is not "sudden and accidental," bars coverage of Occidental's claims.

Hartford Accident & Indemnity Insurance Co, a unit of ITT/Hartford Group Inc., was Occidental's primary liability insurer from 1943 through 1973.

Other insurers that wrote primary liability coverage for Occidental include: Continental Insurance Co.; Highlands Insurance Co.; National Union Fire Insurance Co. of Pittsburgh, Pa., a unit of American International Group Inc.; and Insurance Co. of North America, a CIGNA Corp. unit.

There are also about three dozen excess insurers, including Lloyd's of London syndicates and other London market underwriters, several other AIG units and various other U.S. insurers (*BI*, Feb. 29, 1988).

When the Love Canal pollution was discovered in 1978, Occidental asked its primary insurers to help defend it against lawsuits over the dump, but the insurers refused.

Occidental hired private counsel in 1980, but soon after claims stemming from Love Canal began pouring in, the insurers agreed to provide a defense under a reservation of rights. At the same time, Occidental and its insurers agreed to put their coverage dispute on hold until the underlying litigation was resolved.

In 1987, the coverage dispute was reactivated and, as part of discovery, the insurers asked to see all privileged documents held by Occidental's attorneys.

The insurers argued they had a "commonality of interest" with Occidental against the underlying plaintiffs and that Occidental compromised its right to work-product protection by "injecting" the issues of the underlying suits into its coverage dispute.

The insurers also claimed that because they were expected to pay the litigation costs of the underlying cases, they had a right to see related documents.

"The insurers are fronting a lot of money, so they feel they have a right to know what's going on in the underlying cases," said Robert A. Baker, a partner at Smith, Murphy & Schoepperle in Buffalo, N.Y., who is one of several attorneys representing the insurers.

Occidental countered that there can be no "commonality of interest" when the parties are on opposing sides, particularly because its insurers had been "hostile" about coverage issues "since day one," said George Berger, a partner with Phillips, Nizer, Benjamin, Krim & Ballon in New York, who represented the chemical company.

Mr. Berger also pointed out that collaboration between the insurers and Occidental took place under a reservation of rights and was conditioned on an agreement that expressly preserved Occidental's right to protect some documents under the attorney-client privilege and work-product doctrine.

The trial court judge, though, found for the insurers on all grounds in May 1991. But the appellate court last month reversed and ruled in favor of Occidental.

"The parties expressly agreed that plaintiffs reserved their rights to assert the attorney-client privilege. . .to invoke the work-product immunity. . .and to invoke the immunity from production afforded to materials prepared for litigation," the appellate ruling stated.

"We conclude that defendants have made no showing that the unidentified material sought cannot be obtained through ordinary pretrial disclosure or is otherwise unobtainable," the appellate ruling said.

Policyholder attorneys were pleased with the ruling, but some believed that the court's decision to determine whether the policyholders' documents are protected on a case-by-case basis was not strong enough.

"The court's decision implied," but did not make clear, that "the policyholder's rights to confidentiality are preserved when the carrier defends under a reservation of rights," said Mr. Berger.

Policyholder attorneys would have preferred a more clear-cut ruling on that point.

If there is no guarantee of confidentiality, policyholders may withhold information from their attorneys for fear that they will be asked one day to turn it over, which may hamper their defense, they say.

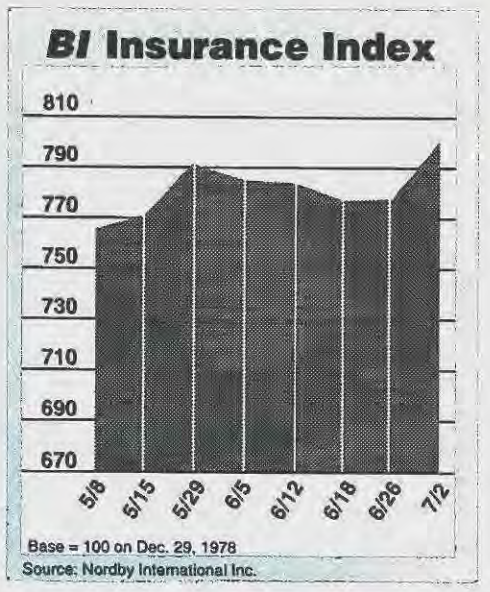
"There is a chilling effect on how you deal with your counsel when what you tell counsel may be handed over to your adversary," said Ms. Warshauer.

