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update

NAIC, business groups agree to risk retention changes

WASHINGTON—The National Assn. of Insurance Commissioners is expected to drop its opposition to legislation expanding the federal Risk Retention Act following a compromise with business groups on new amendments, *Business Insurance* has learned.

The agreed to amendments would require the risk retention groups to:

- Supply an operating plan to

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Crisis regulation

Bill freezes seven insurers' underwriting in Florida

By MICHAEL BRADFORD

TALLAHASSEE, Fla.—At least seven insurers are not writing new commercial property or liability insurance policies in Florida following passage of legislation that would freeze rates, force liability insurance premium refunds this year and authorize that 1987 rates be rolled back to 1984 levels.

The landmark bill, which passed in the early hours of June 7, not only attempts to stem rising insurance prices but also includes tort reform measures and gives the Florida Department of Insurance more authority to control rates.

Last week, observers were confident the bill would be signed by Gov. Bob Graham, a Democrat currently running for the Senate.

Insurers are blasting the legislation, which they say will cost them money at a time when profits are just beginning to reappear on financial statements. Risk managers also criticize the bill, fearing it will cause capacity to dry up even more.



Meanwhile, regulators in others states criticize the premium refund, saying the move could spread to their states. Florida, the sixth-largest state in direct premiums written, is considered a bellweather state for insurance regulation.

In response to the bill, at least seven insurers have stopped writing new commercial policies in Florida, though none have stopped renewing policies.

Several others have spoken out against the legislation and are considering whether to stop writing business.

W. Minor Carter, vp of government affairs for United States Fidelity & Guaranty Co., called the bill "very irresponsible, shocking and saddening. This bill creates a terrible business climate in Florida," where USF&G is the ninth-largest property/casualty insurer. Last year, it wrote $156.7 million in premiums in all lines.

Insurance Commissioner Bill Gunter, however, stands by the new legislation. "In totality, it will be a good bill," he said. "And the insurance industry will find it a good bill in the long-haul," he predicted.

The new rate regulation does not apply to workers compensation, personal lines, surplus lines or reinsurance.

The tort reform portions of the legislation call for a $450,000 cap on awards for non-economic damages like pain and suffering and makes changes in Florida's joint and several liability requirements. Both changes carry "sunset" dates, automatically expiring in 1990.

If a damage award is greater than $25,000, joint and several liability would apply only to economic damages and only to those damages in cases where the fault of the defendant is found to be equal to or greater than the fault of the plaintiff.

Joint and several liability would remain in effect for both economic and non-economic damage awards less than $25,000, as in current Florida law.

Damage awards in Florida also would be reduced by recoveries from other sources unless the defendant has subrogation rights.

Other tort reform measures include imposing structured settlements if one party requests, discouraging frivolous lawsuits by requiring the attorneys' fees of the prevailing party to be paid by the losing party and attorney, and a feature that allows punitive damages in some cases to be limited to three times the amount of compensatory damages.

In addition, 60% of punitive damages are to be paid to the

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Commissioners dispute claim that crisis is 'exaggerated'

By CAROL CAIN

BOSTON—State regulators are vigorously disputing a conclusion by three major insurance trade associations that the liability insurance crisis is not as great as perceived by the public.



Mr. Gates

"The crisis is not as widespread in 1985 and early 1986. Availability problems do exist, but vary by line or class of coverage and geographic region," according to the National Assn. of Independent Insurers, the Alliance of American Insurers and the American Insurance Assn.

"My conclusion, at least for the forepart of 1986, is that the crisis is somewhat exaggerated," Thomas S. Chittenden, the AIA's senior vp and general counsel, said at a press briefing in Boston last week held in conjunction with the annual summer meeting of the National Assn. of Insurance Commissioners.

Mr. Chittenden drew that conclusion based on a report prepared by an NAIC advisory committee, of which the three trade associations are members.

However, insurance regulators were quick to criticize such thinking.

"I have difficulty with your foundation for your inferences (from the report). I don't think the report's data has been rigorously evaluated," Nevada Insurance Commissioner David A. Gates said during a session at the NAIC meeting.

The advisory committee was formed in December to look at the availability of certain lines of liability coverage. The committee's report centers on a six-month survey of the use of market assistance plans throughout the United States.

The information compiled in the report "says to us that state regulation works. There's no need for more regulation; no need to go to Washington to solve this," said

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Florio asks state regulators to detail their crisis solutions

By JERRY GEISEL

WASHINGTON—A House subcommittee chairman is asking state insurance commissioners to detail the steps they are taking to ease the liability insurance crisis.

In a letter sent last week to the National Assn. of Insurance Commissioners, Rep. James Florio, D-N.J., asked the NAIC to tell the House Commerce, Transportation and Tourism Subcommittee by Jan. 15 what state regulators are doing about huge rate hikes, coverage unavailability and policy cancellations.

"The states must demonstrate, chapter and verse, to Congress and the public that effective action has been taken," Rep. Florio said.

"The public will not tolerate prolonged chaos in the insurance system of this country," he added. "The Congress will meet its responsibility. The states must meet their responsibility."

Meanwhile, in a flurry of related developments in Washington last week:

- Rep. Florio introduced a series of tort reform bills that would require federal judges to impose financial penalties for frivolous suits or defense tactics.

In addition, the legislation would limit the maximum contingency fee that a plaintiffs' attorney could collect in a suit filed in federal court to one-third of the accident victim's recovery.



Rep. Florio

Other provisions would require judges to explain why they imposed a punitive damage award and would remove various legal obstacles that block arbitration of disputes.

- House Judiciary Committee Chairman Peter Rodino, D-N.J., released a study that shows insurers have collected far more in premiums than they have paid out in claims and expenses. However, industry officials

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NAIC, buyers agree to changes

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every commissioner in states where it intends to do business before beginning operation. This operating plan would include a rating schedule, coverages offered and limits.

• Submit to regulators in every state it operates a copy of its annual financial statement that it files in its domicile. The statement would have to be certified by an independent CPA with an opinion on its reserves by a qualified actuary.

• Exclude coverage for punitive damages or intentional, fraudulent or criminal conduct to the extent any such coverage is prohibited by state law.

• Use a surplus lines broker if a non-admitted insurer supplies coverage to a purchasing group.

In addition, a risk retention group that engaged in repeated, knowing and willful fraudulent conduct in one state could be enjoined from operating in other states.

The legislation, which would facilitate formation of risk retention groups to fund all commercial casualty risks except workers compensation, could be be considered by the full Senate this month.

Panel OKs tort reform

WASHINGTON—The Senate Commerce Committee has voted to eliminate joint and several liability for non-economic damages in product liability suits.

The 10-6 approval of the proposal by Sen. Larry Pressler, R-S.D., came last Thursday as the Commerce Committee finally began voting on federal product liability legislation after months of delays.

In addition, the committee on a 16-1 vote approved a series of relatively non-controversial "core" amendments. Those amendments, hammered out by the staffs of Committee Chairman John Danforth, R-Mo., and Sens. Robert Kasten, R-Wis, and Slade Gorton, R-Wash., establish that:

• Punitive damage awards only could be awarded if a plaintiff proved by "clear and convincing" evidence a defendant's "conscious flagrant indifference" to the safety of those who might be harmed by a product.

• Plaintiffs would have to file suits within two years of the time they were injured.

• Wholesalers and retailers only could be found liable for injuries caused by their own negligence.

• Attorneys who file frivolous lawsuits or delayed cases could be liable for other parties' legal fees and for court costs.

• In certain situations, a party that rejected a settlement offer—made after a suit was filed—would be liable for the other side's legal fees and costs.

Sen. Kasten said California voters' approval this month of Proposition 51 was a decisive factor in the committee's approval of the joint and several liability provision. Proposition 51 applies to all personal injury cases, not just product liability (*BI*, June 9).

EXEL raises $395 million

HAMILTON, Bermuda—EXEL Ltd., the parent company of Barbados-based X.L. Insurance Co. Ltd., has raised $395 million from 66 U.S. corporate sponsors and has stopped accepting new sponsors.

X.L., developed by Marsh & McLennan Cos. Inc. and Morgan Guaranty Trust Co., eventually expects to provide a general liability limit of $75 million excess of at least $25 million, though the limit actually available will not exceed 10% of the insurer's capital, retained earnings and unearned premium reserves (*BI*, June 2).

EXEL's consolidated assets now total $412 million, allowing X.L. to write a general liability limit of about $41 million excess of at least $25 million.

X.L. also offers directors and officers liability coverage of $15 million excess of at least $20 million.

X.L. started issuing policies to sponsors—who contributed $5 million or $10 million in capital—on May 1, and is now writing coverage for non-sponsor corporations, which must buy EXEL shares when they purchase coverage.

M&M will receive royalties of 1.5% of X.L.'s gross premiums for five years, plus commissions on business placed with X.L.

Greyhound sues D&O insurers

PHOENIX, Ariz.—Greyhound Corp. and a subsidiary are suing four excess directors and officers liability insurers that allegedly have not paid a $20 million claim.

The companies Greyhound is suing are: Insurance Co. of North America, a CIGNA Corp. unit; Fireman's Fund Insurance Co. in Novato, Calif.; Federal Insurance Co., part of Chubb Corp.; and the Home Indemnity Co., part of The Home Insurance Group in New York, according to a Greyhound spokeswoman.

Underwriters at Lloyd's of London have paid the limits of a $1 million primary policy, the spokeswoman says.

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Bunner resigns in California; new commissioner is named

By CAROL CAIN

SACRAMENTO, Calif.—Roxani M. Gillespie is awaiting Senate confirmation as the new California insurance commissioner, following the resignation of Bruce Bunner.

She was appointed June 6 by Gov. George Deukmejian to replace Mr. Bunner, who is resigning effective July 1 to rejoin an accounting firm.

Mr. Bunner denied a June 10 report in The Los Angeles Times that the governor was displeased with him for supporting tougher regulation of insurers following the passage of Proposition 51, a tort reform measure (*BI*, June 9).

That legislation will be introduced with the administration's support, according to Ms. Gillespie.

Mr. Bunner accused the newspaper of "trying to drive a wedge" between the governor and the Insurance Department as part of this year's gubernatorial race in which Los Angeles Mayor Tom Bradley, a Democrat, is challenging the incumbent Republican.

When he accepted the appointment in March 1983, Mr. Bunner said, he intended to stay for four years but didn't know if he would be able to do so. He told the governor several months ago that he would like to leave the post, but remained longer to hammer out a plan to rescue the insolvent Mission Insurance Co. and its subsidiaries. That rescue plan should be finalized next month, Mr. Bunner said.

The newspaper also reported the announcement came only one day after Mr. Bunner advocated at a news conference that the Legislature act quickly to give the commissioner new powers to compel the insurers to sell liability insurance in the wake of the passage of Proposition 51.

But, at a June 10 press conference, Gov. Deukmejian said Mr. Bunner was in close contact with his office and knew the announcement would be made June 6.

Ms. Gillespie, 45, has a law degree from Boston College. She was with Industrial Indemnity Co. from 1972 to 1983, leaving as a vp to join the Insurance Department as chief deputy commissioner. If confirmed, she will serve through Jan. 5, 1987.

Mr. Bunner is returning to Peat, Marwick, Mitchell & Co. as partner in its insurance practice in New York. He had been a partner in Los Angeles before becoming commissioner. He had joined the firm in 1959.

The new insurance and tort reform legislation to be introduced in the Legislature soon will commit the department to creating a voluntary market assistance plan, Ms. Gillespie said. The legislation also would give the department authority to set up a joint underwriting association, which is generally opposed by insurers.

The tort reform bill would amend the collateral source rule, which precludes introducing evidence that a plaintiff has received other compensation for the damages alleged and any offset for that amount. The bill also would cap attorneys' contingent fees. ■

ODECO denies charges of fraud in Mentor case

By KATHRYN J. McINTYRE

NEW ORLEANS—Ocean Drilling & Exploration Co. denies committing any fraud related to the financial statements issued by its now-insolvent captive insurer, Mentor Insurance Ltd.

Answering a suit filed in March by Mentor's liquidators, ODECO also denies allegations that it controlled the affairs of the Bermuda-based insurance company that was placed into court-ordered liquidation last summer by the Bermuda government.

The oil and gas exploration and production company asks the U.S. District Court for the Eastern District of Louisiana to dismiss the complaint, which seeks $300 million to $500 million to cover the estimated insolvency of Mentor (*BI*, March 24).

The ODECO insurance subsidiary underwrote surplus lines insurance and reinsurance from Bermuda since the early 1970s.

The liquidators' complaint alleges common fraud and fraud under the Racketeer Influenced and Corrupt Organizations Act in the issuance of misleading financial statements for Mentor for the years 1982 and 1983.

The financial statements failed to properly disclose the true nature of reinsurance contracts Mentor entered into, the suit alleges. Mentor took credit for the contracts as valid reinsurance, but the contracts did not provide any payment by the reinsurer for 10 years, the complaint says.

The complaint charges that ODECO defrauded Mentor and its policyholders, as well as potential policyholders, by issuing the allegedly false and misleading financial statements that induced others to do business with Mentor.

The complaint also seeks to pierce the corporate veil by alleging that ODECO controlled the management of Mentor.

While ODECO admits in its answer, dated June 9, that Mentor entered

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BI RMIS vendor list upcoming

Business Insurance will publish its first directory of risk management information system vendors in its July 21 issue, which will include a special report on trends in this growing field.

Listings in the directory are provided free of charge, but companies must complete and return a *Business Insurance* questionnaire to be included.

If your company provides software for use by corporate risk management personnel and you have not yet received a questionnaire, please request one by writing Marilou Jones, Directory Editor, *Business Insurance*, 740 N. Rush St., Chicago, Ill., 60611, or call 312-649-5279.

The deadline for returning the completed questionnaires to *Business Insurance* is June 30.

Chevron, insurer must argue leak coverage in court: Judge

By STEPHEN TARNOFF

DENVER—An oil company and its insurer must go to trial to determine if they intended the pollution exclusion clause to bar coverage for gasoline leakage into sewer lines, a federal judge has ruled.

The decision by U.S. District Judge Jim R. Carrigan, in a case involving Chevron U.S.A. and Transport Indemnity Co., is the latest in a series of rulings around the country that found language in the pollution exclusion clause to be ambiguous.

But, unlike some other courts, the judge held off construing the policy in favor of the policyholder.

Because there were facts in dispute on whether the parties intended that coverage existed, Judge Carrigan refused in the April 30 decision to grant summary judgment in favor of Chevron.

The case is one of many in which policyholders are seeking to convince courts to find coverage for gradual pollution claims, even when the policy said it excluded coverage for all but sudden and accidental pollution.

The Chevron case—which marks the first time the issue has been addressed in Colorado—involved leakage of gasoline into sewer lines near a Chevron service station in Northglenn, Colo., in November 1980 that caused personal injuries and the evacuation of 42 families.

The city of Northglenn and some of its residents sue Chevron, and a jury subsequently found Chevron liabl in the first stage of a trial. Chevron later settled 17 personal injury claims and purchased 42 homes in th area, according to the court.

An attorney for Transport Indemnity, which is lo cated in Los Angeles, says court records show tha Chevron settled the underlying litigation with individ uals and homeowners for more than $10 million, but a attorney for the oil company declined to comment.

The Chevron station was leased to Jerald L. Glenn who, under the lease agreement, had been required t obtain comprehensive general liability insurance an excess coverage for certain perils.

The primary coverage was provided by a "Garag Liability" policy" issued by Security Insurance Grou of Hartford, Conn., in three separate policies betwee October 1978 and October 1981. An attorney for Secu rity would not discuss the case, but the Transport attor ney said the Security policy had annual limits o $350,000.

Transport, which is now operating as Mission Ameri can Insurance Co., provided excess insurance fror Sept. 1, 1979, through Feb. 28, 1981, in two separat

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Corporate clout

Risk managers' job gaining importance: Survey

By JOANNE WOJCIK O'HARE

Corporate risk managers' responsibilities are increasing as management becomes more aware of the importance of loss control, a new survey shows.

And some of this increased awareness can be attributed to experiences like the toxic gas leak at the Union Carbide Corp. plant in Bhopal, India, says one of the survey's authors.

Risk managers' "level of responsibility is being monitored by a higher level in the corporate hierarchy," said Richard Meyers, a partner in Logic Associates Inc., the New York-based recruiting firm that conducted the survey.

More and more companies are "making sure that the function doesn't have a second-class reporting structure," Mr. Meyers added.

Although risk managers' specific duties haven't really changed in the last year, the percentage having direct responsibility for most traditional risk management functions has increased.

The survey results could be skewed, however, since a greater number of risk managers responded this year than last, noted Bill Perry, the other partner at Logic Associates, which specializes in the risk and safety management professions.

In all, 1,022 risk managers responded to Logic's 1985 Risk Management Compensation Survey for a 33% rate of return. In 1984, 917 risk managers responded for a 31% rate of return.

The risk managers responding were divided into seven categories based on company sales.

The survey "just gives people a barometer" of risk managers' compensation and responsibilities, explained Mr. Meyers.

Security was one area for which more risk managers reported having direct responsibility in 1985 (see chart).

"With the influx of computerization, data security is becoming more important," noted Mr. Perry.

Risk managers' areas of responsibility
(By company sales in millions of dollars)

	0-$200	$200-$500	$500-$1,000	$1,000-$2,000	$2,000-$4,000	$4,000-$7,000	More than $7,000
Risk financing	74% / 14%	75% / 11%	80% / 12%	74% / 16%	80% / 14%	93% / 5%	80% / 15%
Negotiation of coverage placement	83% / 13%	93% / 4%	87% / 10%	88% / 8%	89% / 7%	91% / 7%	85% / 13%
Claims handling	61% / 21%	51% / 44%	57% / 40%	51% / 44%	46% / 50%	58% / 41%	63% / 63%
Safety/fire loss engineering	33% / 55%	28% / 58%	29% / 57%	27% / 58%	21% / 69%	42% / 51%	15% / 73%
Security	11% / 51%	14% / 49%	8% / 50%	11% / 47%	9% / 57%	15% / 37%	8% / 68%
Benefits administration	17% / 49%	18% / 35%	12% / 28%	12% / 23%	4% / 28%	18% / 20%	10% / 10%
Pension/profit sharing administration	28% / 29%	15% / 21%	11% / 12%	7% / 13%	2% / 12%	12% / 6%	8% / 8%

Direct, hands-on responsibility / Supervisory/advisory responsibility

Source: Logic Associates
Chart: Amy Palmer

The largest increase in security duties was reported by risk managers at companies with annual sales of $2 billion to $4 billion, with 8.9% having direct involvement in 1985, a 147% increase from just 3.6% in 1984.

However, 57% of the risk managers at these companies either advised or supervised another individual, a slight decrease from 58.3% a year ago.

More risk managers at companies in the $4 billion to $7 billion range also reported having direct responsibility for security, although the total percentage of risk managers in some way involved in the function declined to 52.8% in 1985 from 59.1% in 1984.

Fifteen percent of the risk managers at these firms were directly involved in security in 1985, compared with only 6.6% in 1984. A total of 37.3% played either supervisory or advisory roles in 1985, while 52.5% supervised or advised others handling company security in 1984.

At companies with sales of $201 million to $500 million,

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Guaranty funds riddled with flaws: Experts

By KATHRYN J. McINTYRE

BOSTON—The state system of property/casualty insurance guaranty funds is fraught with inconsistencies and problems that hurt policyholders and insurance companies, experts say.

Among the problems cited are:

- Variations in caps on claims payments by the different state insurance guaranty associations, ranging from a low of $50,000 per claim in some states to no cap at all in another state.
- Lack of cooperation among the state guaranty associations in determining which state fund should cover a claim, with the state of New York taking a very different position than the other 49 states.
- Lack of cooperation between insurance company liquidators and state insurance guaranty associations.
- An increasing burden on solvent insurers that are charged assessments to provide the money needed by the guaranty funds.

All these problems are exacerbated by the recent insolvencies of large, commercial insurance companies.

But, there is little agreement among the experts on which are the most pressing problems in the system and even less agreement on how to solve them.

That is the picture that emerged from several discussions of insurance guaranty associations and the state guaranty fund system during a National Institute on Insurer Insolvency sponsored by the American Bar Assn. in Boston June 7-8.

"The dollar volume of one insured's claims today may be greater than an entire previous insolvency, with a

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Oil giants reap pension surplus

By STEVE TARAVELLA

WASHINGTON—Two giant oil companies—Exxon Corp. and Phillips Petroleum Co.—intend to recapture more than $1.4 billion in excess pension assets.

New York-based Exxon announced early this month it plans to recoup more than $1 billion in excess assets—a record amount—from three overfunded defined benefit plans, though it has not said exactly how much it hopes to recover.

A $1 billion reversion would top the record thought to be held held by Chicago-based United Airlines, which recovered $962 million in excess assets when it terminated four of its plans last July (*BI*, June 17, 1985).

According to an Exxon spokeswoman, the three plans had "in excess of $5 billion" in assets as of year-end 1985, while benefit obligations totaled about $3.5 billion, giving the plans a surplus of $1.7 billion.

The excess assets, which accumulated due to "strong financial performance" of the plans' investments, would be earmarked for "general corporate use," says the spokeswoman, who could not elaborate.

Observers note that the reversion would come during a year in which Exxon probably will have no federal income tax liability because of slumping oil prices and a $2.1 billion fine it has paid the Energy Department for overpricing oil.

About 70,000 people, including some union members,

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PBGC still needs reform: Utgoff

By JERRY GEISEL

WASHINGTON—The Pension Benefit Guaranty Corp. remains on the road to insolvency, its executive director says.

Even though Congress in March increased the annual premium that employers with pension plans must pay to the PBGC to $8.50 from $2.60, the agency's liabilities will exceed its assets by $1.85 billion in 1990, says a soon-to-be released PBGC report. The current deficit is $1.5 billion.



Ms. Utgoff

"An $8.50 premium is not enough to handle already promised benefits, let alone anticipated future claims," says PBGC Executive Director Kathleen P. Utgoff. "We still are going to have a large and growing deficit.)"

Assuming that the PBGC's claims experience does not deteriorate and that it is not hit with any jumbo-sized claims—and Ms. Utgoff says that's not a safe assumption—a premium of at least $13.50 per employee is needed to fully fund the agency's deficit, she says.