Also, if policyholders are not guaranteed a right to independent counsel, an attorney provided by the insurer could play the duplicate role of gathering data for the underlying disputes, but then use it later to represent the insurer against the policyholder, attorneys say.

"It's an irresponsible course of action for the insurance companies to take," said policyholder attorney William Greaney of Covington & Burling in Washington.

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Occidental Chemical Corp. et al. vs. Hartford Accident & Indemnity Co. et al, New York Supreme Court Appellate Division, No. 41009/80.



Insurance industry stocks revived last week, as the *Business Insurance* Index climbed 23.0 points to 800.1 on July 2 from 777.1 on June 26. Advancing issues for the week were led by Statesman Group Inc., up 18.1%; United Healthcare Corp., up 10.8%; and NAC Re Corp., up 10.0%. Declining issues followed American Indemnity/Financial, down 7.1%; Markel Corp., down 5.0%; and Lawrence Insurance Group, down 4.8%. The most active issue was U.S. Healthcare, with 3.7 million shares traded. The *BI* Index was up 3.0%; the NYSE Composite was up 2.1%; the Standard & Poor's 500 was up 2.1%; and the Dow Jones 30 Industrials rose 1.5%.

British Issues

July 1 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence	pence
Commrl Union	474	N/M	31.5	6.6	496	474
Genl Accident	454	N/M	35.7	7.9	492	454
Gdn Royal Exch	142	N/M	10.0	7.0	150	142
Royal	222	N/M	15.0	6.7	243	222
Sun Alliance	275	N/M	19.0	6.9	308	275
Brokers						
Bradstock	135	15.2	6.3	4.7	135	135
CE Heath	358	20.7	34.5	9.6	367	358
Hogg Group	160	9.7	10.9	6.8	160	160
JIB Group	163	12.0	10.0	6.1	170	163
Lloyd Thompson	209	20.9	6.0	2.9	209	200
Lowndes Lmbrt	273	10.6	16.8	6.1	273	269
PWS Holdings	43	4.7	5.3	12.3	44	43
Sedgwick Grp	178	13.9	16.0	9.0	189	178
Steel Brrl Jones	247	12.4	17.7	7.2	255	247
Willis Corroon	215	13.6	17.6	8.2	232	215