While a continuing series of premium increase is one way to meet the PBGC's growing deficit, Ms. Utgoff has other ideas.

She says Congress should consider passing legislation to improve pension plan funding, which, in turn, would reduce the number of plans falling into the hands of the PBGC.

Also, she suggests that Congress consider allowing the PBGC to charge individual employers a variable premium based on how well their pension plans are funded. And, she says legislators should examine whether commercial underwriters also should be allowed to sell termination insurance.

The longer Congress delays addressing the PBGC's long-range problems, the closer the agency comes to negative cash flow—when the amount of benefits the PBGC is obligated to pay plan participants exceeds the amount of premium and investment income the agency receives. The PBGC could be forced into such a situation by the turn of the century, Ms. Utgoff says.

Once the PBGC has negative cash-flow, it would be forced to sell assets, principally the assets of the pension plans it has taken over. Eventually, according to this scenario, the problem would continue to balloon and the PBGC would eventually collapse.

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Reinsurers predict good times here to stay

By JUDY GREENWALD

U.S. reinsurers, cheered by vastly improved first-quarter underwriting results and a 58.5% jump in net premiums written, say good times are probably here to stay, at least through 1987—if not beyond.

The 70 U.S. reinsurers surveyed by the Reinsurance Assn. of America posted a 107.7% combined ratio in the first quarter of 1986, a significant improvement from a 121.1% combined ratio for the first three months of 1985.

The 20 largest U.S. reinsurers, based on net premiums written, showed similar improvement, reporting a 107.3% first-quarter 1986 combined ratio, compared with a 120.4% combined ratio in the first quarter of 1985.

In addition, three members of the Top 20 posted underwriting profits in the first quarter.

"Barring any major catastrophic events, the industry ought to at least maintain these ratios for the rest of the year," says Bard E. Bunaes, chairman and president of New York-based Constitution Reinsurance Corp., which reported a 104.7% combined ratio in the first quarter of 1986, compared with a 115.3% ratio in 1985's first quarter.

"The reinsurance business has been hurt so badly that I think memories are going to be longer than they used to be," adds N. David Thompson, president and chief executive officer of North American Reinsurance Co./Swiss Reinsurance Co. in New York.

The "responsible" part of the market will underwrite carefully "for the foreseeable future," which Mr. Thompson defines as this year, next year and "maybe into 1988."

Focusing on his company's results, Mr. Thompson observes that "the first quarter shows significant improvement and the indications are that, barring catastrophes, there will be continuing improvement for the rest of the year."

North American/Swiss Re posted a 112.4% first-quarter 1986 combined ratio, compared with a 118.9% combined ratio for 1985's first quarter.

However, one reinsurance executive says that the glittering first-quarter industry figures reported by the RAA may be misleading.

Don Cole, president and chief executive officer of Constitution State Management Co., a Travelers Corp. subsidiary, notes that while 108 companies reported their year-end 1985 results to the RAA, only 70 submitted first-quarter figures.

"Those that didn't probably didn't have too good results to report," he says, noting that if all companies had submitted first-quarter results, "the industry average would be higher than you see there." That means Constitution State's 111.1% first-quarter combined ratio, an improvement over 113.3% in 1985's first quarter, is actually closer to the industry average than it appears, he says.

Both the entire group of 70 reinsurers included in the RAA survey and the 20 largest companies reported an aggregate 82.3% loss ratio in the first quarter. However, the larger reinsurers did a bit better than the industry norm on the expense side, with the Top 20 posting a 25.0% expense ratio, compared with the 25.4% aggregate expense ratio reported by all reinsurers surveyed.

The Top 20 also reported greater premium growth. Net premiums written increased 64.3% to $2.3 billion among the largest companies, while the entire industry reported a 58.5% gain to $2.9 billion.

But, despite the first-quarter gains, some executives say reinsurers must guard against changing their current strategy.

"The industry must continue to strive for underwriting profits and better loss control, and not be lulled into a false sense of elation

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New York guaranty fund has unique claims criteria

Product liability claims filed against the New York Property/Casualty Insurance Security Fund "present very difficult questions" in determining coverage, admits the head of the liquidation bureau and guaranty fund.

New York's security fund law dictates a unique definition of covered claims compared with other state guaranty fund laws, explains Andrew A. Alberti, special deputy superintendent of the New State Insurance Department Liquidation Bureau, whose responsibilities include the security fund.

Claims are are covered by the New York security fund only if the policy insures property or risks "located or resident in the state."

If a New York-based company bought general liability insurance from a now insolvent insurer covering locations in other jurisdictions, the New York security fund would not respond to a slip-and-fall claim involving an accident in another jurisdiction. "That location is not a risk located or resident in the state of New York," Mr. Alberti explained.

Coverage for product liability claims depends on the circumstances, Mr. Alberti said, giving two examples.

If a manufacturer of products in New York ships them to another state and an accident is caused by improper use, the claim would not be covered by the New York fund because the improper use was not resident in New York.

However, if the product was designed in New York, product design was covered by the policy and the product caused injury in another state attributable to product design, the claim would be covered.

There are no broad guidelines determining coverage for product liability claims, Mr. Alberti said. "After some decisions are rendered by the courts, perhaps we can establish some broad guidelines," he said.

The only pending litigation against the security fund for its stand on covered claims involves Snyder Tank Corp. of Buffalo (see story, page 3). "Others are potentially in claim," Mr. Alberti said. He could not estimate, however, how many claims filed against the security fund raise this coverage issue.

Some manufacturers based in New York "are very upset" about the New York security fund's definition of covered claims, Mr. Alberti admitted. "Philosophically, they are very concerned" about their coverage if their insurer becomes insolvent, he explained.

New York's interpretation of covered claims is not new, but it is raising more concern among policyholders and other state guaranty funds as more large, commercial insurance companies become insolvent, resulting in more product liability claims that may not be covered by the New York security fund.

Mr. Alberti said he doesn't believe that New York should amend its securty fund law to conform with the guaranty fund laws in other states. "New York had one of the first of the guaranty funds. Its protection is broad and deep. It provides very rich benefits—to $1 million per claim and $1 million for unearned premiums," Mr. Alberti pointed out.

Congratulations, Kathryne.



Region I
Kathryne A. Beckwith,
CPIW, Workers Compensation Claims Examiner, Sentry Insurance Company, Concord, Massachusetts, Massachusetts Association of Insurance Women.

Looking good, LaRue.



Region II
LaRue W. Sox,
Claims Examiner Seaboard Underwriters Inc., Burlington, North Carolina, Alamance County Association of Insurance Women.

Wonderful, Juanita.



Region III
Juanita V. Keltner,
Claims Service Manager, The Claimsman, Inc., Atlanta, Georgia, Atlanta Association of Insurance Women.

Beautiful, Barbara.



Region IV
Barbara Metusalem,
AIC, CPIW, Claims Supervisor, United States Fidelity & Guaranty Company, Toledo, Ohio, Insurance Women of Toledo.

Kudos, Christie.



Region V
Christie Lynn Curran,
AIC, Supervisor of Claims, United States Fidelity & Guaranty Company, Lisle, Illinois, I.D.E.A.

Way to go, Melba Jo.



Region VI
Melba Jo Monroe,
CPIW, Claims Manager, Emett & Chandler Texas, Inc., Houston, Texas, Insurance Women of Houston.

Bravo, Bertina.



Region VII
Bertina W. Floyd,
CPIW, CCLA, Regional Claims Operations Manager, CIGNA Corporation—INA, Overland Park, Kansas, Insurance Association of Suburban Kansas City.

Marvelous, Marcia.



Region VIII
Marcia Ann Karlstedt,
Branch Secretary, deVries and Company, Sacramento, California, Camellia City Insurance Women.

Magnificent, Maxine.



Region IX
Maxine A. Manor,
CPIW, Branch Claims Manager, Viking Insurance Company of Wisconsin, Salem, Oregon, Insurance Women of Salem.

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Guaranty funds

Continued from page 3

single insurance guaranty association's aggregate financial exposure reaching into the millions," warned Thomas B. Ridgley, a partner with Vorys, Sater, Seymour & Pease in Columbus, Ohio.

The ABA institute, which preceeded the midyear meeting of the National Assn. of Insurance Commissioners, also held in Boston, broke recent attendance records for ABA institutes, attracting 370 registrants. The large turnout for a weekend institute evidenced the widespread concern about insurance company insolvency, speakers asserted.

As the safety net for policyholders of insolvent insurers, state insurance guaranty associations were a hot topic of discussion.

The state guaranty fund system is designed to cover claims when licensed insurance companies become insolvent. Except New York, which pre-assesses insurers to maintain a fund of at least $150 million, the states assess insurers licensed in their states as needed to cover the cost of claims.

The 50 states, the District of Columbia, Puerto Rico and the Virgin Islands all have property/casualty guaranty funds.

However, the coverage provided varies greatly.

Five states cover claims only up to $50,000, while Rhode Island and New York cover claims to $1 million and Maryland imposes no cap, pointed out Mr. Ridgley. The majority of the states have adopted a $300,000 cap as recommended in a model bill adopted by the NAIC, while others use caps of $100,000, $150,000 or $50,000.

However, all states limit recovery to the policy's limits.

"We need uniform caps," Mr Ridgley said, a plea that was echoed by other speakers.

Which guaranty association should respond to a claim is also a growing problem, Mr. Ridgley pointed out.

Almost all the guaranty associations determine coverage based on the policyholder's residence, but determining a corporation's residence can be difficult due to the multistate operation of many companies and the inconsistency among state statutes defining corporate residence.

The National Committee of Insurance Guaranty Funds has adopted six criteria to help decide which fund is responsible. These include: where the executive offices or corporate headquarters are located; the location of the operation where the insured event occurred; where the policyholder is incorporated; where the applicable insurance policy was issued or delivered; where the applicable premium taxes were paid or should have been paid; and, the policyholder's primary domicile for state income tax purposes.

Twenty-eight guaranty associations have signed these guiding principles, Mr. Ridgley noted.

Meanwhile, the NAIC amendments adopted in December to the model act governing property/casualty guaranty funds provide that "the resident of a claimant or insured is the state in which its principal place of business is located at the time of the insured event."

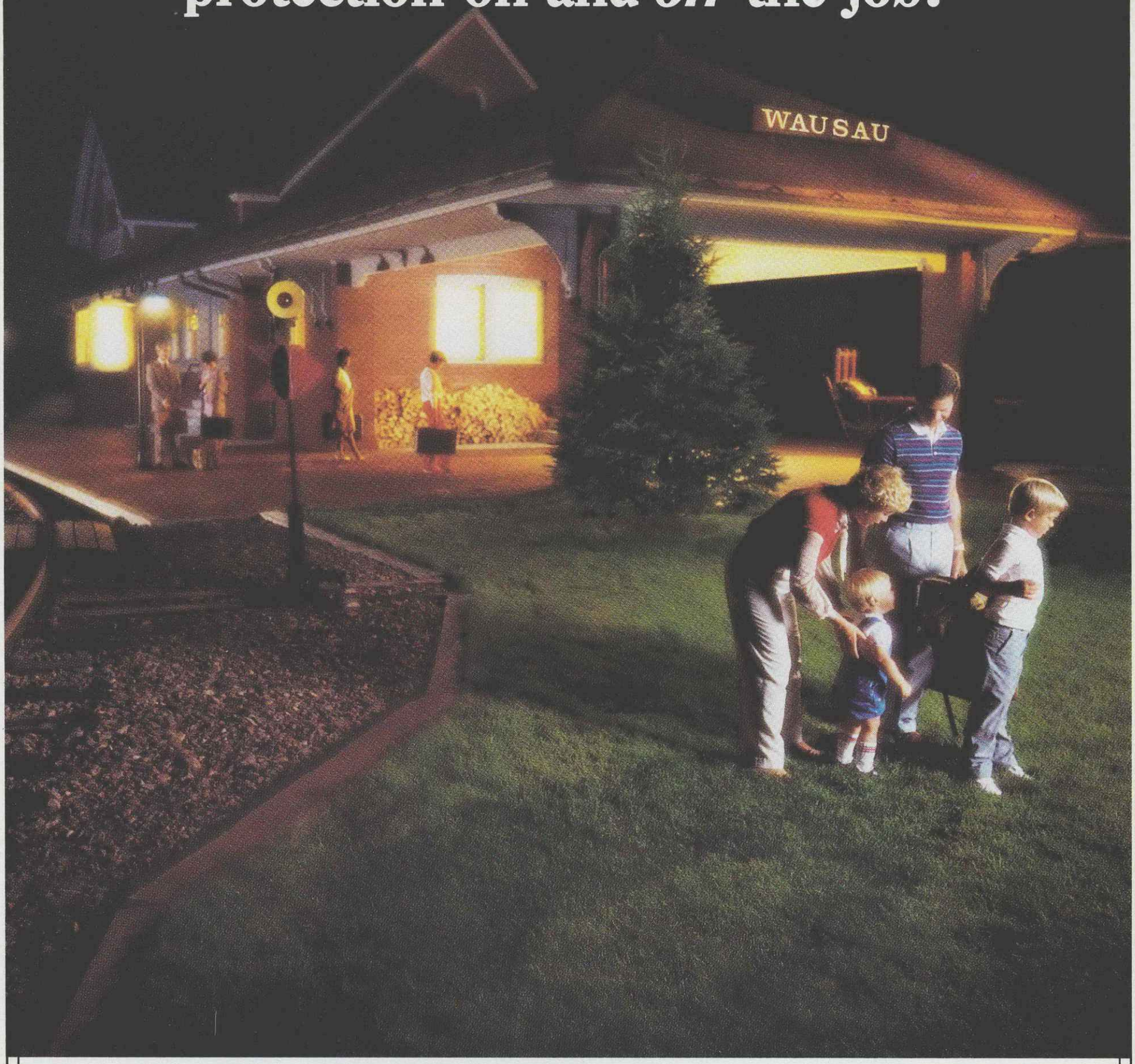
Mr. Ridgley observed: "This amendment, if adopted, will greatly simplify residence determinations."

However, it will not solve what Mr. Ridgley termed "The New York problem."

Stressing that his remarks on New York were his own and not those of his firm or the Ohio Insurance Guaranty Assn., Mr. Ridgley described how New York's intepretation of a covered claim "creates serious problems" for policyholders and other guaranty funds.

Continued on page 6

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Guaranty funds

Continued from page 4

New York's security fund uses a unique definition of "allowed claim" as one "based on a policy insuring property or risks located or resident in this state."

New York takes the position that this language mandates that the incident that gives rise to a claim must occur within New York for the fund to be responsible for a claim against an insolvent insurer. This interpretation has been upheld by the state's highest court.

In product liability cases, New York also has asserted that the product must have been manufactured in New York and the product must be located in New York at the time of the incident causing injury, even if the corporate policyholder is a New York resident.

Other states, such as Ohio, are handling claims for corporate policyholders resident in their state regardless of where the claim occurred, Mr. Ridgely pointed out.

And, other state funds also have been paying claims that Mr. Ridgley characterized as properly belonging to New York.

"As a result, to date, insureds and claimants have not suffered greatly from the New York aberration. However, as states begin to adopt the amended model act languange, there will be the risk that those IGAs will have no responsibility to pay the claims and New York will disclaim responsibility for them.

"This has the potential to create a major gap in the nationwide safety net" protecting policyholders, Mr. Ridgely pointed out.

Already, litigation has erupted over New York's stance on covered claims.

The Ohio Insurance Guaranty Assn. and Snyder Tank Corp. of Buffalo, N.Y., are suing the New York Superintendent of Insurance as administrator of the state's security fund and liquidator of Union Indemnity Insurance Co. to force New York to provide Snyder Tank with coverage for a product liability claim.

Snyder Tank, a Union Indemnity policyholder, was denied defense and indemnity coverage under New York's security fund for a product liability claim stemming from an accident in California involving one of its fuel tanks.

According to the coverage suit, filed in March in State Supreme Court in Erie County, the tank was manufactured in part in New York and in part in Ohio.

The Ohio Insurance Guaranty Assn. is defending Snyder, reserving its rights against the New York superintendent and security fund. Ohio caps coverage at $300,000, however, while the New York security fund provides coverage to $1 million, which was also the limit of the Union Indemnity policy.

"New York remains outside the mainstream of the insurance guaranty association system and in many respects works at cross purposes with the system," Mr. Ridgley said. "Its status as a large commercial and corporate center exacerbates the problem."

But, besides a lack of cooperation among all the guaranty funds, liquidators of insolvent insurance companies and the guaranty associations do not always cooperate as they should on "early access" to the insolvent insurer's available assets, observed Joseph C. Tanski, a partner with Hutchins & Wheeler in Boston and counsel to the Massachusetts Insurers Insolvency Fund.

The concept of "early access" to an insolvent insurer's assets by guaranty associations "hasn't been as great a financial help that people thought it could," he observed. "The system could be made to work more beneficially," he suggested.

Under the concept of early access, he explained, the available assets of the insolvent insurer should be used to help fund the cash needs of guaranty associations since the guaranty associations are generally the largest creditors in insurer insolvency proceedings.

Although the NAIC adopted a provision on early access in its model act governing insurance company rehabilitations and liquidations, the model law and the state laws as adopted leave many areas of concern open to interpretation, according to Mr. Tanski.

For example, the receiver has wide discretion in determining what assets are available.

"Guaranty associatons have attempted to accelerate the marshaling of assets so as to maximize the amount of liquid assets available while receivers have tended to provide in the plan as much flexibility to the receiver as possible," Mr. Tanski observed.

Another problem, the financial capacity of guaranty funds to cope with large, commercial insurance company insolvencies was addressed in part by the NAIC in December when it passed amendments to the model law to limit the scope of coverage under the funds.

Previously, the model act excluded coverage for life, title, surety, disability, credit, mortgage guaranty and ocean marine.

The new excluded lines of coverage under the model act include: annuity and health insurance, which are covered by the life and health guaranty funds; financial guarantees; fidelity insurance, bonding obligations, insurance of warranties or service contracts; transactions that transfer no more than the investment or credit risk; any claims by an affiliate of an insolvent insurer; punitive or exemplary damages; premium returns under a retrospective rating plan and any claims covered by a governmental insurance or guarantee program.

In addition, a $10,000 cap was adopted for recovery of unearned premiums, dropping the limit from $300,000. And, for liability claims, the guaranty fund will pay claims up to $300,000, but it will have the right to subrogate against the policyholder if the policyholder is an affiliate of the insolvent insurer or has a net worth exceeding $50 million.

Now under consideration is the financial capacity of the funds and how they should be financed, said Michael P. Duncan, assistant vp and assistant general counsel of Allstate Insurance Co. in Northbrook, Ill. Mr. Duncan also is chairman of the Industry Advisory Committee to the NAIC Guaranty Fund Task Force.

Among the reforms discussed are:

- A proposal by Hartford Insurance Group to surcharge premiums up to 2% to create a fund that would transfer money to the guaranty fund as needed.
- A proposal by State Farm Insurance Cos. to create a single national guaranty facility owned by private insurers. The fund would cover only private passenger automobile, dwelling fire, homeowners and "selected" commercial coverages, including workers comp.

Insurers also would be required to establish a policyholders security account that would place with a custodian an amount sufficient to satisfy loss and loss expense reserves plus unearned premium reserves, or at least 70% of written premiums for the prior year.

- A proposal by Nationwide Insurance Co. to create a state chartered not-for-profit reinsurance company to underwrite solvency reinsurance. The reinsurer would cover claims exceeding what a guaranty fund could cover with a 1% of premium assessment against insurers.
- A proposal by Crum & Forster Corp. to surcharge up to 2% of premium after an insolvency to fund the guaranty funds. Any assessments levied against insurers would be recoupable from subsequent surcharges. ■



N.J. surplus guaranty fund in trouble: Lawyer

By KATHRYN J. McINTYRE

BOSTON—The 2-year-old New Jersey Surplus Lines Insurance Guaranty Fund is facing a funding crisis, a lawyer says.

The original estimate of the cost of claims against the fund filed by policyholders of the insolvent Ambassador Insurance Co. was $10 million, says Richard R. Spencer Jr. Now, the estimate is $50 million.

"In four years, we will be lucky if we get $20 million," he said of the revenue-raising potential of the surplus lines fund.

Mr. Spencer, a partner in the Newark, N.J., law firm of Stryker, Tams & Dill, which is legal counsel to the surplus lines guaranty fund and the New Jersey Property/Liability Insurance Guaranty Assn., spoke at a National Institute on Insurer Insolvency conference sponsored by the American Bar Assn.

However, he stressed that his remarks were his opinions and not necessarily those of the guaranty fund, the guaranty association or the state insurance department.

The New Jersey Surplus Lines Insurance Guaranty Fund, the first and only guaranty fund in the country to cover claims against insolvent surplus lines insurers, is funded by a one-time mandatory $25,000 fee charged surplus lines insurers writing in the state and a premium surcharge of up to 4%. In addition, the fund has access to a standby loan of up to $10 million from the guaranty association, which is the guaranty fund covering claims against insolvent admitted and authorized insurers in the state.

The surplus lines guaranty fund legislation also authorizes the state insurance commissioner to adjust the fund's obligation to pay claims to any percentage of the claim filed, which will control the fund's liabilities.

Currently, the commissioner has established that only 40% of the principal amount of any covered claim filed by an Ambassador policyholder is to be paid. The cap on claims payment at 100% is $300,000.

"Forty percent is better than nothing," Mr Spencer declared, noting that if the state had not created the surplus lines guaranty fund in 1984, Ambassador policyholders in New Jersey would have received no payment toward their claims.

Ambassador, domiciled in Vermont, wrote most of its business in New Jersey as a surplus lines insurer. When it was found to be financially impaired, the New Jersey Legislature passed a bill creating the surplus lines guaranty fund to protect policyholders.

Establishing the 40% cap on claims payments reduced the cash flow needs of the fund, Mr. Spencer said, but it now faces an acute funding crisis.

As of March 31, the fund had raised $8.3 million—including a $3 million loan from the guaranty association—and had a balance of $774,708.

Additional funds from the $25,000 assessment will be realized only if new surplus lines insurers enter the state. Currently, 33 insurers are writing on a surplus lines basis in the state and have paid total fees of $825,000. Fifteen surplus lines insurers that had been writing in the state withdrew since the fund was created, Mr. Spencer noted.