Source: Philip Olsen, Insurance Industry Analyst, London

BI Industry Stock Report

JUNE 29, 1992 THROUGH JULY 2, 1992

BROKERS		Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
Alexander & Alexander	NYS	21.75	1.75	6.10	23.38	18.00	361	1.00	4.60	136	13.10	1.66
Gallagher Arthur J. & Co.	NYS	22.63	4.02	1.12	25.25	19.00	40	0.64	2.83	18	5.88	3.85
Frank B. Hall	NYS	3.75	3.45	-11.76	5.50	3.13	142	0.00	0.00	-3	1.95	1.92
Hilb, Rogal & Hamilton	OTC	11.38	0.00	-14.15	11.50	11.38	0	0.00	0.00	-	3.56	3.20
Marsh & McLennan	NYS	77.50	-0.16	-4.76	83.75	70.00	263	2.68	3.46	18	28.00	2.77
Poe & Associates	OTC	13.88	-0.89	15.63	16.00	10.75	64	0.40	2.88	16	2.82	4.92
BROKERS	AVERAGE		1.4	-1.3						2.0	26	
CONGLOMERATES & HOLDING COMPANIES												
Berkley W.R. Corp.	OTC	33.50	0.00	9.84	36.25	23.50	693	0.36	1.07	12	36.95	0.91
Berkshire Hathaway Inc.	NYS	9350.00	4.18	3.31	9350.00	254.69	0	0.00	0.00	30	7270.00	1.29
ITT (Hartford Group)	NYS	64.88	1.17	12.34	70.63	50.00	1219	1.84	2.84	11	112.05	0.58
Sears (Allstate)	NYS	39.50	-0.63	4.29	48.00	32.50	2531	2.00	5.06	11	34.50	1.14
CONGLOMERATES	AVERAGE		1.2	7.4					2.2	16		
INSURERS/REINSURERS												
AEGON N.V.	NYS	36.00	3.60	2.86	36.00	27.38	6	1.14	3.17	7	N/A	N/A
Aetna Life & Casualty	NYS	43.25	3.59	-1.70	47.00	31.88	951	2.76	6.38	8	87.60	0.49
Allied Group Inc.	OTC	23.50	6.21	38.24	23.50	16.00	41	0.64	2.72	8	19.85	1.18
American General	NYS	48.13	-0.26	8.15	48.88	38.00	582	2.08	4.32	11	60.00	0.80
American Heritage Life Ins.	NYS	31.63	-0.39	3.27	32.25	20.06	5	0.84	2.66	16	N/A	N/A
American Indemnity/Fin'l	OTC	6.50	-7.14	36.84	9.25	4.50	44	0.08	1.23	5	12.93	0.50
American International	NYS	88.38	0.57	-10.17	99.38	78.63	1560	0.56	0.63	12	99.30	0.89
Aon Corp.	NYS	47.00	6.52	18.61	47.00	34.75	597	1.68	3.57	12	39.70	1.18
Argonaut Group	OTC	26.75	1.90	12.63	30.25	21.75	52	0.84	3.14	8	20.96	1.28
AVEMCO Corp.	NYS	26.88	4.37	7.50	28.00	19.63	11	0.40	1.49	24	9.55	2.81
Baldwin & Lyons Inc.	OTC	30.00	1.69	16.50	31.75	22.75	8	0.28	0.93	8	24.29	1.24
Belvedere Corp.	ASE	6.13	0.00	88.46	6.25	2.88	0	0.04	0.65	17	7.65	0.80
Chandler Insurance	OTC	5.75	4.55	76.92	6.00	2.13	39	0.00	0.00	52	5.95	0.97
Chubb Corp.	NYS	73.63	4.62	-4.38	78.00	60.75	956	1.60	2.17	11	72.95	1.01
CIGNA Corp.	NYS	55.75	0.90	-8.79	61.75	41.25	823	3.04	5.45	11	117.15	0.48
CNA Financial Corp.	NYS	86.38	3.13	-11.86	104.50	76.25	54	0.00	0.00	9	70.23	1.23
Continental Corp.	NYS	29.38	5.86	6.33	30.38	23.25	282	2.60	8.85	25	40.00	0.73
EXEL Ltd.	NYS	35.25	0.71	-6.00	40.25	27.38	152	0.92	2.61	8	N/A	N/A
Fund American Corp.	NYS	69.25	0.00	-0.89	70.50	62.00	28	0.68	0.98	30	36.11	1.92