The $10 million loan provision, meanwhile, is "fragile," because the association must "deal with its own insolvencies," he said.

The 4% surcharge on premiums provides the only "meaningful revenue source," Mr. Spencer said. This will serve as the funding workhorse, but the fund receives these payments only quarterly, which Mr. Spencer says is a slow funding device.

Futhermore, if premiums fall or the marketplace shinks, there will be less revenue generated for the fund, he pointed out.

Overall, Mr. Spencer contends that the New Jersey fund has "worked better than its detractors would have wanted us to believe—especially the administration of the fund—but its performance is less than its proponents would have had us believe." ■



Obstacles face liquidators in Bermuda

BOSTON—Two major problems face liquidators of insolvent insurance and reinsurance companies in Bermuda, a Bermuda attorney says.

These problems are the inconsistent treatment of the proceeds of letters of credit that had been issued to ceding companies and the lack of recognition of Bermuda law in the Unitied Kingdom, explains Dianna P. Kempe, a partner with Appleby, Spurling & Kempe in Hamilton, Bermuda.

nnThe contractual documentation accompanying LOCs issued by Bermuda-based reinsurers to U.S. insurers to secure reinsurance obligations does not address how the proceeds of the LOCs should be handled if the reinsurer is declared insolvent, Ms. Kempe said.

If the ceding company draws down the entire amount of the LOC in excess of paid losses, should that excess amount be held by the ceding company as a constructive trustee and should that money be invested?, she asked. And, should the investment income pass to the cedent to cover incurred losses as they become payable or should the investment income be payable to the liquidator of the insolvent reinsurer?

In two current Bermuda insurance company insolvencies, liquidators are taking different stances on these issues, creating confusion and allowing ceding companies to act to their best advantage without regard to the liquidators' request, Ms. Kempe commented.

"The contractual documents supporting LOCs should address this issue," she advised.

The second problem is not so easily solved. Federal law recognizes foreign liquidations and U.S. courts have protected the rights of foreign liquidators, such as the right to take possession of assets and records belonging to the insolvent company.

But, British law affords no similar recognition. As a result, a Bermuda liquidator faces problems in the United Kingdom that interfere with the orderly administration of a liquidation, she observed.

Ms. Kempe also pointed out the four significant differences between liquidation proceedings in Bermuda and the United States:

- There are no guaranty funds in Bermuda.
- The liquidation is administered by the private sector.
- Creditors contribute significantly to the administration of the liquidation, through a representative committee of inspection that meets with the liquidators.
- There is no alternative similar to rehabilitation in Bermuda. ■

opinions

Is cure worse than cause?

FLORIDA'S NEW LEGISLATION designed to cure the liability insurance crisis in the state could backfire on commercial insurance buyers (see story, page 1).

There's nothing insurers can do to avoid the premium refund the state is imposing—unfairly, we think—but insurers certainly can refuse to write new policies in the state if they consider the new prospective rate regulation too onerous. And seven insurers already have said they will stop writing new policies.

That may be too quick a response on the insurers' part. We reserve judgment on the new prospective rate regulation, depending on how it is implemented.

But, if the implementation of the regulation is so heavy-handed that insurers leave the state in droves, what will Florida have accomplished?

Insurance Commissioner Bill Gunter points out that if insurers pull out of the state, businesses and professionals can more easily self-insure in groups under the new legislation, adding that insurers will forever lose that business.

We don't think the threat of more self-insurance is going to keep insurers in Florida if they think the new rate regulation will preclude them from making a decent profit. Furthermore, while it may indeed be shortsighted on the part of insurers, we haven't found too many insurers that are concerned about market share right now.

We do, however, endorse the new freedoms extended for group self-insurance contained in the legislation.

And, we endorse the tort reforms contained in the legislation, especially the provision that 60% of punitive damage awards be paid to the Public Medical Assistance Trust Fund in cases of wrongful death and personal injury or to the general revenue fund in other types of cases.

We have advocated for more than 10 years that punitive damage awards should not be a windfall to the plaintiff and his or her attorney.

It's very interesting to note, however, that the punitive damage reform and several other tort reforms in the legislation are subject to a 1990 sunset provision, but there are no sunset provisions attached to the new regulations imposed on insurers.

As we have warned in the past, new regulation spawned by this liability insurance crisis will outlive the crisis for many years, if not forever.

Other state legislatures now inclined to follow Florida's lead thankfully will be blessed with a summer hiatus and will have the opportunity to witness how much market disruption Florida's new law creates before they follow suit.

PBGC problems require answers

THE MASSIVE FINANCIAL problems facing the Pension Benefit Guaranty Corp. will not be easily solved. Thus, it's encouraging that the agency's current executive director, Kathleen P. Utgoff, is proposing concrete reforms to put the PBGC in the black, rather than just asking for more money from employers to finance a system doomed to growing deficits.

Years of inaction have pushed the PBGC to the brink of bankruptcy. It took Congress five years to approve an increase in the premium paid by employers with pension plans to fund the agency's termination insurance program, even though the PBGC's deficit ballooned during the interim. Now, despite an increase in the annual premium to $8.50 per plan participant from $2.60 retroactive to Jan. 1, Ms. Utgoff says the agency's deficit will still grow $350 million by 1990.

Ms. Utgoff says the answer to the PBGC's problems is not a series of premium hikes, but fundamental changes in the way the termination insurance program is structured (see story, page 3).

She suggests Congress consider several reform proposals, including:

• Setting individual employers' PBGC premiums according to their plans' funding levels.

• Allowing commercial insurers to sell termination insurance in competition with the PBGC.

A so-called risk-related premium, similar to the way commercial insurers rate almost all lines of coverage, is a fine idea. Why should a company that has conscientiously met its pension obligation subsidize an employer that, for whatever reason, cannot fully fund its pension plans? And we agree with Ms. Utgoff's contention that an employer that cannot afford a premium based on the risk its plan poses to the PBGC cannot afford to offer the plan.

We view with a bit more skepticism the proposal to allow commercial insurers to sell termination insurance. What if a private insurer is unable to pay benefits to retirees after the termination of an underfunded plan? No state guaranty fund would assume this burden, so the liability would revert to the PBGC.

Still, this proposal, like the prospect of risk-related premiums, deserves careful study. The PBGC's problems are too great to ignore for five more years.

letters

'Mr. LTD' still battling LTD establishment

To the editor: Once again O'Brien is going to bat for long-term disability coverage consumers in "Picking up the LTD tab"(*BI*, May 19)!

For more than 10 years now, we've seen Peter B. O'Brien, senior vp of Alexander & Alexander Services Inc., fight the establishment to get us broader coverage at lower rates!

Keep up the good work Mr. LTD!

Nicholas H. C. Davis
Treasurer
Venture Capital Assn. of Colorado

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

Some insurers provide lower-cost software

To the editor: I certainly agree with the premise that personal computers are the answer to flexible benefit plan administration for many employers, as stated in "Software untangles flex plan knots" (*BI*, May 26). However, there are alternatives that cost much less than the $50,000 cited.

Several insurance companies, including Pacific Mutual, offer software packages to their clients for administering flex plans. Relatively small user fees make this approach attractive for employers with a few hundred employees. The first-year cost, including hardware and training, would be about $10,000 for a 300-life group. These packages incorporate areas such as flex enrollment, reimbursement accounts, benefit statements, and 401(k)s.

PC administration for flexible benefits has a lot of value to the 2,000-life employer but there is no reason that the 200-life employer can't enjoy it just as well.

Ronald C. Mason
Product Manager
Pacific Mutual Life Insurance Co.
Fountain Valley, Calif.

EBIS coverage is sincerely complimented

To the editor: I read with great interest your May 26 issue. Your coverage of employee benefit information systems provided a good cross-section of information about a market that is growing rapidly.

My compliments to your staff of reporters and particularly Steve Taravella, who demonstrated that he thoroughly researched this subject. The articles surveyed all segments of the market and provided your readers with a good overview of systems and implementation strategies.

Business Insurance is the first publication that has provided this breadth of coverage. My sincerest compliments.

John L. Krakauer
Vice President
General Manager
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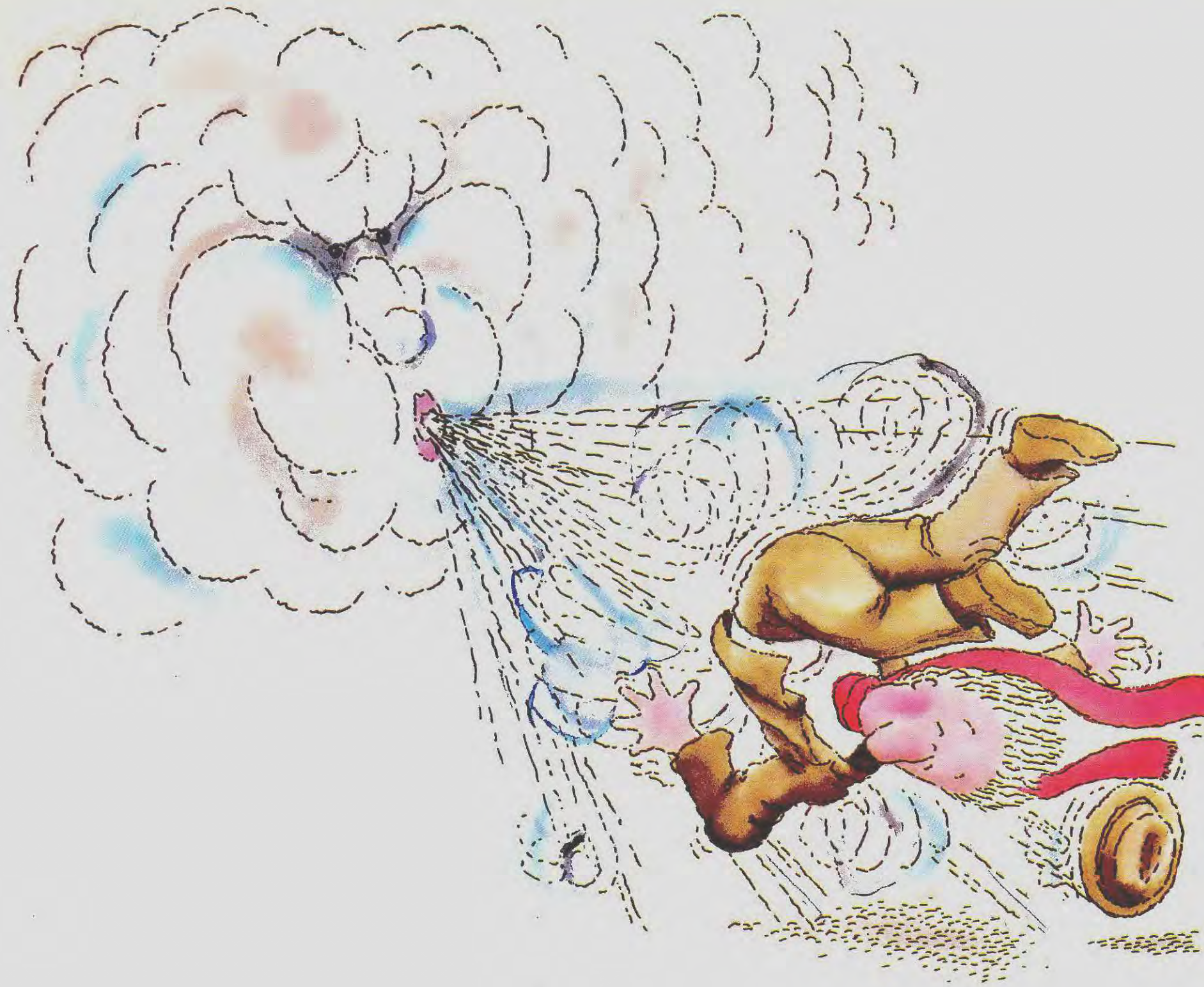
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Texas to study commercial liability claims

By KATHRYN J. McINTYRE

BOSTON—The Texas Board of Insurance is conducting a closed-claim commercial liability claims study to provide statistics that state lawmakers want to use in considering proposed reform of tort law and insurance regulation.

The results of the study of claims filed against Texas-based policyholders will be ready before the Legislature convenes in January.

Lyndon L. Olson Jr., chairman of the Texas State Board of Insurance, announced the claims study during a luncheon address at the National Institute on Insurer Insolvency sponsored by the American Bar Assn. in Boston June 7-8.

"We are not doing this for ratemaking purposes," Mr. Olson said.

Instead, the board is responding to a request for statistics from the House/Senate Joint Committee on Liability Insurance and Tort Law and Procedure.

The committee has before it 75 proposals for tort reform, 71 proposals for insurance reform and 14 miscellaneous recommendations, Etti Baranoff, administrator of technical programs for the insurance board, said in a later interview.

The largest insurers in Texas, holding about 75% of the market share, will be asked for claims information, Mr. Olson said.

This information will cover certain claims filed against general liability policies, Section 2 of the Texas commercial multiperil policy and commercial automobile liability policies, explained Dixie Evatt, director of research and information services for the insurance board, who was interviewed with Ms. Baranoff.

The study is focusing on claims closed during specific time periods, including: November and December 1983; January, February, November and December 1984; Janaury, February, November and December 1985; and January, February, July, August, September and October 1986.

By value, the study is focusing on claims resulting in indemnity payments of $25,000 or more and any claims for which loss adjustment expenses exceed $10,000.

"We are looking at defense costs," Mr. Olson pointed out. Insurers record defense costs as a loss adjustment expense.

However, the study seeks information on all claims closed under general liability and multiperil policies during September and October 1986.

The caps of $25,000 for indemnity and $10,000 for loss adjustment expenses will apply only to commercial auto claims closed in September and October because of the large volume of small claims in this line of insurance.

In addition, the study also will seek information on malpractice claims against hospitals. The questionnaire and the parameters of this part of the study are still under review and will be considered by the board June 17, said Ms. Evatt.

The board expects to receive information on 30,000 claims by the end of November so that the results can be compiled by January. Insurers must comply with requests for information under Texas insurance law.

The study will not include product liability and medical malpractice claims against doctors because other groups are gathering information on these claims, according to Ms. Baranoff.

The Texas State Board of Medical Examiners in Texas has collected claims against doctors since 1977, said Ms. Evatt.

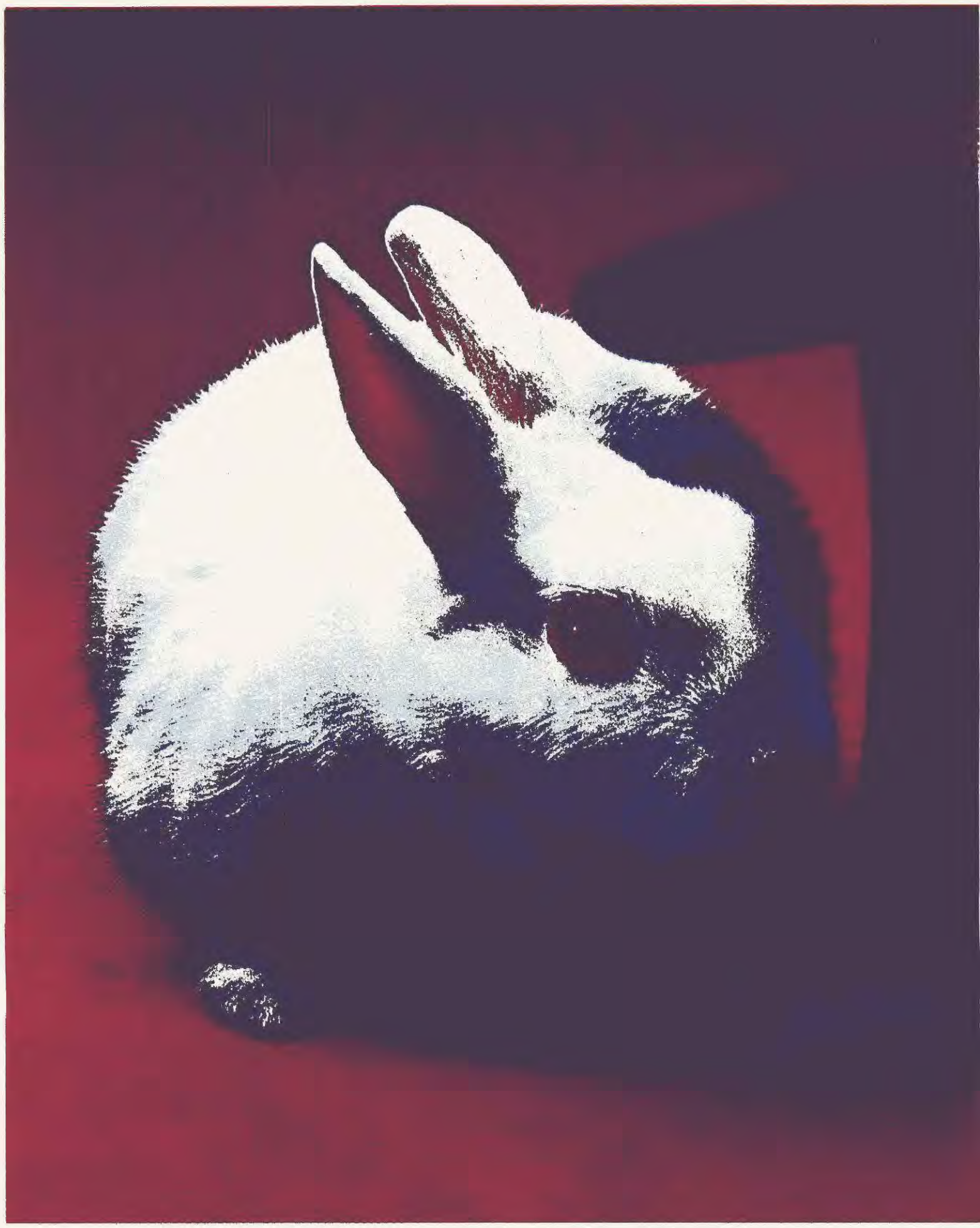
And, The Alliance of American Insurers is conducting a nationwide closed claim study on product liability claims, she said.

The Alliance study is being conducted in conjuction with companies that are members of the American Insurance Assn.

Twenty of the largest writers of product liability insurance have provided information on product liability claims closed in 1985 for which the claim payment and loss adjustment expenses totaled more than $100,000.

Information on more than 500 claims was provided by the 20 participating insurers, which wrote about 40% of all general liability insurance premiums, said Larry Soular, senior research manager for the Alliance in Schaumburg, Ill.

The Alliance expects to have a preliminary report on its study by August, Mr. Soular said. ■



Insolvency doesn't cancel arbitration

BOSTON—Disputes over reinsurance contracts that contain an arbitration clause must be arbitrated even if one of the companies is in liquidation, a lawyer says.

"The Federal Arbitration Act creates a compelling federal policy in support of arbitration," explains Ronald A. Jacks, a partner with Isham, Lincoln & Beale in Chicago.

Citing the applicable Supreme Court cases, Mr. Jacks said the following frequent defenses are ultimately no bar to arbitration of disputes involving insolvent insurers and reinsurers:

- The existence of a state court order staying litigation against an insolvent insurer.
- State law or policy forbidding arbitration.
- Claims involving the Racketeering Influenced & Corrupt Organizations Act.
- The assertion that the McCarran-Ferguson Act precludes arbitration.

"Insolvencies are not the business of insurance," Mr. Jacks said, and therefore are not included within the protection of the McCarran-Ferguson Act. ■

Regulators could be liable for errors: Lawyers

By KATHRYN J. McINTYRE

BOSTON—State insurance commissioners could be liable for their actions, or inactions, involving an insurance company insolvency, two lawyers say.

Only a half-dozen suits have been brought against insurance commissioners claiming damages for their handling of an insurance company insolvency, says Richard J. Medalie, a partner with Friedman & Medalie in Washington, D.C.

However, a commissioner may, under the appropriate circumstances, be sued in his capacity as a regulator of insurance companies and as a court-appointed liquidator or rehabilitator, according to Mr. Medalie.

"At least in part, some of these insolvencies are due to regulatory failure, and regulators have to accept some of the responsibility," added Steven R. Gilford, a partner with Isham, Lincoln & Beale in Chicago.

Suits against state insurance commissioners for misconduct in the regulation and liquidation of insurance companies were discussed at a National Institute on Insurer Insolvency sponsored by the American Bar Assn. in Boston June 7-8.

"As more companies go insolvent, the cry goes up: 'Whom can we hold liable?'" Mr. Medalie commented.

Questions arise in considering who is responsible for an insurer insolvency, Mr. Medalie said. These include: "What in the world was the insurance commissioner doing while this company was going down the drain? What tune was he fiddling while we were getting burned? And, can we get him to pay the piper?"

In his capacity as regulator, an insurance commissioner is protected by the doctrine of official qualified immunity, Mr. Medalie said.

As a result, an insurance commissioner cannot be held liable to any injured party if he makes an honest mistake or is negligent in examining an insurance company's financials, fails to discover irregularities or an impaired financial condition or, after reviewing the evidence, erroneously or negligently determines that the company is not insolvent or financially imparied.

However, a court could find the commissioner liable to parties injured by an insolvency—including policyholders, shareholders or creditors—under different circumstances.

These circumstances would include:

- If the commissioner, as regulator, fails to act decisively or unduly prolongs the determination that an insurer is insolvent or financially impaired.
- If the commissioner determines that the insurance company is not insolvent or financially impaired despite mounting evidence of statutory violations and fiscal mismanagement.

Under these circumstances, the court may consider the commissioner's actions or inactions as being in bad faith or motivated by malice or corruption and therefore beyond the protection of qualified immunity.

In the capacity of liquidator or rehabilitator, the commissioner may not be protected by any doctrine of official immunity and may be subject to the liability that falls to a fiduciary like any other receiver or trustee in bankruptcy, Mr. Medalie said.

The actions under question could include failure to recover property of the estate or to make a pro rata distribution to all creditors.

If his actions or inactions are honest, good faith, mistakes of judgment, he will not be held liable, Mr. Medalie said. However, if he intentionally or maliciously acts or fails to act, he can be held liable as a fiduciary for negligent breach of his duties.

Under these circumstances, the commissioner could be sued in either state or federal courts, Mr. Gilford pointed out.