Fremont General Corp.	OTC	21.25	2.41	-12.82	26.00	17.00	67	1.00	4.71	5	45.55	0.47
Frontier Insurance Group	NYS	33.25	0.76	23.15	37.63	19.91	36	0.56	1.68	13	26.65	1.25
Gainsco Inc.	ASE	15.63	-0.79	11.61	16.56	9.75	15	0.04	0.26	18	3.37	4.64
General RE Corp.	NYS	85.88	1.78	-15.71	104.75	77.50	688	1.80	2.10	12	78.65	1.09
Guaranty National Corp.	NYS	15.50	5.08	6.90	17.00	12.63	156	0.48	3.10	11	N/A	N/A
Hanover Insurance Co.	OTC	36.13	3.21	1.05	42.75	27.13	6	0.44	1.22	9	37.44	0.96
Harleysville Group	OTC	19.00	-2.56	-10.59	23.25	16.75	98	0.64	3.37	8	22.99	0.83
Hartford Steam Boiler	NYS	56.00	3.70	-2.61	58.88	45.13	44	2.00	3.57	17	35.50	1.58
Kemper Corp.	NYS	26.00	8.33	-31.80	46.13	23.25	405	0.92	3.54	7	50.00	0.52
Lawrence Insurance Group	ASE	7.50	-4.76	-32.58	11.13	7.25	1	0.48	6.40	17	4.71	1.59
Liberty Corp.	NYS	30.00	1.69	35.59	31.38	19.50	199	0.48	1.60	14	29.35	1.02
Lincoln National	NYS	61.50	0.61	12.33	62.25	45.38	174	2.92	4.75	10	81.00	0.76
Markel Corp.	OTC	23.75	-5.00	7.95	28.25	17.50	60	0.00	0.00	7	15.59	1.52
Mutual Risk Mgmt. Ltd.	NYS	30.00	6.19	-14.59	37.75	20.25	43	0.12	0.40	20	-	-
NAC Re Corp.	OTC	29.00	9.95	-7.94	33.00	21.75	275	0.16	0.55	13	18.90	1.53
National Re Holdings Corp.	NYS	18.38	-3.92	N/A	23.63	17.00	185	0.12	0.65	9	N/A	N/A
Navigators Group	OTC	33.00	-3.65	-19.51	48.25	29.50	8	0.00	0.00	19	13.52	2.44
Nobel Insurance LTD.	OTC	5.00	-1.24	25.00	6.00	3.38	23	0.00	0.00	3	7.76	0.64
NWNL Companies	NYS	37.50	7.14	20.48	38.50	18.63	125	1.48	3.95	11	62.65	0.60
Ohio Casualty Corp.	OTC	54.50	0.46	10.10	58.25	43.50	102	2.68	4.92	9	18.00	3.03
Old Republic Int'l	NYS	21.88	-0.57	23.24	22.38	13.88	295	0.40	1.83	8	33.09	0.66
Orion Capital Corp.	NYS	35.13	1.81	11.07	35.50	27.25	43	0.92	2.62	6	43.50	0.81
Phoenix RE Corp.	OTC	11.00	4.76	4.76	11.75	8.50	272	0.20	1.82	27	13.30	0.83
Provident Life	OTC	22.25	5.95	-4.30	24.25	16.75	233	1.00	4.49	9	39.50	0.56
Re Capital Corp.	ASE	12.63	-2.88	-12.17	17.50	12.63	5	0.24	1.90	13	15.05	0.84
Reliance Group Holdings	NYS	5.13	2.50	24.24	5.88	3.50	126	0.32	6.24	3	6.40	0.80
RLI Insurance Corp.	NYS	19.75	-3.66	19.70	21.25	11.88	43	0.48	2.43	9	14.41	1.37
St. Paul Companies	NYS	70.00	0.00	-3.95	75.75	57.13	306	2.72	3.89	7	86.60	0.81
SAFECO Corp.	OTC	50.13	-1.23	2.82	51.63	35.50	864	1.64	3.27	11	51.65	0.97
SCOR U.S. Corp.	NYS	17.00	0.74	10.57	18.88	12.50	8	0.28	1.65	9	11.19	1.52
Seibels Bruce Group	OTC	5.75	0.00	4.55	8.75	4.00	21	0.36	6.26	-3	10.60	0.54
Selective Ins. Group	OTC	20.75	-2.35	23.88	21.50	14.00	59	1.12	5.40	8	30.75	0.67
Statesman Group Inc.	OTC	6.13	18.06	6.52	6.88	4.13	625	0.00	0.00	3	2.48	2.47