Federal court would be preferable to state court, Mr. Gilford said, recognizing the political problems created by suing a state official in state court.

But, the 11th Amendment to the U.S. Constitution generally precludes the use of federal courts for actions against the state and for actions against public officials where the state is the real party in interest.

There are exceptions to this bar, Mr. Gilford said. These include:

- When the insurance commissioner has acted outside of his authority, exposing him to personal liability.
- When seeking prospective relief from a violation of federal law, if the action does not seek retroactive relief or damages.
- If the state or insurance commissioner has waived 11th Amendment protection by filing suit in federal court, as long as the claim arises from the same transaction or series of transactions.

Each of these exceptions applies when the commissioner is sued for regulatory misconduct, such as the failure to commence liquidation proceedings, Mr. Gilford said.

In addition, the 11th Amendment should pose no bar to a suit in federal court against an insurance commissioner in his capacity as liquidator because that is a private capacity and not an arm of the state.

However, even if no 11th Amendment issues are raised, the federal courts could abstain from considering an action against an insurance commissioner out of deference to the state regulation of insurance and insurance company insolvencies. ■

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PBGC problems

Continued from page 3

Presumably, the Single Employer Pension Plan Amendments Act of 1986—the legislation that increased the PBGC premiums to $8.50 and closed some loopholes that made it relatively easy for some companies to terminate underfunded pension plans—was designed to prevent such a situation (*BI*, March 31; March 10).

However, it took five years to pass a premium increase, and by the time the law was finally signed by President Reagan on April 7, it was too little too late, experts say.

Ms. Utgoff acknowledges the new $8.50 premium only has put off the day that the PBGC will run out of money—unless Congress continually raises the premium.

How high the premium could eventually go is anyone's guess. Some pension experts believe a $100 per plan participant PBGC premium is well within the realm of possibility.

And, they add, the higher the premium rises, the more likely that employers with well-funded defined benefit plans will terminate those plans and set up defined contribution plans, which are not covered under the PBGC program.

Such an exodus would exacerbate the PBGC's already serious financial problems by shrinking the premiums paid.

But, there are alternatives to ever-escalating premiums, Ms. Utgoff says, admitting they would require tougher rules that would restrict the ability of employers to terminate underfunded plans.

Ms. Utgoff says employers must recognize they can't have maximum flexibility to terminate underfunded plans and expect to pay a low PBGC premium.

"What flexibility really means is that employers who have incentives" to underfund and terminate their pension plans "will use them and raise the cost for everyone else," she says.

The changes suggested by Ms. Utgoff include:

- Requiring faster pension funding.
- Giving the PBGC a higher status as a creditor in bankruptcy proceedings.
- Making it more difficult for companies to transfer pension liabilities when they buy and sell subsidiaries.

Employers have objected to such changes, believing they give the PBGC too much power over normal business transactions.

While Ms. Utgoff says that no one is more committed than she to minimum government interference in private business, she points out that all employers will continue to pay high PBGC premiums until plan termination rules are toughened.

"Wheeling-Pittsburgh Steel Corp. promises pension benefits and can't deliver...then the entire pension community shares the costs," she says referring to the financially troubled Pittsburgh steelmaker's proposed termination of several pension plans, which would shift an estimated $475 million in unfunded liabilities to the PBGC.

The current system encourages financially troubled companies to underfund their pension plans, Ms. Utgoff contends. Because tax deductions for contributions to pension plans are irrelevant to a company losing money, those companies naturally underfund their pension plans, she says.

That's a fundamental problem with the PBGC system, Ms. Utgoff says.

The system needs a complete overhaul to create incentives for all plan sponsors to properly fund promised benefits, she contends.

For instance, she says Congress should consider making the PBGC a true insurance program by basing an individual employer's premium on the risk that that company will terminate its pension plan.

Such a risk-related premium would be based on the financial condition of a company's pension plan. Employers with poorly funded pension plans would pay much higher premiums than those with well-funded plans, as compared with the current system in which all employers pay the same premium per plan participant.

"We're using money from healthy, responsible employers to subsidize troubled employers' pension promises," Ms. Utgoff explains. "We should consider moving the costs of the system more to the firms that are getting a subsidy. It is assigning the costs to where they are being generated."

Ms. Utgoff concedes that a risk-related premium could be very expensive for some companies.

For instance, a risk-related premium for a company like Wheeling-Pittsburgh with several massively underfunded pension plans might be as much as $400 per participant, she said.

While some companies would not be able to afford such a high premium and would terminate their defined benefit plans, Ms. Utgoff questions whether such terminations would be a loss.

"If they can't afford $400, then they can't afford to contribute to their pension plan. If they can't afford it, is there any reason why we should subsidize any form of compensation for a company that can't make it economically?"

In addition, companies whose pensions plans are fully funded no longer would subsidize those companies with poorly funded plans, which would spell relief from continual PBGC premium increases.

But risk-related premiums only can work if the premiums are based on the PBGC's true exposure to claims, Ms. Utgoff says. If Congress were to set a narrow range in which premiums could vary—such as between $7 and $11 per plan participant—there would not be enough of an economic incentive for some companies to improve plan funding, she says.

Further, she says, if Congress does approve risk-related premiums, there is no reason the PBGC should be a monopoly provider of pension plan termination insurance.

Ms. Utgoff says she likes the idea of "privatization," in which commercial insurers could sell termination insurance coverage to employers, though the PBGC would be the provider of last resort should coverage be unavailable in the commercial market.

"Having the PBGC unilaterally set prices in general is not a good idea. If companies believe they are being charged an excessive price, the PBGC could say: 'Fine, if you can get good insurance, go elsewhere,'" Ms. Utgoff says.

Since the PBGC could set a company's premium based on the financial condition of its plan, presumably the agency could charge enough to cover the exposures created by poor-risk companies that are unable to find coverage in the commercial market and are forced to buy coverage from the PBGC.

Despite Ms. Utgoff's enthusiasm for risk-related premiums and eventual privatization, such proposals may face stiff opposition in Congress.

For example, one influential congressional staffer is known to have told Ms. Utgoff the only way a risk-related premium would be passed would be over her dead body.

But Ms. Utgoff is optimistic that change is possible. She notes that when she said that her first goal was to pass SEPPA, this year's PBGC legislation, she was told "good luck" in rather discouraging tones.

Now, pension lobbyists say Ms. Utgoff deserves much of the credit for the legislation's approval.

"She worked very aggressively to have SEPPA adopted. She, and her staff, took a lot of initiative to get the bill moving," said Stuart J. Brahs, executive director of the Assn. of Private Pension & Welfare Plans in Washington.

While Mr. Brahs has his doubts about whether Congress would support a change like privatization, he notes that Ms. Utgoff has the ability to change congressional and public opinion.

"She understands the political process and knows that the development of public policy is not done in a vacuum. She is enthusiastic and has raised public consciousness about the agency and its problems," Mr. Brahs says.

By speaking out about the problems facing the PBGC, Ms. Utgoff says she hopes policymakers will begin to consider alternatives—other than higher premiums—to putting the program on a sound, sensible footing.

But it may take several more huge terminations that push the agency to the brink of bankruptcy before legislators and some members of the pension community realize changes are necessary, Ms. Utgoff notes.

Perhaps then, "People will recognize that what we are doing is running an industrial subsidy program and not an insurance program," she says. ■

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Chevron cover

Continued from page 2
policies at $1 million per year.

In a third-party complaint filed after Northglenn sued Chevron, the oil company contended Transport was liable to reimburse it approximately $1 million for each of the two years the policy was in force.

In attempting to determine whether there was coverage for Chevron, Judge Carrigan noted that the Security policy provided it would pay all sums because of bodily injury or property damage caused by an accident and resulting from garage operations.

The policy defined "accident" to include "continuous or repeated exposure to the same conditions resulting in bodily injury or property damage neither expected nor intended."

However the "pollution exclusion" clause provided that insurance does not apply to "bodily injury or property damage caused by the dumping, discharge or escape of irritants, pollutants or contaminants" unless the discharge is sudden and accidental.

"It is undisputed that the conditions and exclusions contained in the primary policy were adopted and incorporated into Transport's excess policy," the court said.

Relying on a case from Washington state, Chevron argued that the pollution exclusion clause applies only to acts committed by "intentional or active" polluters and does not apply in this case.

It also argued that the pollution exclusion clause does not exclude coverage for pollution damage that was neither intended nor expected by Chevron.

Moreover, because previous case law had interpreted the pollution exclusion in this manner, Transport and the insurance industry generally were on notice regarding the provision's application to losses at issue here, Chevron argued.

Transport, however, contended that the Washington decision was inapplicable and that under Colorado law, it was the intention of the parties that was paramount in construing an insurance policy.

The parties intended and understood that losses caused by gradual seepage and pollution were excluded from coverage under the policy, Transport argued.

In his decision, Judge Carrigan said only if the terms of the agreement are ambiguous does other evidence as to intent become relevant.

The primary policy defines "accident" as including "continuing" conditions, the court said. But the policy excludes coverage for the escape of pollutants unless they escaped suddenly and accidentally.

"I conclude that because of these apparently conflicting provisions, the language employed in the policy is ambiguous," Judge Carrigan said.

However, he added there would have to be an examination of the parties' intent before he would resolve ambiguous provisions against the insurer and in favor of the insured.

A "critical" issue as to intent will be evidence supplied by a surplus lines insurance broker in a deposition that there were discussions with Chevron and others that the standard CGL form excluded losses caused by gradual seepage and pollution, Judge Carrigan said.

A senior insurance analyst for Standard Oil Co., the parent of Chevron U.S.A., also testified that he never expected Chevron to have coverage for gradual pollution, he added.

Chevron, however, contends that none of those parties discussed coverage under the pollution exclusion clause at the time the policy was executed.

An attorney for Transport said he would present a "strong case" the parties contemplated there would be no coverage because of the pollution exclusion clause.

"The decision was absolutely solid on the law," said Paul Renner with the Denver firm of Renner & Rodman.

"I can find no fault whatsoever. . .in the memorandum opinion," he said.

An attorney for Chevron said the company would argue there was no agreement by the parties as to how the pollution exclusion clause applies. ■

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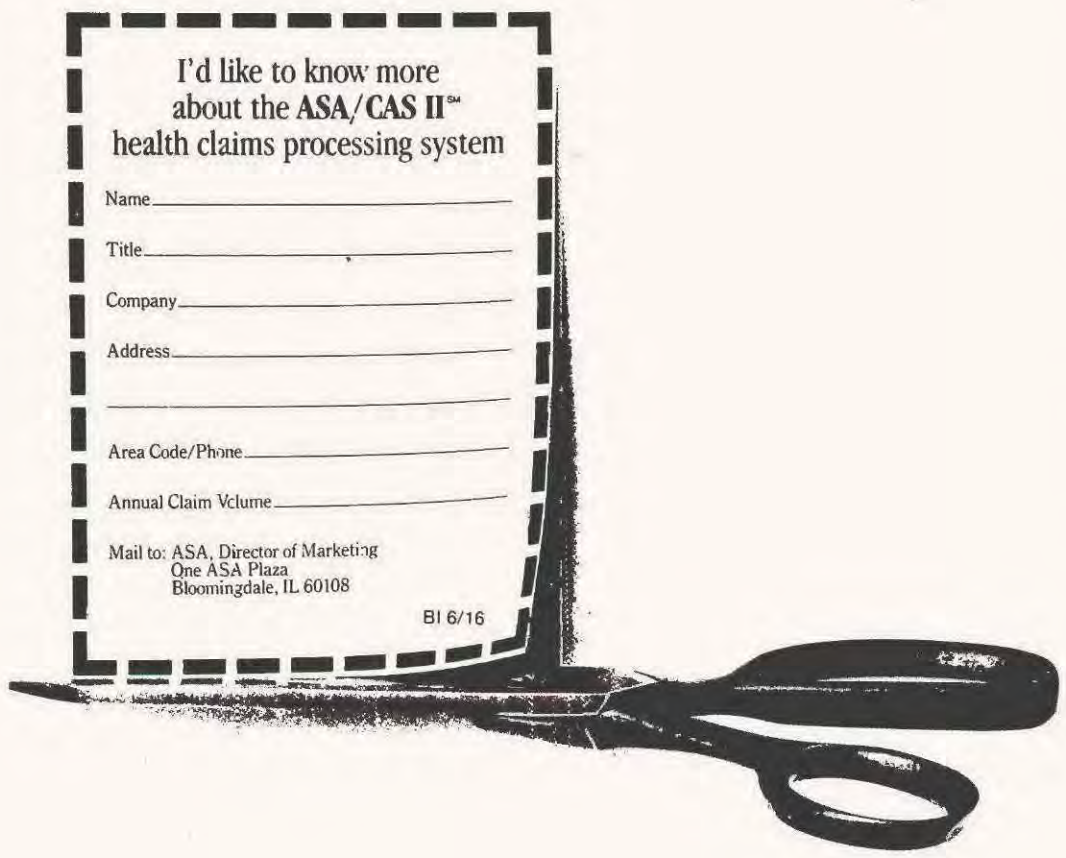
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BI 6/16



New York MAP taps 21 insurers

NEW YORK—Twenty-one property/casualty insurers are providing coverage to 170 New York municipalities through the state's Municipal Market Assistance Program, according to the New York Insurance Department.

Limits of at least $1 million have been provided in most cases, said a spokesman for the department.

More than 200 applications have been processed, he added, noting that the remaining applicants had been able to obtain coverage.

An additional 46 applications are still pending, the spokesman said. He anticipates that almost all will be able to obtain insurance.

Applications are "coming in at a lessening rate," the spokesman noted.

The 21 insurers participating are: American International Group, Aetna Casualty & Surety Co., CIGNA Corp., Chubb & Son Inc., Commercial Union Property & Casualty Insurance Co., Continental Insurance Cos., CNA Insurance Group, Crum & Forster Insurance Co., Fireman's Fund Insurance Co., General Accident Insurance Group, The Hartford Group, The Home Insurance Group, Liberty Mutual Insurance Cos., Maryland Casualty Co., Nationwide Group, Royal Insurance Co. of America, St. Paul Fire & Marine Insurance, Travelers Group, United Community Insurance Co., United States Fidelity & Guaranty Co. and Wausau Insurance Cos.

No additional insurers are expected to join the program, which was intended as a temporary measure, the spokesman said. "Acting as a quasi-broker is an unusual stance for (the Insurance Department) to be in," he added.

The New York Insurance Department spokesman pointed to legislation, slated to be introduced as part of a tort reform package within the next two weeks, as the long-term solution to the municipalities' insurance woes.

"We're optimistic as far as legislation is concerned. We expect public entities will have an easier time," the spokesman said. ■



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JUNE 19. The HMOs Are Coming! The HMOs are Coming! seminar in New York, sponsored by the New York Business Group on Health Inc.; $30 for members; $75 for non-members. New York Business Group on Health Inc., 622 Third Ave., New York, N.Y. 10017; 212-808-0550.

JUNE 22-25. 1986 Professional Insurance Mass-marketing Assn. conference in Amelia Island, Fla.; $445 for PIMA member and family; $225 discount rate for PIMA member and family if more than two members from the same organization register; $595 for non-member and family. PIMA, 4733 Bethesda Ave, Suite 330, Bethesda, Md. 20814-5228; 301-951-1260.

JUNE 22-27. 1986 Fundamentals of Employee Benefits Management course in Brookfield, Wis., sponsored by the International Foundation of Employee Benefit Plans; $800. Also **Oct. 5-10.** IFEBP, Registration Department, 18700 W. Bluemound Rd., P.O. Box 69, Brookfield, Wis. 53008-0069; 414-786-6700.

JUNE 23-24. Asset/Liability Management for Insurance Companies seminar in New York, sponsored by Peat Marwick Mitchell & Co.; $750. Registrar, Peat Marwick Mitchell & Co., Executive Education, New York N.Y. 810 Seventh Ave., New York, N.Y. 10019; 800-762-3932.

JUNE 23-27. Modern Safety Management conference in Atlanta, sponsored by the International Loss Control Institute; $695. Also **Aug. 4-8.** ILCI, P.O. Box 345, Loganville, Ga. 30249, 800-554-6001.

JUNE 25. Hedging With Financial Futures in the Insurance Industry program in New York, sponsored by Peat Marwick Mitchell & Co.; $400. Registrar, Peat Marwick Mitchell & Co., Executive Education, 810 Seventh Ave., New York, N.Y. 10019; 800-762-3932.

JUNE 25. Association Captives: How to Maximize Your Operations conference in Washington, D.C.; sponsored by Applied Risk Funding Services and D.J. & Associates; $250. Eileen Callahan, conference director, Tillinghast, Nelson & Warren Inc., 722 Post Road, Darien, Conn. 06820; 203-655-9791.

JUNE 25. Employee Assistance Programs and Human Services seminar in Philadelphia, sponsored by Penjerdel Employee Benefits Assn.; $35 for PEBA members; $50 for non-members. Linda Collier, PEBA, Suite 1830, 1346 Chestnut St., Philadelphia, Pa. 19107; 215-545-1234

JUNE 29-JULY 2. Third Annual International Conference on Insurance Taxation in London, sponsored by the Hartford Institute on Insurance Taxation; $550. Frances V. Goodman, Director, Continuing Education, Hartford Institute on Insurance Taxation, P.O. Box 845, Avon, Conn. 06001; 203-674-9444.

JUNE 30-JULY 1. Dollars and Sense of Risk Financing and Self-Insurance—Is It the Answer For You? conference in Dallas, sponsored by the Joseph Ivy Co.; $245 for two-day registration; $165 for one-day registration. **Also July 14 in Los Angeles and August 18-14 in Washington, D.C.**, Dubravka Romano, Joseph Ivy Co., P.O. Box 26780, Austin, Texas 78755; 512-451-6275.

JULY 8. Computer-assisted Horsepower seminar in Camp Hill, Pa., sponsored by the National Assn. of Professional Insurance Agents Micro Newtork; $125 for micro-network members; $145 for nonmembers; $30 deduction for each additional registrant from same organization. Micro Network, PIA, 400 N. Washington St., Alexandria, W.Va. 22314; 703-836-9340.

JULY 20-23. 1986 Public Employees Conference in San Diego, sponsored by the International Foundation of Employee Benefit Plans; $450 IFEBP members; $525 for non-members. IFEBP, 18700 W. Bluemound Road, P.O. Box 69, Brookfield, Wis. 53008-0069; 414-786-6700.

JULY 20-25. Eleventh Annual National Wellness Conference in Stevens Point, Wis., sponsored by the National Wellness Institute; $360 for the week; $85 per day; $25 discount for members of the National Wellness Assn. National Wellness Institute, South Hall, University of Wisconsin-Stevens Point Foundation, Stevens Point, Wis. 54481.

JULY 23-24. 1986 National Workers' Compensation Seminar in Hyannis, Mass., sponsored by Workers Compensation Monthly; $195. WCM, P.O. Box 829, East Falmouth, Mass. 02536; 617-548-7023.

JULY 28-AUG. 1. Loss Control Management seminar in Atlanta, sponsored by the International Loss Control Institute; $695. International Loss Control Institute, P.O. Box 345, Loganville, Ga. 30249,800-554-6001.

AUG. 3-6. Corporate Benefits Management conference in Monterey, Calif. sponsored by the International Foundation of Employee Benefit Plans; $530 for members; $605 for non-members; International Foundation of Employee Benefit Plans, 18700 Bluemound Road, P.O. Box 60, Brookfield, Wis. 53008-0069; 414-786-6700.

AUG. 3-8. The Basic Course in Reinsurance in Tarrytown, N.Y., sponsored by the College of Insurance; $895 for college sponsors; $1,050 for non-sponsors. Ronnie Kranis, The College of Insurance, One Insurance Plaza, 101 Murray St., New York, N.Y. 10007; 212-962-4111.

AUG. 4-5. Employee Benefit Communications: A Changing Environment Offers New Choices conference in New York, sponsored by *Business Insurance*; $625; 10% discount to additional registrants from the same organization. Ann Vazquez, Registrar, *BI*, 220 E. 42nd St., New York, N.Y. 10017; 212-210-0137.

AUG. 7-8. Governmental Insurance Conference in Austin, Texas, sponsored by the Professional Development Institute; $245. Professional Development Institute, North Texas State University, P.O. Box 13288, Denton, Texas 76203-3288; 817-565-2483.

AUG. 8. Hazardous Waste Management for Small Generators course in Los Angeles, sponsored by the Institute of Safety and Systems Management, University of Southern California; $135. Institute of Safety and Systems Management, University of Southern California, Office of Extension and In-service Programs, 3500 S. Figueroa St., Suite 102, Los Angeles, Calif. 90007; 213-743-6523

AUG. 11-15. Hazardous Materials: Handling & Disposal course in Los Angeles, sponsored by the Institute of Safety and Systems Management, University of Southern California; $700. Institute of Safety and Systems Management, University of Southern California, Office of Extension and In-service Programs, 3500 S. Figueroa St., Suite 102, Los Angeles, Calif. 90007; 213-743-6523

AUG. 14-15. Joint Florida Risk & Insurance Management Society Conference in Palm Beach, Fla.; $35; $50 for registering at the door. James Taglia, Tampa Electric, P.O. Box 111, Tampa, Fla. 33601; 813-228-4111.

AUG. 18-19. Application of Microcomputers to Occupational Health & Safety course in Los Angeles, sponsored by Institute of Safety and Systems Management, University of Southern California; $375. Institute of Safety and Systems Management, University of Southern California, Office of Extension and In-service Programs, 3500 S. Figueroa St., Suite 102, Los Angeles, Calif. 90007; 213-743-6523

AUG. 22. MCA: Managing and Controlling Asbestos Contamination/Exposure course in Los Angeles, sponsored by Institute of Safety and Systems Management, University of Southern California; $150. Institute of Safety and Systems Management, University of Southern California, Office of Extension and In-service Programs, 3500 S. Figueroa St., Suite 102, Los Angeles, Calif. 90007; 213-743-6523

AUG. 24-27. Benefit Communication Institute in Atlantic City, N.J., sponsored by the International Foundation of Employee Benefit Plans; $450 for members; $525 for nonmembers. IFEBP, 18700 Bluemound Road, P.O. Box 69, Brookfield, Wis. 53008-0069; 414-786-6700.

AUG. 25-27. Industrial Hygiene Sampling Strategies course in Los Angeles, sponsored by Institute of Safety and Systems Management, University of Southern California; $450. Institute of Safety and Systems Management, University of Southern California, Office of Extension and In-service Programs, 3500 S. Figueroa St., Suite 102, Los Angeles, Calif. 90007; 213-743-6523

SEPT. 2-5. Reinsurance Accounting & Finance for Cedents & Assumers in Ossining, N.Y., sponsored by Robert W. Strain Seminars Inc.; $1,295. Strain Seminars Inc., P.O. Box 1000, Wingdale, N.Y. 12594; 212-677-5974 on Monday-Wednesday; 914-832-9384 on Thursday and Friday.

SEPT. 8-12. Fundamentals of Industrial Hygiene Monitoring course in Long Grove, Ill., sponsored by National Loss Control Service Corp.; $500. John Garis, NATLSCO, K-3, Long Grove, Ill. 60049-0075; 312-540-2026; 800-323-9585 (outside Illinois).

OCT. 19-22. Asia/Pacific Conference in Singapore, sponsored by the Risk & Insurance Management Society Inc.; $500. RIMS, Conference Department, 205 E. 42nd St., New York, 10017; 212-286-9292.

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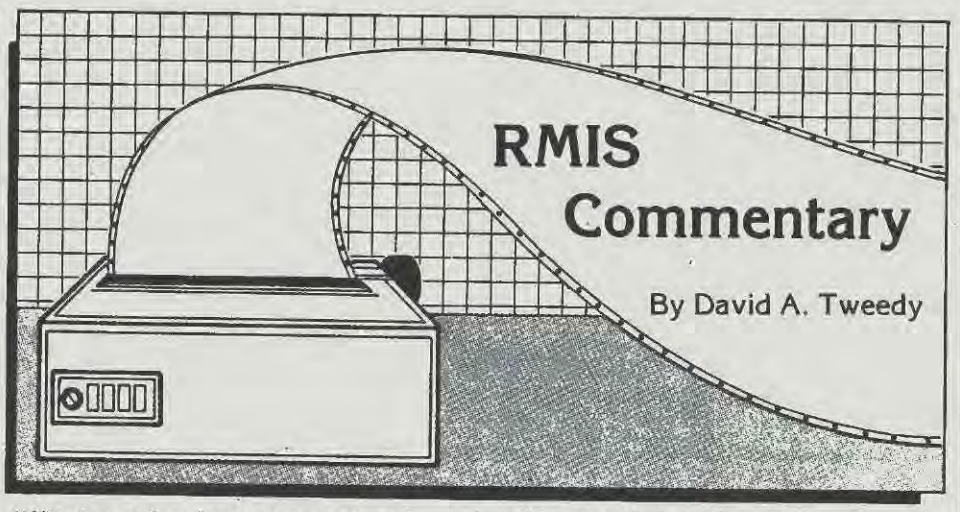
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BIDDING ON AN RMIS

After determining need, risk manager should get estimates



TWO MONTHS AGO, we discussed development of users' specifications as the final step in the needs identification process leading to the purchase and installation of a risk management information system (*BI*, April 21). Next, the risk manager must present these needs and specifications to several bidders before the actual system selection can be made.

A good request for proposal, a subject on which we touched upon briefly in the earlier column, is quite important in the system selection process.

Essentially, a good RFP will help to differentiate among risk management information system vendors that are not really qualified—either from technical or service vantage points—to handle your system needs. Also, the risk manager would not want to relax his or her efforts at this point after going through the exhaustive needs determination and specifications development sections that we outlined in columns earlier this year (*BI*, Jan. 20).

A poorly designed RFP will mislead the bidders and cause an unwanted—and expensive—breakdown in the system selection process.

How does one devise a good request for proposal? There are really no standard formats; RFPs will vary depending on the particular situation. But no matter what, an RFP should present, clearly and definitively, what the risk manager wants in a system.

The RFP sets the proper direction and emphasis for bidders. It is meant to modify and emphasize—or de-emphasize—parts of the specifications.

For smaller systems, such as for an in-house or personal computer-based system, the RFP may include the specifications, combining the general guidance and overall concepts. The specifications will be attached to the RFP to provide the details.

Generally, an effective request for proposal should include the following:

• **Clearly stated objectives.** Above all, the RFP is meant to instruct the RMIS vendors on what is desired by the organization.

To accomplish this end, the objectives must be clearly stated in the beginning of the RFP to prevent the vendor from following up on less significant points in the specifications. The RFP also should indicate the amount of time the vendor spends detailing how the proposed systems can respond to the stated objectives. The specifications, if done properly, will provide exact details.

Without this clarity, it would be difficult to select from among several proposals because each vendor may have its own interpretation of a loosely defined RFP.

• **Vendor credentials.** To gauge the vendor's capability to provide systems and services to clients, the following criteria are worth considering:

1. Hardware requirements. For the purposes of the RFP, the vendor should comment on the type of hardware it utilizes, whether or not it sells hardware and whether there is a possibility of a link-up between client and vendor.

Another good question is if a vendor can take data from a variety of different hardware sources and input that data into its own hardware environment. If so, is there a charge for this, or is it included in the basic contract price? Your specifications package should comment on this detail as well.

2. Documentation. This should be the basic request of any RFP. Solid documentation on the system's structures, codes and regular updates provides a good foundation for the client to begin to understand how to use the new system. Also, it provides a good test of the vendor's capabilities.

At past Risk & Insurance Management Society conferences, several new system vendors have had terrible documentation (or no documentation), which should immediately create suspicion in the minds of any potential buyers.

3. References. A very important consideration is the vendor's references from similar projects and clients.

The risk manager will want to speak with each of these references to determine the nature of the system's reliability and servicing abilities. It would be even better if the potential buyer could speak to a number of former users serviced by this potential vendor to get a feel for what might be wrong with the system.

• **Implementation.** How the system will be installed and brought up. Items to be included in the RFP dealing with implementation include:

1. System installation time. The RFP should request specific information on the length of time needed to fully implement the system. You must be clear in identifying your time frame for getting the system fully operational.

2. Personnel training. Depending on the complexity of the RMIS, personnel training costs and time are critical factors. You should ask for a clear statement of initial training costs for the persons in your department who will need to know how this system operates. Also, information on availability and cost of regular update training seminars should be requested.

Some of the questions normally asked pertaining to personnel training are: Where does the training take place? Is there a training manual? How often is it updated? Is there a contact person at the vendor if something goes wrong?

• **Management issues.** The important considerations include:

1. Confidentiality agreement. Because so much of the information contained in your system may be sensitive, you should expect a confidentiality agreement between the vendor and you. This, obviously, is essential if the vendor is managing your system and handling the claims and personnel data on your behalf. It is also true if there are any taped conversions performed by the vendor.

A reputable vendor will have no problem in signing this confidentiality agreement. If a vendor objects, you should wonder about the quality and professionalism of that vendor.

2. Servicing. The implementation section touched on this element. Yet, it is important as an ongoing concern. After all, you have not only invested in an RMIS, but a service provider. The system may be only as good as the people backing it up. Systems change over time, new features are added, modifications are made and problems occur.

For these and other related concerns, good solid servicing agreements should be a part of any relationship between a risk manager and an RMIS vendor. This is especially true with a vendor support system, but is true for a stand-alone system as well.

Even a stand-alone system, with most of the responsibility for operations transferred to the risk manager, changes and bugs will occur from time to time. It is recommended that the risk manager have easy access to the original providing vendor for service purposes, if necessary.

• **Price.** Last, but certainly not least in the mind of the RMIS buyer, is the price being charged for the system and related services.

Because each vendor may offer the pricing in different forms—like price per claim added to the system, price per module, price per 1,000 claims, price per hours, time-sharing, etc.—the risk manager is advised to clearly delineate how he or she would like the price quoted.

For instance, a good method is to devise a bid tabulation sheet identifying how you would like the quote to be made. You may desire to have a price per 100 claims added to the data base, or as broad as a price per monthly usage of the system.

Obviously, for stand-alone systems, the pricing methodology is simpler in that you can ask for a price per module (like a claims administration module) and a yearly servicing fee estimate.

The important point is to aid the bidder in conforming to your pricing structure so that you may be able to compare the proposals on an equal basis.

To summarize, a well-designed request for proposal will assist vendors in properly interpreting the specification and providing the type of proposal sought by the risk manager.

Although there are no set standards for a request for proposal, it should be structured with clear objectives, concise questions concerning the vendor's qualifications, description of training and servicing abilities and system documentation.

In addition, references with situations and needs similar to yours, as well as a confidentiality agreement, should be standard requests in the RFP. Pricing structure should be as similar as possible to ease the risk manager in decision making.

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



The information system selection process continues. . .

RMIS Commentary, *Business Insurance's* monthly column devoted to risk management information systems, has recently focused on the steps that should be taken by risk management professionals who are contemplating acquiring an RMIS. For the benefit of those wishing to follow all steps in the design and implementaion of an RMIS, issue dates and subject matter are listed below:

• Jan. 20. Needs determination. This article outlines steps to be taken to determine whether the system will be simply a luxury or an actual benefit to risk management.

• Feb. 24. Cost/benefit analysis. This article tells what is required to justify expense of an RMIS to senior management.

• March 17. Consultant selection. This article explains how to determine whether a consultant can assist with technology and applicability questions. It also gives suggestions on how to select an RMIS consultant.

• April 21. Specifications. This article identifies RMIS requirements in order to develop the system's specifications.

perspective



Help workers beat substance abuse

By Loretta G. Wiedrich

FORM A MENTAL PICTURE of an alcohol or drug abuser. Do you see an image of skid row bums leading useless lives in a stoned stupor, bothering no one except themselves—degenerate vagrants who spend their days drinking, using drugs and sleeping off their hangovers?

That stereotype is almost completely false. A large majority of alcoholics and other drug abusers are employed—97% are in the workforce. Their disease—the third-biggest health problem in the nation—not only robs them of their own health but also costs U.S. industry plenty, with estimates ranging as high as $120 billion each year.

Much of that is in workers compensation claims: One-third to two-fifths of all accidents that happen at work are alcohol-related.

This multibillion-dollar loss—which also is caused by absenteeism, illness, lost productivity and theft—should not be accepted as an unfortunate expense over which management has no control. Alcoholism and other drug dependencies are treatable diseases.

The typical drug user is late to work three times more often than the average employee, leaves early twice as often, uses sick leave three times as much, files workers compensation claims five times more often and has accidents almost four times as often.

The drug abused may be as commmon as wine, beer and other liquor. Narcotics, such as heroin, cocaine and marijuana, also are affecting workers, as are barbituates, amphetamines and tranquilizers. Each of these drugs may be taken alone, but poly-drug use is increasing, making the problem more severe.

Insurers can help employers fight this battle. For example, the Kemper Group's loss-control department offers a presentation to its workers compensation clients that alerts them to the problem of substance dependency in the workplace and assists management to help employees with the disease. All companies need to watch for such behavior. No company is immune.

Consider this example: A staff nurse at an industrial company reports several employees on the second shift of an assembly line are coming to work obviously drunk. Some are even bringing alcohol to work with them. The problem has become so noticeable that top management has told her to do something about it.

My advice: Top management must take a stand and, of course, put a ban on bringing liquor to work. Then, the company must develop a corporatewide policy concerning employees who have a problem with drugs.

One component of such a policy, employee assistance programs, are gaining wide recognition as effective tools for helping employees deal with all types of personal problems that affect their job performance. At latest count, there are more than 5,000 EAPs in the country with new ones forming every day.

There are a number of options we suggest when talking to a company about setting up an EAP:

- Using an interested employee to act as a referral person to Alcoholics Anonymous or other support groups.
- Providing a structured program within the company that refers troubled employees to appropriate community services and programs.
- Contracting with an outside vendor to provide EAP services. This agency, which may be an individual or a group operating independently or in affiliation with another organization, may offer any service the company desires, from counseling and recommending hospitalization to a "broad brush" approach covering all types of living problems. Contract agencies are usually the most costly of the options, as they often assess a specific dollar amount per employee.

When choosing an EAP, management should consider size, location and demographic characteristics of its employee population. A company often has a good idea of how serious the problem of drug and alcohol abuse is among its employees. But if this is not the case, management may want to start a small-scale EAP and then enlarge it as the need becomes apparent.

Employers will not see all the benefits of implementing such a program at once. It takes several years for a program to pay off fully. But a company almost immediately will notice a decline in losses related to lowered productivity (see related story).

But, if a company does establish an EAP, it must adhere to a few basic "rules":

- Confidentiality is paramount. Employees who believe the counseling sessions are not private will not use the program in the future and word will travel.
- The person in the organization who is meeting with the substance abusers should not have a say about promotions, raises or transfers. The EAP professional should be completely impartial.
- If possible, even the supervisor of the abuser need not know that the employee is meeting with the program specialist—unless that employee wants to offer that information.

This is not to say, however, that the supervisor does not have a part to play in these programs. In fact, at Kemper about one-third of all EAP referrals in 1984 were by supervisors.

EAP personnel can train supervisors to look for signs of impaired physical or mental ability to perform work tasks, unexplained daily absences from the work area, a shift in work patterns, a general change in disposition, frequent mood swings and deterioration of physical appearance.

In a company with an EAP, the supervisor who recognizes the signs of a chemically dependent worker will document the signs of dependency and meet with the company's EAP professional to discuss referral of that employee.

The alcoholic or drug-addicted employee's disease is not only affecting his or her own work, but also that of the worker's entire department. The supervisor who in the past has covered up the dependent worker's disease undoubtedly has felt resentment, as have the co-workers who may have had to work harder to compensate for the abuser's lack of productivity. An EAP can help them recover, too.

The success of an employee assistance program depends in large part on top management. They are responsible for developing a company policy about alcoholism and drug abuse as well as formulating procedures on how to deal with chemically dependent workers. They must develop policies on disciplinary procedures, the agencies to which employees will be referred and how a relapsed employee will be treated.

These policies should be spelled out in a statement on substance abuse, and they must be fully supported and enforced.

Loretta F. Wiedrich, R.N., is a senior staff occupational health consultant in Kemper Group's loss-control department in Long Grove, Ill.

speaking out

EAP helps thousands

In 1962, Kemper Group Chairman James S. Kemper Jr., himself a recovering alcoholic, founded Kemper's Personal Assistance Program.

Since its inception, more than 3,000 Kemper employees have received assistance for substance abuse and other living problems through the program and over 2,250 managers and supervisors have consulted with the program staff to resolve employee job problems. Studies show that employees with such living problems cost a company roughly 25% of its annual salary in lost productivity.

Based on this, a recent seven-year analysis of Kemper's personal assistance program showed that comparing the $8.8 million in restored employee productivity to the $70,000 program expenses demonstrated a better than 12-to-1 cost ratio.

insurer topics

A special editorial section sent exclusively to insurers and reinsurers

On-line investing

Portfolio managers agree: Computers help answer 'What if?'

By AVRA WING

Insurance company portfolio management is going on-line.

Insurers that use computer software and financial research data bases to manage their portfolios say they are making rapid, beneficial decisions about buying and selling fixed-income securities.

These insurers began their pioneering efforts two to four years ago and today are still adding to their systems. They are constantly reviewing the financial software and service offerings and looking for ways to better integrate their existing networks.

By using stand-alone software, which runs on mainframe and personal computers, and financial research data bases, insurers say they reap two key advantages:

- Immediate access to a vast, complex universe of constantly changing financial information.
- The ability to reformulate that information in various ways to optimize it for their particular needs.

Insurers, armed with up-to-date pricing, can perfom elaborate "what if" manipulations of data on personal computers by plugging in a range of variable situations. For example, they can plot comparative performance of bonds screened for certain characteristics to determine which would be the better investment.

Several programs even offer the capability of outputting holdings information in a format identical to Schedule D of an insurance company annual statement.

Before insurers turned to computerized systems, portfolio management was done "by hand," pointed out John Ingram, second vp-securities for Jefferson-Pilot Investments Inc., a unit of Jefferson-Pilot Corp. in Greensboro, N.C. "And we struggled."

At Metropolitan Life Insurance Co. in New York, the on-line system has allowed those on the investment staff to "control their own destinies," commented Gladys Villalobos, assistant vp for corporate investments/systems.

With electronic management, "We have control over the decision-making process," explained David Gardner, executive vp of Meridian Asset Advisors Inc., a subsidiary of Meridian Mutual Insurance Co. in Indianapolis: "We have the maturity and judgment to make decisions. We don't want to have to wait to make decisions."

At The Home Insurance Co. in New York, Steve Wilson, director of equity research and president of Home Capital Services, said a computerized system allows the company to "speed through tons of statistics and boil them down into useful information. Our research is more thorough and more timely.

"We are able to screen potential, attractive companies and screen out for certain variables which we were unable to do before," he said.

And at the Hartford Insurance Group, Daniel Sullivan, director of investment systems, commented that the insurer's portfolio managers "wouldn't care if they never saw a printed report, as long as they can call up (the information) on their screens."

Insurers are using the software primarily to access bond information, and to a lesser extent equity data, according to Andrew Hyde, founder of Financial Data Services in San Francisco, a financial consultant to the insurance industry.

"Bonds are the hardest area to get information on," Mr. Hyde noted.

Insurers need technical analysis support in order to chart prices and screen securities as well as fundamental analyses to project stock values, Mr. Hyde said.

Although there are relatively few software programs specifically produced for insurance companies, most surveyed found the available offerings provided them with extensive, real-time information on bonds and other securities and the capability of translating that data into considered investment decisions.

Those companies that considered the off-the-shelf products insufficient to satisfy their needs have developed proprietary programs.

The costs for computer-based portfolio management vary, depending upon the software chosen, the number of financial data bases—called timesharing services—being tapped, the type of hardware chosen, the number of systems being used and the size of the investment staff.

While insurers are using different programs and services, the vendor of choice for the hardware is clearly International Business Machines Corp. in Armonk, N.Y. In fact, a 1985 survey of property and casualty underwriters conducted by the National Assn. of Independent Insurers indicated IBM equipment was used by 80% of the participating firms for all their data processing needs.

Those interviewed for this report most often cited the IBM PC AT, which has 512KB of random access memory, a 30MB hard disk drive and is priced in the $4,500 range, as the system they have installed. The various personal computer software packages insurers are using are tailored to run on the PC AT or compatibles.

Even with assets in the billions and issues in the thousands to manage, a company's investment department would need only one AT plugged into the insurer's mainframe, along with several PCs, tagged at approximately $1,600 with 256K RAM and a 10 MB hard disk, or dumb terminals, to be effective.

Other necessary equipment would include, for example, a Princeton HX12E high-resolution monitor for about $600, a Hayes 2400 modem costing approximately $700, and an Epson LQ1500 printer priced in the $1,400 range.

Guardian Life Insurance Co. of America in New York depends on a single AT to monitor information on $3 billion in assets held in 1,300 different issues, including 900 bonds, according to Alex Grant, technical coordinator of securities investments. Six personal computers are used by the company's traders to make transactions, and the firm's mainframe runs the Securities Management System produced by Policy Management Systems Corp. in Dallas.

The program, which can format data into a Schedule D,

Continued on next page

Taxable trend

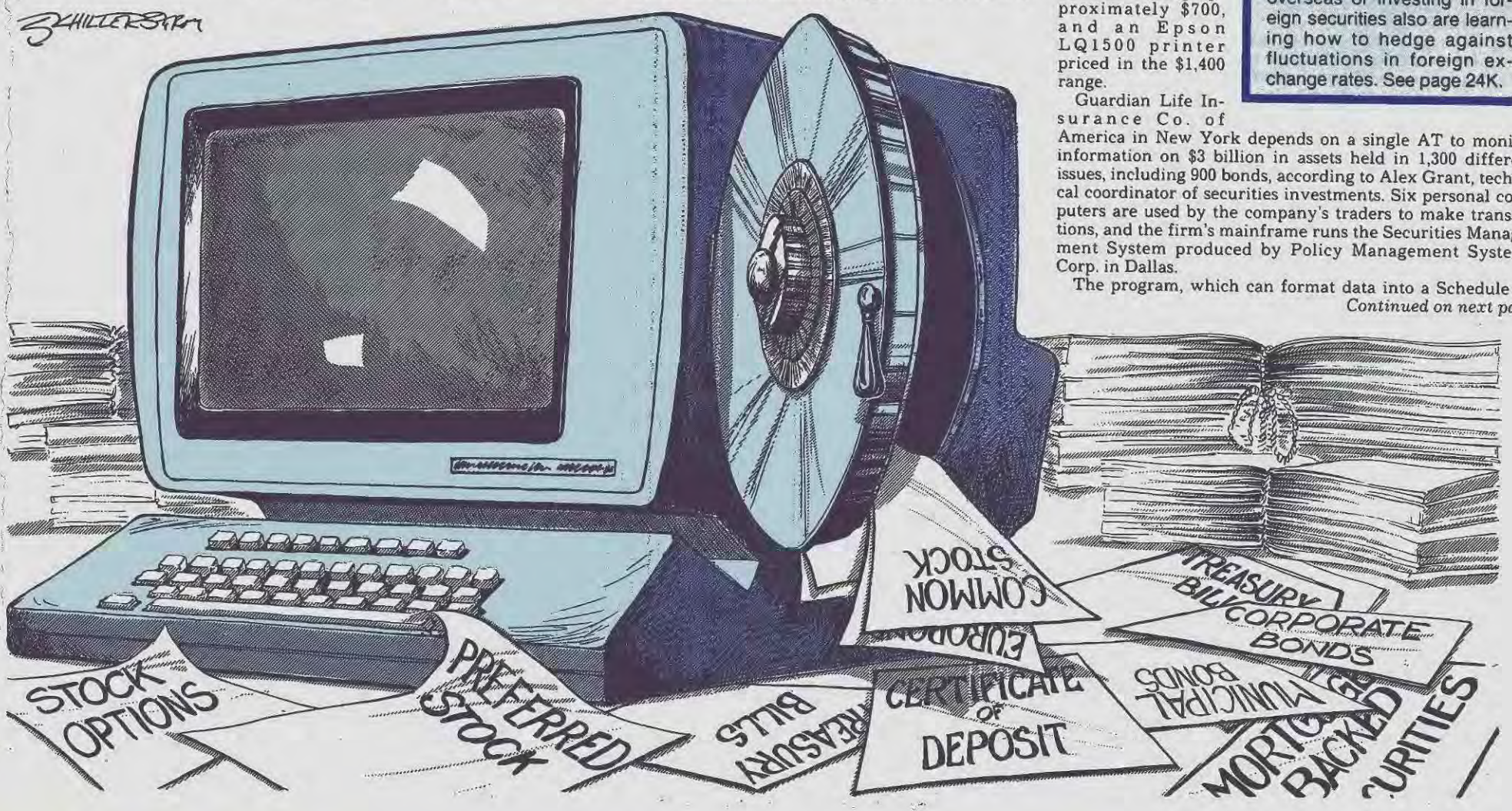
Despite property/casualty insurers' recent surge in profitability, the companies' investment portfolios are still focused on taxable investments because of tax losses carried forward from more competitive times. See page 24D.