Tokio Marine & Fire	OTC	40.25	5.23	-21.84	55.25	32.25	1	0.00	0.00	-	70.93	0.57
Torchmark Corp.	NYS	66.00	0.19	14.04	67.13	46.50	415	1.60	2.42	14	40.95	1.61
Transamerica	NYS	44.38	2.01	11.29	46.75	31.25	810	2.00	4.51	30	55.00	0.81
Transatlantic Holdings	NYS	32.75	2.34	-15.76	39.63	29.00	142	0.24	0.73	10	18.38	1.78
Travelers Corp.	NYS	20.63	1.85	-4.62	23.75	17.25	692	1.60	7.76	8	59.00	0.35
Trenwick Group Inc.	OTC	28.00	-0.44	-1.75	30.75	23.00	43	0.72	2.57	10	21.71	1.29
United Fire & Casualty	OTC	39.00	2.63	30.00	41.34	28.00	8	1.00	2.56	11	35.39	1.10
USF&G Corp.	NYS	13.50	-1.82	86.21	14.25	5.63	1904	0.20	1.48	-9	12.30	1.10
UNUM Corp.	NYS	41.63	4.06	2.78	41.75	28.81	1080	0.64	1.54	13	37.70	1.10
USLIFE Corp.	NYS	50.13	-0.74	4.70	51.50	38.50	259	1.68	3.35	10	84.55	0.59
Unitrin	OTC	33.50	0.37	-6.29	38.50	31.00	487	1.00	2.99	13	37.23	0.90
USLICO Corp.	NYS	17.50	0.72	-5.41	21.00	17.00	46	1.00	5.71	-14	33.15	0.53
Washington National	NYS	20.13	1.90	26.77	20.63	13.50	57	1.08	5.37	-35	33.50	0.60
Zenith National Ins.	NYS	18.50	2.78	9.63	18.50	13.75	289	1.00	5.41	9	13.14	1.41
INSURERS/REINSURERS	AVERAGE		1.7	7.9					3.3	12.2		
HEALTH MAINTENANCE ORGANIZATIONS												
FHP International	OTC	17.25	2.22	21.05	27.00	9.88	693	0.00	0.00	16	15.50	1.11
HMO America Inc.	OTC	11.38	7.06	-32.09	24.88	9.63	97	0.00	0.00	12	0.61	18.65
Pacificare Health Sys.	OTC	57.50	0.00	45.57	62.50	21.50	168	0.00	0.00	21	28.25	2.04
Safeguard Health Enter.	OTC	10.00	1.27	6.67	14.75	5.38	42	0.00	0.00	15	3.53	2.83
Sierra Health Services	ASE	18.38	-2.65	-0.68	27.50	12.38	41	0.00	0.00	10	1.78	10.32
United Healthcare Corp.	NYS	86.25	10.75	15.77	93.00	40.25	547	0.03	0.03	33	43.60	1.98
United Medical Corp.	ASE	7.25	0.00	3.57	9.75	5.88	6	0.20	2.76	28	8.79	0.82
U.S. Healthcare	OTC	51.25	9.92	23.49	57.75	21.25	3700	0.56	1.09	23	20.55	2.49
HMOs	AVERAGE		3.6	10.4					0.5	20		
ALL COMPANIES	AVERAGE		2.0	6.1					2.7	14		

System design: Nordby International Inc.

Webster wasn't kidding

Daniel Webster said, "The past at least is secure." But we know the future is another matter.

At Duncanson & Holt, we create innovative reinsurance products to meet the demands of an ever-changing world. Over the last 25 years, we've built a reputation for financial security, integrity and sound management. Our strength has made us the largest accident and health reinsurer in North America, with over $350 million in earned premium and a per occurrence capacity of $70 million. And that's security you can build your future on.

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