The 'match game'

Life insurance companies, battered by soaring interest rates during the 1970s and early '80s, are now turning to shorter-term instruments to better match their investments with the liabilities they face. See page 24H.

Foreign exchange

Avoiding foreign exchange losses when claims are due is easy. But, insurers operating overseas or investing in foreign securities also are learning how to hedge against fluctuations in foreign exchange rates. See page 24K.



Investment systems

Continued from previous page

provides information on all types of securities, performs portfolio management and accounting functions, interfaces with several pricing services and can be downloaded to a PC for modeling and "what if" manipulations of the data, according to Lee Lowry, a marketer for Policy Management System. Monthly licensing fees for the program vary, according to PMSC.

Mr. Grant, originally called in by Guardian as a consultant, set up the insurer's system about two years ago, and then stayed on in a full-time capacity. Before he came to Guardian, the insurer was depending more heavily on the mainframe, which then was more accounting- rather than trading-oriented, he said.

"The idea is to have information there when you need it," he noted. "The mainframe is always two weeks behind—providing information as of settlement date—while the PC gives it as of trade date. Even if the security hasn't settled, we own it. With just the mainframe, we may not know what we actually own."

On the AT, Guardian uses several modules of the Financial Software Series by Technical Data Corp. in Boston, which initially cost $8,000. The insurer also pays yearly maintenance costs, which, according to TDC, are 20% of the purchase price.

TDC's program, via its Report Writer function, also provides Schedule D writing capability.

TDC's software accomodates government, agency, corporate and municipal securities; money market and discount securities; domestic term certificates of deposit, Eurobonds and Euro CDs; odd first coupon securities; mortgage-backed pass-through securities; sinking funds and private placements; and floating rate securities.

In addition, it will handle common and preferred stock, futures and options and foreign securities.

The series includes: The Fixed Income Portfolio Manager (with Report Writer) for $5,500; The Bond Swap Analyzer, $1,700; The Mortgage Calculator, $1,500; The Rate of Return Analyzer, $2,500; The Yield Calculator, $375; The Performance Evaluator, $1,000; The Cash Flow Projector, $500; and Confirmations, $1,500.

Also offered are several timesharing hookins: Interactive Data Corp. Interface, $250; Bond Buyer/ Lloyd Bush Interface, $1,000; and Kenny Information Systems Interface, $1,000.

Met Life's system allows the investement staff to 'control their own destinies,' says Ms. Villalobos.

The series enables the user to store necessary information on securities, maintain portfolio positions, analyze the portfolio, perform yield and mortgage calculations, analyze bond swap profitability and measure the impact of interest rates on various holdings.

Guardian's investment department is also running Lotus 1-2-3, from Lotus Corp. in Cambridge, Mass., on six PCs in conjunction with TDC's package, at a one-time cost of $350 per system, Mr. Grant said.

As a mutual company, Guardian was "not trying to take too many gains. In fact, we want to take some hits," he said, explaining that for tax reasons the company does want some losses.

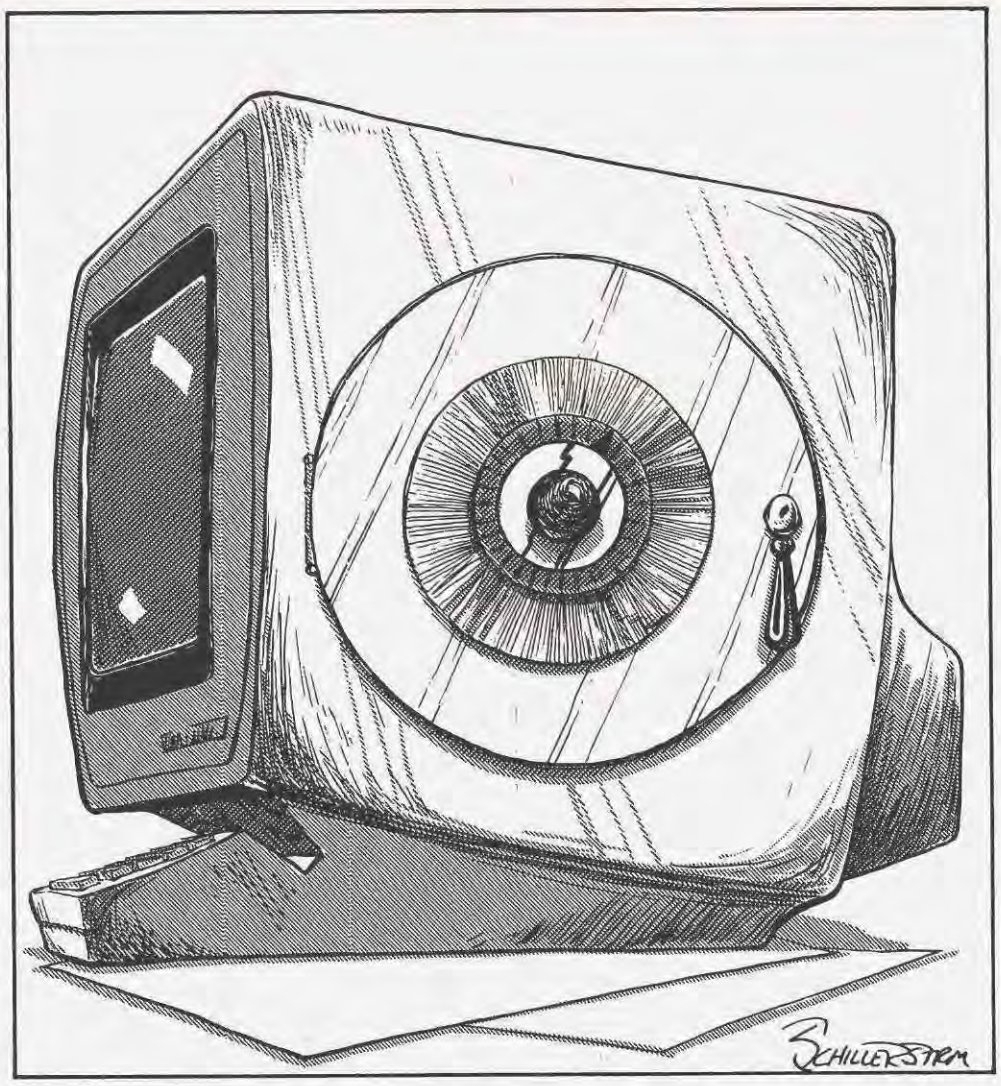
"We need to know unit costs as well as market value. The combination of TDC and Lotus shows us the loss possibilities," Mr. Grant noted.

One problem he is encountering, however, is that the PCs cannot directly access the TDC program.

The insurer also uses BondScholar from Investek Inc. in Jackson, Miss., a progam which was originally designed for insurance companies, according to Investek Vp Carolyn Raines.

The program's features include a modeling capability to incorporate the insurer's own tax rates and to calculate aftertax yield, average life, compound rate of return, future value and par bond equivalent. BondScholar is able to monitor sinkers, Ms. Raines noted.

Cost of the package is $1,995; four additional modules, at $500 each, are also available. These include a bond swap analyzer, a mortgage pool speed-of-payment calculator, a portfolio evaluator and a reinvestment module.



Metropolitan Life has a nationwide network of more than 200 IBM PCs, ATs and XTs tied into two mainframes for managing about $76.5 billion in assets, says Michael Ehrenzweig, assistant vp for investment information and securities administration.

Using IBM equipment almost exclusively, over the last four years Metropolitan's investment department has developed proprietary programs to integrate data bases, accounting functions and management operations.

One such program computes internal rate of return; another, dubbed "bond rollover," is a refinancing package, Ms. Villalobos explained.

Currently, the company is involved in customizing an IBM mainframe query language, SQL, and training Metropolitan's investment department staff to use the language, according to both Mr. Ehrenzweig and Ms. Villalobos.

The goal is to have a "single-access vehicle" that each person can use to make direct, detailed, tailored queries about securities and obtain information within a half-hour, Mr. Ehrenzweig said.

Without such a system, producing a report can take weeks or months, he added. That is an ineffective way of conducting business, Ms. Villalobos noted, considering the volatility of the stock and bond markets. "You need information instantaneously," she commented.

On the mainframe, Metropolitan's investment department also uses another IBM language, PROFS, as a central communications program. Users accessing through PROFS are presented with a menu of options from which to chose. For example, financial research data bases from both Compustat, a data tape service of Standard & Poor's Corp., and The Dun & Bradstreet Corp. can be tapped through PROFS.

At the PC level, Metropolitan uses a number of off-the-shelf programs in addition to its internally developed software. These include Microscan from Lotus, used for equity screening, and TDC's full series. The TDC program runs on a single AT and has been customized for the insurer, Ms. Villalobos noted.

Metropolitan chose the TDC program beacuse it can handle "large populations of issues"—up to 4,000, Ms. Villalobos said. Even this, however, is not large enough for Metropolitan's portfolio of more than 10,000 issues, she noted. The company manages $42 billion in bonds.

The insurer pays tens of thousands in a combination of soft and hard dollars yearly for software purchases, maintenance and development, but, proportionate to the size of the portfolio, software represents one of Metropolitan's lowest costs for managing its assets, Mr. Ehrenzweig noted.

Foremost Insurance Co. in Grand Rapids, Mich., equipped with an IBM PC and Hayes modem, is tied into financial information services offered by Dow Jones & Co. and E.F. Hutton & Co. Inc., according to Donald Welch, investment officer.

Both services provide current and historical stock quotes, financial information on individual companies and financial news among other data, which are downloaded to the Lotus 1-2-3.

Mr. Welch estimated that Foremost's monthly timesharing costs are $200. Timesharing services usually charge by the minute, but, as Mr. Welch points out, "You can get a lot of information in a minute."

Still, he feels the need to upgrade Foremost's current system of managing its $550 million portfolio, which was set up four years ago. Mr. Welch is currently considering adding the timesharing service offered by Kenny Information Systems in New York, which would provide information on municipal bonds.

Kenny's Munibase, for a monthly subscription fee of $150 plus a charge of 25 cents per request, provides "complete descriptions" of all available municipal bonds, according to Guy Hubbard, assistant vp for the municipal bond broker.

Hartford's portfolio managers 'wouldn't care if they never saw a printed report,' Mr. Sullivan says.

Foremost also is looking at the Investment Portfolio Accounting system from Interactive Planning Systems in Atlanta, Mr. Welch said. The package, which costs $2,000 plus $400 yearly, provides data on state, county, municipal and Treasury bonds.

At Meridian Mutual, Mr. Gardner's unit is equipped with ATs linked via an IBM S/36 to a mainframe. Meridian subscribes to the Research Portable, a timesharing service from Goldman, Sachs & Co. in New York, to research and screen securities.

The service is free to clients of Goldman Sachs, but users are charged $22.50 an hour by Compuserve, into which the Research Portable taps. It provides investment research data on 700 companies as well as an index of options and futures.

The service is geared more toward equity markets rather than fixed-income securities, according to Frederick Litt, vp and coordinator of Goldman Sachs' electronic research services.

Meridian also has generated its own software integrating management and spreadsheet functions.

Mr. Gardner is looking to upgrade Meridian's system, and is evaluating TDC's Financial Software Series, PMSC's securities management program and The Professional Portfolio by Advent Software in Boston.

The Advent program, which costs $5,200 plus a yearly maintenance charge of $600, is a portfolio management system which is geared toward handling bonds and cash positions. A streamlined version is available for $1,750 with a $250 annual upkeep.

The Chubb Group in New York, uses a combination of IBM PCs and XTs, according to Tony Gleason, investment systems consultant. (The XT 20 Meg with 512K RAM retails for about $3,000.)

Chubb screens securities through DAIS (Decision Analysis Investment Systems) offered by Drexel Burnham Lambert in New York.

DAIS offers a combination of fundamental and technical analyses plus earnings estimates, according to Robert Butman, vp for quantitative research at Drexel Burnham. There is no monthly or per-use charge to institutional clients of the firm, but there is an annual fee based on a fixed designation of soft dollars, ranging from $10,000 to $50,000, Mr. Butman said.

In addition, Chubb has used Lotus 1-2-3 to develop its own templates to track earnings estimates and fundamental data on companies, Mr. Gleason noted. About a dozen templates a year are generated, which Mr. Gleason said take half a man-year each to develop.

Mr. Wilson at Home Insurance is in charge of a six-person department which manages Home's $3.7 billion portfolio on four systems —two ATs and two XTs.

Starting in late 1983, when the investment unit went on-line, Home has been developing a proprietary database for screening securities, Mr. Wilson said.

"We have a very focused equity investment style," he explained, which emphasizes companies' "historic numbers over the last five years. We look broadly at a range of price variables and return measures. We have a returns formula we use."

Although Mr. Wilson said that he constantly reviews offerings from software vendors, The Home has so far preferred its internally developed program because using an outside source means "having to conform to (someone else's) definitions of variables."

He does use, however, the Nexus database from Mead Data in Dayton, Ohio, as well as the news retrieval and current quote service from Quotron.

At Jefferson-Pilot, Mr. Ingram's three-person department depends on Technical Data's Financial Software Series, which it runs on a single PC, to manage three portfolios of fixed-income securities worth a total of $1.4 billion.

Jefferson-Pilot set up its system two years ago, and Mr. Ingram said he is satisfied with its performance.

The "driving force" in choosing the TDC package was the "flexibility of writing reports" which it offered, Mr. Ingram pointed out.

Once the insurer had implemented the report writer function, he explained, it went on to use the other capabilities, and currently depends most heavily on the bond swap analyzer and mortgage calculator.

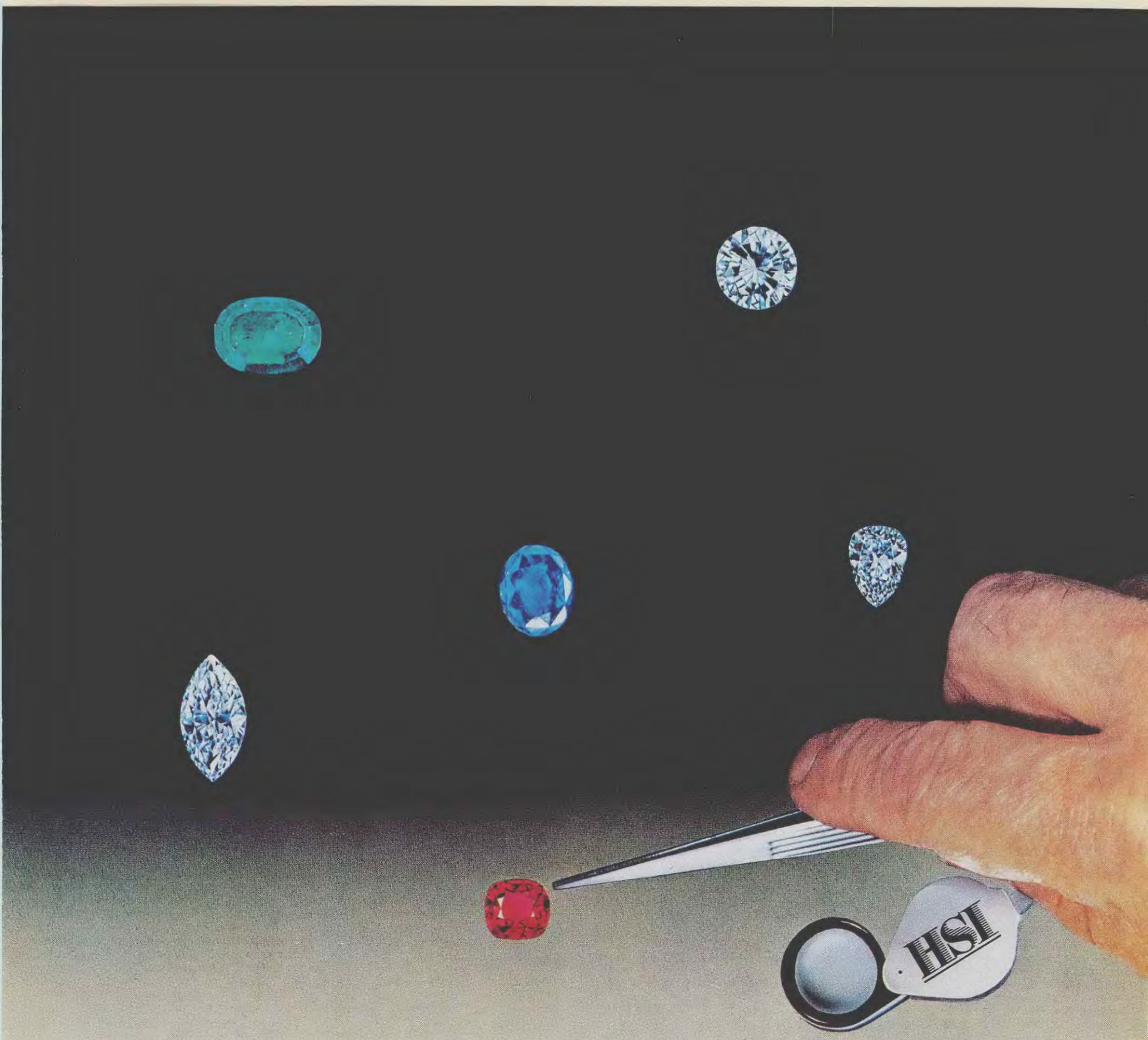
At The Hartford, Mr. Sullivan said the company is in the process of testing a new system which will integrate its investment management and accounting functions. Intellimation Systems Inc. of Connecticut advised the insurer on how to set up that system.

The insurer plans to use its existing 15 to 20 ITT Corp. microcomputers to access either Control Data Corp.'s Investment Management Information System (IMIS) or an internally generated program to run on either an IBM 4300 series or the Wang Laboratories Inc. VS100 series system.

The systems are priced at about $400,000 each, Mr. Sullivan noted.

With the new system, he added, his department "has not had to say no to any request" for manipulating data from the portfolio managers.

Hartford's investment staff of 30, managing a portfolio of approximately $10 billion, currently uses the Oscars program from Information Systems of America in Atlanta, along with Connecticut-based Interactive Data Corp.'s Xport program. ■



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USF&G's plan

Continued from previous page

come in 1984, which is reflected in its operating income.

Another item included in the restatement involved $8.7 million the company posted in reduced income tax expense in 1984 as a result of the sale and leaseback of its headquarters building. It was determined this tax expense should not have been taken, and USF&G's 1984 operating income was reduced by this amount.

Also eliminated was $8.9 million in net realized gains the company recorded by establishing positions in equity securities and purchasing and selling other positions in the same securities on the same day. These should have been recorded as unrealized rather than realized gains, according to USF&G's 10-K.

USF&G also reclassified $81 million in dividend income from operating income to realized gains. As a result, while USF&G's operating income was reduced, no direct impact on its net income was reported.

USF&G's strategy was to sell securities shortly before the ex-dividend dates, but with a delayed settlement provision that reduced USF&G's proceeds from the sale by an amount equivalent to the dividend payable.

The $81 million amount reflects USF&G's sale of equity securities shortly before their ex-dividend dates. The ex-dividend period is the span of time during which investors who buy a stock are not entitled to a dividend.

Paul W. Schlough, director of investor relations for USF&G, explained that, for instance, if a dividend is payable June 25 to shareholders of record June 6, the stock becomes ex-dividend May 30. The ex-dividend period starts a week earlier because of the paperwork involved in a stock sale.

Usually, a stock's price moves up by the amount of the dividend as the ex-dividend date approaches, then falls by the amount of the dividend after that date, since buyers of a stock during the period will not have the benefit of receiving the dividend.

For instance, Mr. Schlough said as an oversimplified example, a company announces it will pay a 50-cent dividend and its stock closes on May 29 at $35. On May 30 the stock will sell "ex" at $34.50.

Shareholders as of May 29 will receive the 50-cent dividend. If a stockholder sells the stock on June 2 or 3 at $34.50, he would still receive the dividend, though it is not payable until June 25.

USF&G's strategy was to sell securities shortly before the ex-dividend dates, but with a delayed settlement provision that reduced USF&G's proceeds from the sale by an amount equivalent to the dividend payable.

In this way, a portion of the company's proceeds from the sale would be dividend income, which was advantageous to USF&G from a tax-shelter basis, Mr. Raley explained.

Mr. Schlough pointed out that if a corporation buys a stock and holds it for at least 45 days, it has to pay the full corporate tax rate on only 15% of the dividend.

To take advantage of this shelter, USF&G tried to increase the dividends it collected in any given year by frequently buying and selling stock, Mr. Schlough said.

But he noted that USF&G attempted to sell the stocks during periods when the market was advancing, since the smaller the decline in a stock price during the ex-dividend period, the smaller the capital loss, if any, USF&G would have to report on the sale.

However, because the company in its restatement decided that neither dividend income nor capital losses should have been recorded on these transactions, $81 million was removed from operating income and added to realized gains.

While USF&G still plans to sell stocks to take advantage of dividend payments, Mr. Raley said USF&G does plan to stop using the technique of delayed settlements when arranging the sale of stocks to prevent further accounting problems.

In addition, as a result of the change in accounting procedures, expenses related to the sale of securities by USF&G now are being charged against operating income rather than used to reduce realized gains. A total of $12.4 million in related transaction expenses was removed from operating income for 1984 by the restatement, while $11.2 million was added to realized gains, reducing USF&G net income by $1.2 million.

Mr. Schlough explained that the $1.2 million difference is the result of some additional "minor accounting changes" involving the fact that security transactions were conducted by USF&G through both an internal common stock portfolio and one operated by its subsidiary, the Light Street Income Fund.

The company also reclassified $18.9 million in covered call option income, removing that amount from operating income and adding it to realized gains.

A call option gives the holder the right to buy a stock at a particular price until a specified date.

A covered option is an option contract backed by the shares underlying the option. For instance, if USF&G owned 500 shares of a particular company's stock, it could sell call options in exchange for a premium and be in a covered option position. If the company's stock goes up, and the buyer of the option excercises its right to buy the stock, USF&G has the stock to deliver to the buyer.

The restatement involved options written by the company that were "in-the-money," meaning the stocks' market price exceeded the exercise price.

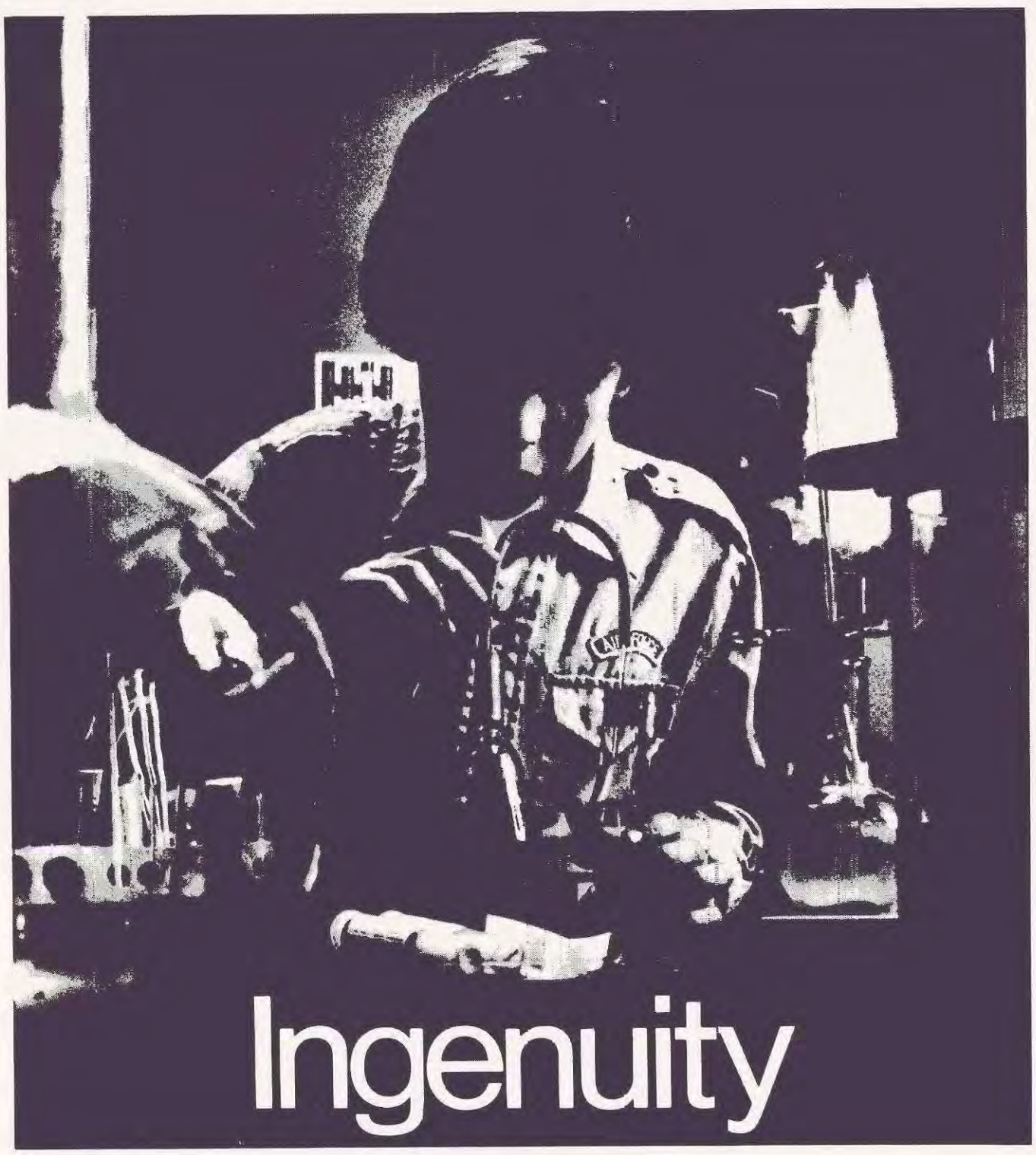
Under the present method, the portion of sum of the option premium and the exercise price that exceeds the market price of the stock on the date the option was written is included in investment income, and the remainder is treated as realized gains.

Previously, the portion of the sum of the option premium and the exercise price that exceeded the price that USF&G paid for the stock—not the price of the stock on the date the option was written—was considered investment income, and the remainder was considered realized gains.

Because the market price of the stock when the option was written was presumably higher than the price USF&G paid for the stock, the effect of this change is to increase realized gains and reduce investment income, USF&G says in the 10-K.

According to Form 8-K filed with the SEC by USF&G on May 7 concerning the change in accountants, the accounting treatment of USF&G's transactions, particularly those involving buying and selling equity securities around the ex-dividend date and writing covered call

Continued on next page



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Continued from previous page

options, "raised difficult and highly judgmental issues."

The company decided to restate its earnings "based upon advice from Coopers & Lybrand," which resulted in "numerous and lengthy deliberations," the filing notes.

However, USF&G states that it "does not consider the foregoing to constitute a disagreement under the reporting requirements" and notes that Coopers & Lybrand had never qualified USF&G's financial statements. A letter sent to the SEC by Coopers & Lybrand says it does not disagree with these statements.

USF&G's put option transactions were not affected by the restatement, Mr. Raley noted.

In a put option transaction, a property/casualty insurer sells municipal bonds to another company for their cost, plus a small premium. The buyer is also given a "put," entitling it to sell the bonds back at a specified price to the insurer after a period of time. The insurer then takes the proceeds of the sale, invests them in taxable instruments and may eventually buy back the municipal bond.

Through put option transactions, insurers were able to switch from municipals, even if their value was down, to taxable instruments without dipping into their policyholder surplus.

USF&G, as well as Aetna Life & Casualty Co., Ohio Casualty Corp. and Hartford Insurance Group have participated in put option deals (*BI*, March 25, 1985; June 17, 1985).

Meanwhile, the complaint filed by shareholder Gaza Kenna names USF&G, Coopers & Lybrand and various USF&G officials, including Jack Mosely, chairman; Paul J. Scheel, executive vp; Charles H. Foelber, a retired vp-administration; and H. Furlong Baldwin, J. Owen Cole, J. Stevenson Peck and George S. Wills, who are directors and members of the board's audit committee.

The suit states the defendants "acting in concert, undertook and carried out a plan and scheme, and engaged in fraudulent and deceitful acts and practices" in failing to reveal USF&G's "true earning results" for 1984 and the first nine months of 1985.

The complaint also notes that the same day USF&G said it would restate its earnings, it also announced it would take a charge of about $100 million for 1985's fourth quarter to strengthen its property/casualty reserves.

"In ignorance of the true facts," the complaint alleges, stockholders bought USF&G stock "at artificially inflated prices and were thereby damaged." The complaint asks for compensatory and punitive damages in addition to court cost.

USF&G's stock, which is traded on the New York Stock Exchange, reached a high of $41.50 in in the fourth quarter of 1985. Last week, the stock was trading between $40.50 and $41.38.

According to USF&G's 10K filing, the lawsuit is not expected to have any "material adverse impact" on the company's finances.

The company had no additional comment, and an attorney for the plaintiff could not be reached for comment.

A USF&G spokeswoman said the company had directors and officers liability coverage, but she could not furnish further details.

Even though the restatement has lowered USF&G's operating results over the past three years, analysts don't anticipate any negative long-term implications for the company.

"They should never have been allowed to do it" in the first place, said Michael A. Lewis, a vp and financial stock analyst with E.F. Hutton in New York, referring to USF&G's original accounting methods. But Mr. Lewis nevertheless believes the situation will not have a significant impact on future earnings.

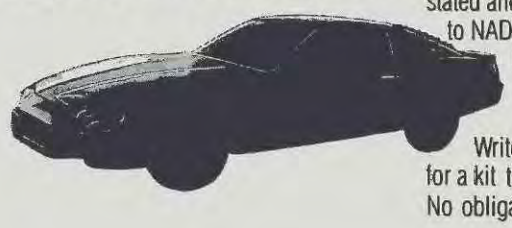
'It's somewhat of a blow to their credibility," says Merrill Lynch's Mr. Wells.

"It's somewhat of a blow to their credibility," observed David P. Wells, an analyst with Merrill Lynch Pierce Fenner & Smith Inc. in New York.

However, he added that it is not expected to have an impact on USF&G's future cash earnings or return on investment.

To a degree, the entire matter was a question of accountants "practicing academics," Mr. Wells said. ■

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Life insurers eye short-term investments

By MICHAEL BRADFORD

Life insurers, which in the last decade have learned the value of "matching" investments with the liabilities created by different life insurance products, are backing away from traditional long-term investments in favor of shorter-term instruments.

"Our investment strategy is product-driven," explained Richard Robertson, executive vp and chief financial officer of Lincoln National Corp. in Fort Wayne, Ind.

"Beginning in 1980, we adjusted our company policy to strive to match the maturities of our assets with our contracts' obligations," Mr. Robertson said. "We restructured our portfolio to accomplish that.

"We had a surplus of long investments," Mr. Robertson observed, noting that since 1980 the insurer has invested almost exclusively in short- to intermediate-term securities. Maturities range from one year up to 10 years, but "more frequently seven years," he said.

According to Mr. Robertson, the Lincoln National portfolio is primarily made up of publicly traded bonds and private placements, investments that he said match well with the new breed of life insurance products like universal life insurance and variable annuities.

"In the last five or six years, our primary focus has been to improve our ability to invest assets in accordance with the benefits in our insurance contracts—matching," Mr. Robertson stressed.

"Prior to 1980, we didn't pay any attention to that. We were going for yield, then."

While life insurers certainly do not overlook investment yields when structuring their portfolios, "the growing theme is matching assets and liabilities," noted Bill Bethke, managing director of the Capital Markets Group of Prudential Investment Corp., a unit of Prudential Insurance Co. of America.

Prudential sees the need for shortening maturities to match with interest-sensitive products like Individual Retirement Account and universal life policies.

"Those types tend to need short-duration assets," said Mr. Bethke, noting that Prudential has increasingly matched the liabilities created by those policies with publicly traded bonds.

Although most life insurers have been actively shortening the maturities of their investments, it is a process that is not accomplished overnight.

"I guess 20 years ago, the average maturity might have been 20 to 25 years," noted Lawrence H. (Jim) Lucey, vp of The Chicago Corp., which manages assets totaling $200 million for small to medium-sized insurers.

And although insurers are putting "new money" into investments with maturities of around 10 years, portfolios are still speckled with long-term investments that have yet to mature, and the average maturity probably remains at around 12 years.

"It's coming down, but it takes time," he said.

Mr. Lucey explained that rising interest rates in the 1970s helped transform life insurers' long-term liabilities into shorter-term obligations, which meant changes in investment strategy.

Before interest rates soared in the '70s, life insurers "had a very stable business," he noted. For example, a whole life policy written for a 30-year-old man would appear to create a liability of around 38 years, the expected life span of the policyholder.

Therefore, the insurer may have counted on on a positive cash flow from premiums for the next 38 years, Mr. Lucey explained.

However, as the policyholder paid premiums, he also built up a cash value in the policy. That meant the policyholder could either surrender the policy for its cash value or borrow against that value at a rate set by the insurer in the original contract—usually around 5%.

The rise in interest rates to 16% to 18% in the 1970s created a flood of policyholder borrowing, Mr. Lucey pointed out. In some cases, policyholders borrowed from their policies, invested the funds at the high rate, repaid the loan to the insurer and still made a profit.

Compounding the problem for the insurer was the fact that the value of long-term bonds purchased to back up the liabilities were decreasing in value as interest rates rose.

"Some companies had serious problems," Mr. Lucey noted, pointing out that insurers were faced with the choice of selling the bonds at a low price to raise cash to meet policyholders' demands or borrowing from banks at a high rate to finance the surrender of policies.

"They realize that can happen again," and in response life insurers have decided to shorten asset maturities in case interest rates again rise sharply, he said.

Life insurers agree they learned an important lesson in the 1970s.

"One thing that has changed is we have simply updated our understanding of our liabilities," observed Arthur C. Reeds III, senior vp of the portfolio management division of CIGNA Investments Inc., which manages investments for CIGNA Corp. insurance units.

"In our life company portfolio, our general investment strategy is an attempt to match the nature of our assets with an understanding of the nature of the liabilities those assets are supporting," Mr. Reeds explained. "It's a matching strategy, rather than a total rate of return.

"Our basic strategy of matching has not changed," Mr. Reeds added. But he noted that higher interest rates for short-term maturities resulted in some shorter assets in CIGNA's life portfolio.

Mr. Reeds said that CIGNA over the past few years has purchased "medium-quality, fixed-rate investments" for the life insurance investment portfolio. These include publicly traded bonds, private placements and commercial mortgages.

The fixed-rate instruments are "designed to offer as high a current yield as possible without taking undue risk," he added.

Other changes, besides the switch to matching strategies and the purchase of shorter-term investments, are occurring in life insurance investment departments.

For instance, as the investment climate becomes more complex and volatile, life insurers have begun stressing improved communications and interaction among de-

Continued on next page

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Vice-presidents, general managers and other administrative personnel ... 2,756

Financial:
Chief financial officers and vice-presidents of finance ... 2,016
Secretaries, treasurers, controllers and other financial personnel ... 6,484

Risk/employee benefits:
Vice-presidents, directors, managers, and other related department personnel of: insurance, risk, employee benefits, personnel, compensation, pension, safety, security, industrial relations, human resources and employee/labor relations ... 8,111

Sub-total ... 22,354

Associations ... 483
Government, unions and educational systems ... 1,252

Commercial Consumers
Sub-total ... 24,089

Insurance agents and brokers ... 10,285
Insurance companies ... 6,498
Financial institutions ... 748
Actuaries, attorneys, adjusters, appraisers and consultants ... 3,808
Others allied to the field ... 1,308

TOTAL ... 46,977

* Source Business/Occupational breakdown of qualified circulation, Nov. 25, 1985 issue, as submitted to BPA for December 1985 BPA Publisher's Statement.

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Continued from previous page

partments that for years had little contact.

"We are putting more emphasis on investment policies that match the needs of the products," noted Mr. Bethke of Prudential. That means there is more interaction between the investment professionals and actuarial personnel, he added.

"Investment people are taking a much more proactive stance with the actuarial side" in developing investment strategies, said Edward J. Boudreaux Jr., senior vp and treasurer at John Hancock Mutual Life Insurance Co. in Boston.

Hancock's investment strategy makes it particularly important for different departments to coordinate investment decisions, because the insurer has developed a "segmentation" approach to matching assets and liabilities.

Mr. Boudreaux explained that life insurers' investment patterns were "fairly stable and predictable" until the mid-1970s, noting they would "play the yield curve and lock in long-term investments" as a routine practice. Hancock had developed specialties in mortgages and real estate investment, he added.

But during the upheaval of the '70s, the insurer decided to change its investment tack and segment investment strategies while "developing a management information flow to better match assets with liabilities," Mr. Boudreaux explained.

The result was the development of portfolios for different types of life products. For instance, a portfolio has been structured to match liabilities created by individual life products, while another addresses investments geared to group insurance products.

"Each segment gave us the ability to look at the products and the liabilities associated with them," Mr. Boudreaux said. "Instead of one big pot of cash that the insurance company would try to invest," Hancock now closely tailors investments to match particular products, he said.

"It became increasingly important to develop coordination" among actuaries and investors, he noted. And now, separate investment managers for bond, mortgage, real estate and other investment instruments work out individual investment policies with insurance personnel that understand the "liability streams" of the different products offered by the insurer.

"Each segment has its own investment policy that is reviewed by the board," Mr. Boudreaux said.

Because life insurance companies are taxed differently than property/casualty operations, life companies have traditionally invested more heavily in taxable securities.

Timothy Holt, portfolio manager of the property/casualty companies at Aetna Life & Casualty Co. in Hartford, Conn., explained that with the current tax structure for life insurance companies, yields on tax-exempt securities are not high enough to justify purchasing the instruments. So, life insurers have generally sought the higher yields of private placements, commercial mortgages and publicly traded securities, while avoiding municipals.

At Prudential, a relatively newfound interest in publicly traded bonds has led to a change in investment strategy.

Of the $61 billion in assets managed by Prudential, 64% are bonds, according to Mr. Bethke. Half of those are private placements and the remainder are publicy traded.

"The biggest change is in publicly traded bonds," Mr. Bethke said of the Prudential portfolio. "Five to 10 years ago, it was all private placements."

He said Prudential has increased its publicly traded holdings because New Jersey, Prudential's domicile, has eased restriction of life insurer investements, which has given the company easier access to the public market. And those securities match well with the company's product mix, he noted.

In addition, Prudential is putting more money in overseas investments, according to Mr. Bethke. "We are increasingly looking globally to find the best investment opportunities. We're putting more money in foreign stocks and bonds."

He noted that foreign investments are weighted heavily toward Japan and Great Britain, where the local currencies are surging. "It has been tremendously rewarding," Mr. Bethke said of the foreign investments.

Dave Dunford, vp of portfolio management and public bonds for Travelers Corp. in Hartford, observed that insurer's life portfolio in the last two years has seen "an increasing representation of commercial mortgages. There are some particularly attractive yield spreads on those."

Mr. Dunford said the insurer has increased its investments in mortgages, while maintaining private placements and fixed-income securities to diversify the portfolio and add liquidity.

Like their counterparts in the property/casualty business, life insurance companies keep an eye on inflation but don't expect it to influence investing strategy in the near future.

However, Hancock's Mr. Boudreaux noted that because his company has invested heavily in real estate, current rates of inflation have raised questions on how solid the investment remains.

"In disinflationary times, it is natural to feel real estate is not a good investment," Mr. Boudreaux explained.

"We're waiting to see if the bloom is really off the rose in terms of real estate. We feel the value is still there." ■

Finding the right 'match'

Conceding that it may be no more than a matter of semantics, one investment expert warns life insurers that they may be taking the term "matching" too seriously.

Lawrence H. (Jim) Lucey, vp of The Chicago Corp., prefers the term "relating" when discussing how life insurers pair investments with how liabilities mature.

Mr. Lucey, whose firm manages around $200 million in insurance company assets, warns that "matching is a strong term" that is more applicable to the investment strategy applied to pension products.

"Many of the liabilities that an insurance company has cannot be that accurately defined," says Mr. Lucey.

"You can construct the asset side when you want to predict cash flow, but on the liability side you kind of throw up your hands because it is almost impossible to be that accurate."

Insurers should be aware that they can only "relate" assets to liabilities, Mr. Lucey says, because "if you use the term 'matching,' you might get more comfort out of it than you should. If you think your assets and liabilities are matched, they're not. They're related. Matching denotes that the balance sheet is pretty structured on both sides."

Whether the term "matching" or "relating" is used, Mr. Lucey says he is a big proponent of such a strategy because it has helped insurers become more effective investment managers.

"In the past, no one was paying attention to the two sides of the balance sheet. At least now they can put them in pretty good alignment." ■

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Few insurers are bullish on junk bonds

By MICHAEL BRADFORD

Insurers are a little skittish about high-yield securities, and as a result most are keeping only a small percentage of "junk bonds" in their portfolios.

They admit that properly managed, these bonds' higher yield over investment-grade securities could be a welcome addition to their portfolio. But, there is concern about how safe the unrated or lower-rated securities are and whether they belong in an insurer's investment portfolio.

High-yield securities include those issued by companies that can be classified as "emerging" businesses, or ones that do not have long histories of successful earnings. They also can include companies with a questionable ability to repay debt and "fallen angels"—companies whose ratings have slipped from investment-grade.

Larry Post, senior vp with investment banker Drexel Burnham Lambert Inc. in Beverly Hills, Calif., contends that insurers can reap the increased yields from high-yield bonds without unduly increasing risks.

These bonds can yield 200 to 300 basis points more than U.S. Treasuries, he pointed out.

Insurers whose portfolios feature less than 20% of high-yield bonds are "underinvested," Mr. Post contends.

But not everyone is so bullish on the bonds.

William Cornish, executive vp of rating agency and investment research firm Duff & Phelps in Chicago, acknowledges that investors who "research carefully and understand the market" can achieve above-average returns.

But, "because of the added risk, they should achieve above-average returns," he added.

Investors have to be concerned about potential bankruptcies among corporations that issue high-yield securities, Mr. Cornish warned. "Bankruptcies are a problem, have been a problem, and always will be a problem," he said.

However, Mr. Post counters that "bankruptcies are rare."

"It's a very competitive world," Mr. Post said. Insurers have to maximize their investment returns to price their products competitively and grow quickly, he noted.

Executive Life Insurance Co. in Los Angeles has invested in high-yield bonds and as a result "has grown quickly."

Alan Chapman, chief actuary and senior financial officer at Executive Life, said around 25% of his company's bond holdings are high-yield securities, which is probably higher than for most insurers.

In fact, Executive Life's $9.5 billion portfolio is invested almost entirely in bonds to the tune of $8 billion, according to Mr. Chapman. "Most insurers have invested much more heavily in other instruments, like mortgages," he added.

"The label 'junk bonds' has kept a lot of people out of the market," he said. "The label put on by Wall Street has given regulators and others problems with investing in those instruments."

Mr. Chapman said Executive Life is attracted to the high-yield marketplace because the company devotes a lot of time and management expertise to analyzing issuers.

Bond ratings issued by organizations like Standard & Poor's Corp. and Moody's Investors Service Inc. are often determined by "junior-level people. By historical values, it has been a mechancial function."

"We do our own credit analysis," Mr. Chapman said, explaining that Executive Life looks for companies it believes have been rated too low.

"We've been quite successful. We've had substantial capital gains, primarily from issues that have been upgraded after we acquired them," he boasted.

Brian F. Wruble, president of Equitable Capital Management Co., the asset-management arm of Equitable Life Assurance Society of the United States in New York, said that although high-yield bonds are only a small percentage of the insurer's portfolio, it is a big investment at excess of $100 million. Equitable Capital's portfolio totals $22 billion.

Mr. Wruble explained that the life insurer believes "high-yield bonds, when carefully selected, can provide a high rate of return.

But Mr. Wruble cautions that junk bonds have to be part of a highly diversified portfolio that is actively managed, and management has to be experienced in the marketplace. "It's hard to adequately diversify without a staff that has the experience," he asserted. "We have a large staff (30) devoted to credit analysis."

Bill Bethke, managing director in the capital markets group of Prudential Investment Corp., said Prudential Insurance Co. of America has some high-yield bonds in its portfolio but shies away from the securities because of the call risk generally associated with the bonds.

"You could be buying into what looks like a 10-year maturity but have it come back much sooner," he explained.

Mr. Cornish of Duff & Phelps also cited the call provision as a feature that tarnishes the bonds image, and he added that "marketability" of the securities is unpredictable.

"They are very thinly traded, and you're never sure whether they are going to trade once a week, every month or year," Mr. Cornish remarked.

State insurance regulators also are concerned that insurers portfolios may get top-heavy with junk bonds.

Bruce Bunner, California insurance commissioner, said his department does not restrict insurers from investing in the bonds.

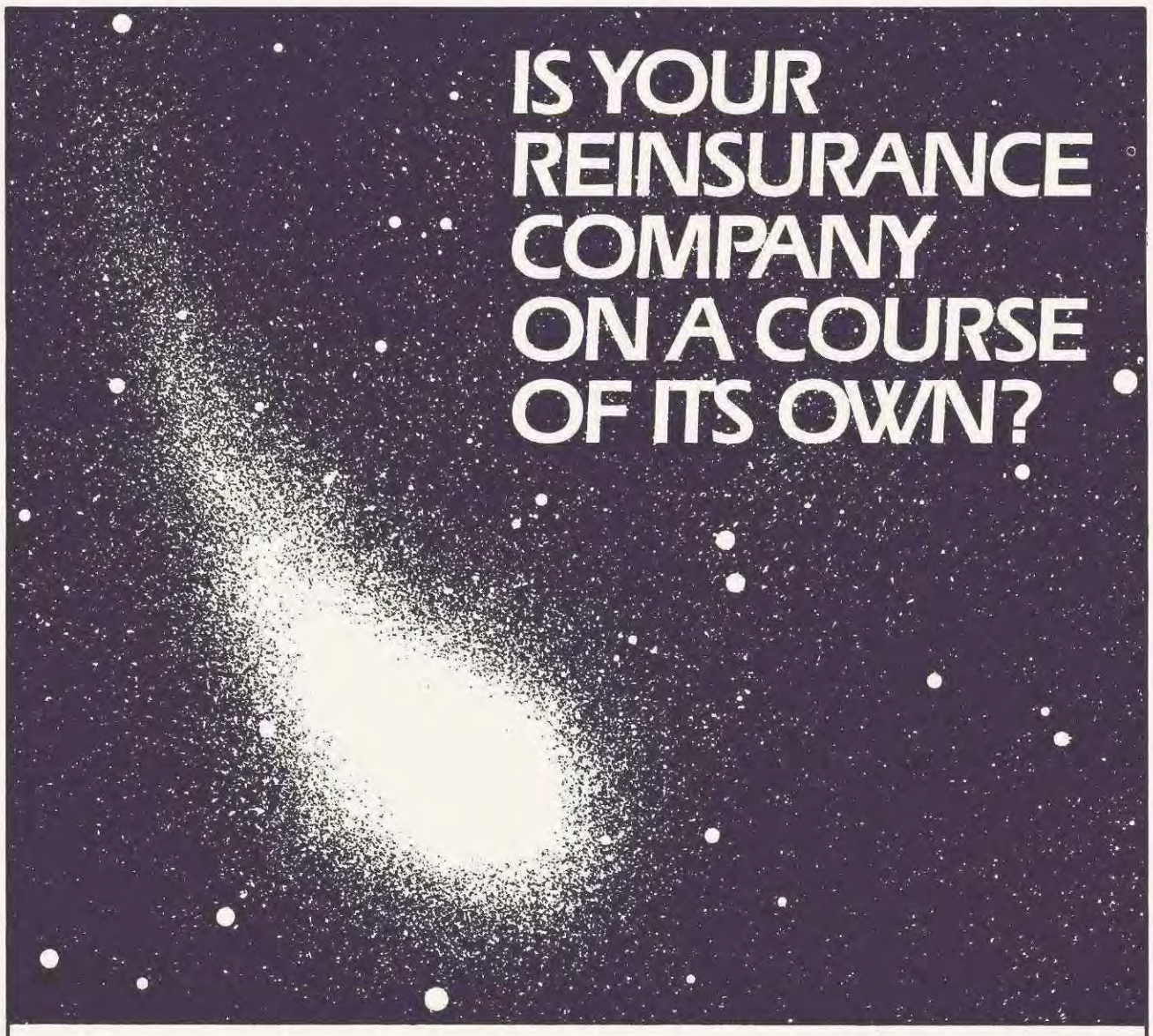
"We certainly have a concern for so-called junk-bonds," he noted. But he added, "We don't think it's appropriate to say an insurance company can't invest in them."

In Oregon, Chief Examiner Lynn Pendlebury of the insurance department, said, "We expect companies to invest in high-quality securities."

However, Mr. Pendlebury said he has noticed insurers turning to junk bonds in an effort to maintain high yields.

"If they want to reduce the quality of their portfolio, we can't give a blessing to that. It depends on how much is invested" in high-yield bonds, he said.

While insurers are not specifically restricted from investing in high-yield bonds, their investments are limited to those listed by the Securities Valuation Office of the National Assn. of Insurance Commissioners. ■



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U.S. insurers increasing foreign exchange hedges

By MICHAEL BRADFORD

Insurers' foreign exchange exposures are growing bigger than just their claims reserves.

"I've noticed more and more that insurers, particularly property/casualty companies, with exposures in overseas operations are actively purchasing international securities," observes Lawrence A. Roth, vp of Manufacturers Hanover Trust Co.'s foreign exchange division in New York.

Previously, insurers were most concerned about hedging against foreign currency exposures related to their loss reserves on non-domestic writings if they did reserve for losses in the local currency.

But apart from hedging against that scenario, insurers also must be concerned with techniques to protect holdings like foreign stocks and bonds and investments in foreign operations.

Smaller property/casualty companies have become especially interested in purchasing bonds in the United Kingdom and Japan recently, said Mr. Roth.

"Many have had no experience in hedging and we are advising them and executing contracts for them," he added.

"There are a number of techniques, if you have an overseas operation or if you are hedging your investment portfolio," Mr. Roth says.

"The most traditional way is to take out forward exchange contracts or forward exchange options."

By purchasing forward exchange contracts, Mr. Roth explained that insurers are "attempting to lock in a return by locking in the price of currency on the foreign exchange market." The contract gives the insurer the ability to purchase or sell currency or securities at a set price on a specified future date.

"The same is true with an option," he added. With an option, the insurer has picked a "strike price" for the securities and can exercise its right to buy or sell, depending on which way prices fluctuate.

Shaun Matthews, assistant vp and treasurer in the international treasury department at Aetna Life & Casualty Co. in Hartford, Conn., said the insurer uses the forward exchange market as a seller of currency to hedge against the net worth exposure of its foreign operations.

Because those operations match their liabilities with assets in local currency to protect insurance exposures from currency changes, "the exposure for Aetna is the net worth of those operations," he explained.

"In total, Aetna has $400 million to $500 million invested in offshore insurance/financial service operations," including operations in Canada, Australia, the United Kingdom, Hong Kong, Chile and Indonesia, said Mr. Matthews.

Roger Conant, senior vp and head of The St. Paul Cos. Inc.'s investment department in St. Paul, Minn., said when his company decides to make a significant overseas acquisition, it "freezes the cost by...hedging in the futures market."

To offset the currency risk, St. Paul holds both long and short positions in the futures market, selling short on the completion date of the acquisition, according to Mr. Conant.

Currency forwards are also employed by Travelers Corp. in Hartford, says Dave Dunford, vp of portfolio management and public bonds.

"We're involved in the purchasing of foreign denominated securities, and we hedge the currency aspect of that through forwards," he explained.

While insurers lean towards forwards to hedge against currency fluctuations that could affect securities holdings, they often take away the risk of losing money on devalued premiums simply by matching assets and liabilities in local currency.

If they did not match assets and liabilities in the local currency, fluctuations in exchange rates could cost an insurer a bundle.

Consider an insurer that is forced to pay a claim in one currency but holds reserves in an-

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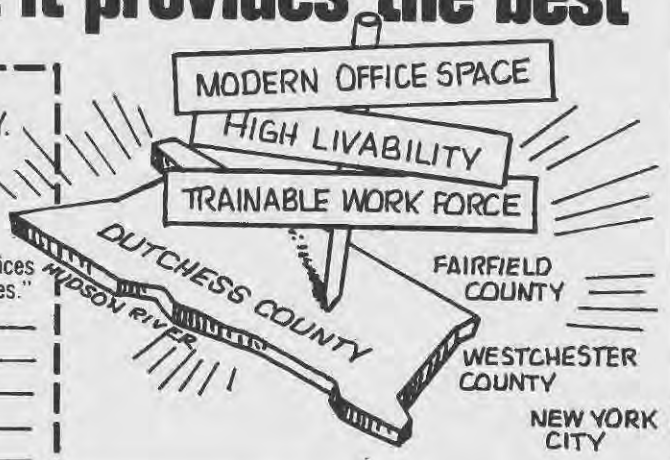
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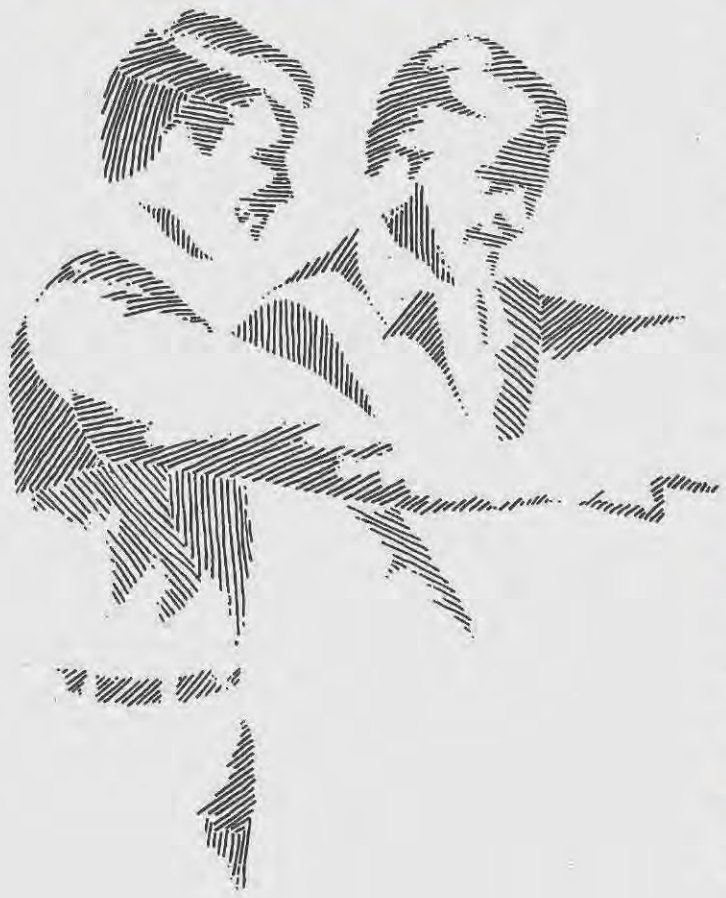
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Insurers trade foreign currency on the spot

U.S. insurance companies conducted most of their foreign currency transactions on the spot market last year, trading a total of approximately $11 billion in spot business, a recent report states.

In addition, the insurers were involved in about $4 billion worth of currency forwards trading, $251 million in currency swaps and $158 million in currency options transactions, according to a report on foreign exchange services conducted by Greenwich Associates, a Greenwich, Conn., consulting firm.

The consultant surveyed 17 insurers as part of the study, which tallied data from a total of 642 multinational and domestic companies and foreign subsidiaries.

Those insurers responding to the survey included eight life insurance companies, four property/casualty insurers, three reinsurers and two insurance brokers.

The companies are among the largest in the nation and represent all regions of the country according to Deborah Fuhr, supervisor of research at Greenwich Associates, who declined to identify the insurers that took part in the report.

Other types of businesses included in the survey ranged from the chemical, food, machinery, and oil and gas industries to financial institutions, retailers and utilities.

Fifteen of the insurers participating in the report were active in foreign currency spot trading last year. Five of the companies were involved in spot transactions of more than $150 million, two in trades of between $51 million and $150 million, three in spot business of between $20 million and $50 million, and five in trades of less than $20 million.

Eight of the participating insurers were active in currency forwards transactions. Of those, four had volume of more than $150 million, one was involved in trades of between $51 million and $150 million, one traded in the $20 million to $50 million range, and two traded less than $20 million in forwards.

Only two of the insurers surveyed were involved in currency swaps. One transacted swaps of more than $150 million, none did business in the $20 million to $150 million range, and one was involved in less than $20 million worth of swaps.

In currency options, again only two insurers were involved. None traded options worth more than $150 million, one conducted transactions in the $51 million to $150 million range, one other company at the $20 million to $50 million level, and none at less than $20 million.

To conduct their currency trading, the insurers used an average of 4.6 banks each: 2.9 U.S. banks, 0.2 U.S. investment banks, 0.7 Canadian banks, 0.3 United Kingdom banks, 0.2 Scandinavian/Continental banks, and 0.3 Australian/Far Eastern banks.

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James H. Davies

During the last few months, subtle signs have surfaced, indicating that personal lines markets indeed are tightening. Some companies apparently are reviewing their entire approach to personal lines—re-underwriting whole blocks of business, rejecting risks that once were routinely accepted.

Others are indirectly turning away personal lines by cutting commissions significantly, forcing agents to move the business to other carriers.

And demands for personal lines premium volume are becoming so high in some cases, many agents have no choice but to look for other markets.

Some feel it may be a sign of the times, and maybe inevitable with underwriting still in the red, overall. Companies are motivated by a need to restore stability and profits. That's certainly understandable.

But at what cost?

This unfortunate trend comes at a time when the property/casualty industry is under heavy attack by consumers and government.

The lack of availability and affordability of commercial liability insurance has cast a dark shadow over the industry.

Insurance is coming under ever-closer scrutiny by regulators and legislators.

If personal lines markets follow the path of commercial business, we can expect a backlash from consumers, regulators and legislators that could lead to a crisis in public confidence in our industry—and to greater regulation of the way we do business.

In the mid-1970s, tighter personal lines markets and reduced commissions led to a significant loss in marketshare for the agency system. Let's learn from history and from the current problems our industry is facing. Let's not let personal lines be next.

J. H. Davies

James H. Davies
President

PIA — Professional Insurance Agents

National Association of Professional Insurance Agents
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Foreign currency

Continued from previous page

other. A strong movement in the exchange rate that favors the currency of the claim payment could cost the insurer dearly.

Mr. Conant of St. Paul points out that the insurer's foreign liability exposures are "relatively minor," but matching is used to make sure assets and liabilities balance.

For example, he notes, "For the policies written in Canada, we try to have Canadian assets on the financial side. Matching, in effect."

At Aetna, Mr. Matthews points out that the insurer's foreign underwriting exposures are only a small percentage of its total exposure, but like other underwriters, it matches assets and liabilities in local currency.

But he also points out, "That is not to say that we don't give investment managers the opportunity to invest in foreign securities when they see a good opportunity."

Experts point out that there are other methods of hedging foreign exposures that are not used as frequently as matching.

"In theory, you could use a pricing policy to protect you," says Mr. Matthews.

For example, he pointed out, if premiums written in Germany are paid in deutschemarks and converted to U.S. dollars, a rise in the value of the foreign currency of 10% would mean a corresponding drop in income to the insurer.

That loss theoretically could be recouped by raising prices 10%, Mr. Matthews said. "But I say in theory, because when you do that, do you become 10% less competitive?"

Another technique, according to Mr. Matthews, would be to "aggressively dividend from foreign operations," so that retained earnings don't build up in local currency and become subject to foreign exchange risks.

Mr. Roth pointed out that expertise among insurers who manage foreign exchange exposures varies widely.

"Some are as expert as the banks," he said. "Some are far from expert and some have called in investment banks or accounting firms."

He added that a company like American International Group Inc. in New York "that is watching 68 currencies in 130 locations around the world is constantly reviewing currency movements. But the majority of the others are much less sophisticated."

Mr. Roth also cited Aetna as a top manager of foreign investments and exposures. The insurer has a five-person staff devoted to monitoring overseas positions.

Insurers have only in the past few years begun to realize that they can write a profitable book of business overseas.

Part of the reason U.S. underwriters haven't been in foreign markets earlier is because other countries have made it difficult for insurers to get a license overseas, he noted.

But, adds Mr. Roth, countries like Japan have loosened restrictions on licensing and the Philippines, South Korea and other countries in that part of the world are now viewed as profitable soil for insurance companies.

And as far as investments are concerned, insurers and others have only in recent years begun actively participating in foreign markets because of an overall lack of familiarity with overseas trading.

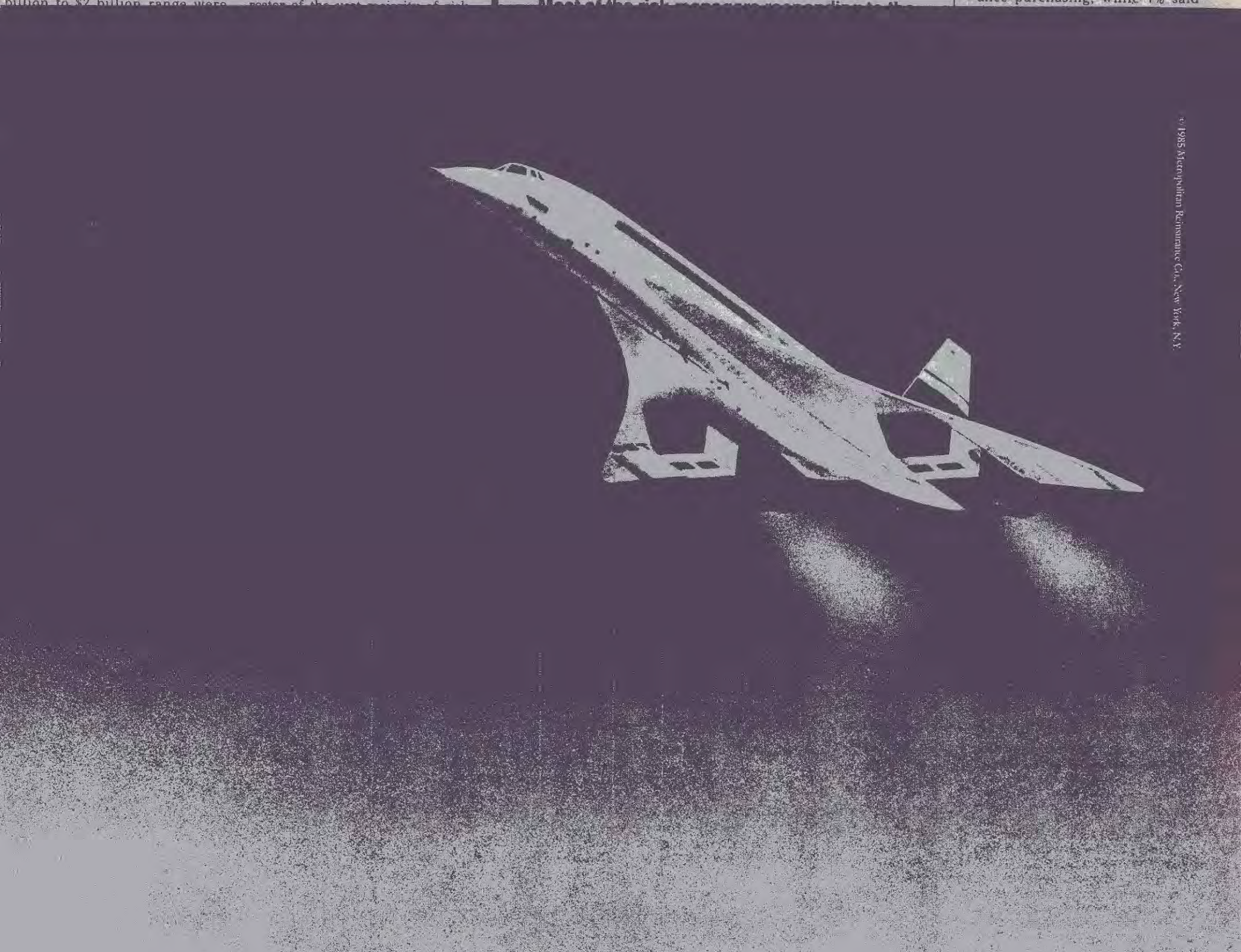
"Even securities firms were fairly late," says Mr. Roth. "They haven't been active until the late '70s and early '80s."

Many were afraid to invest outside of the United States because they didn't fully understand some markets "that don't run as smoothly as the U.S. market," said Mr. Roth. ■

Continued from previous page
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Logic survey

Continued from previous page
pension/profit-sharing administration.

At companies with sales of $7 billion or more, only 8% of the risk managers surveyed said they had direct responsibility over pension/profit-sharing administration. An equal percentage said they advised or supervised another person handling the plans.

Twelve percent of the risk managers at companies with sales of $4 billion to $7 billion said they were directly responsible for administering their companies' pension and profit-sharing plans, while 6% said they had supervisory involvement.

Only 2% of the risk managers at companies with sales in the $2 billion to $4 billion range reported direct responsibility for these benefits, while 12% said they played supervisory or advisory roles.

At companies with sales of $1 billion to $2 billion, 7% said they were directly involved in pension and profit-sharing, while 13% said they had advisory or supervisory duties in the area.

Eleven percent of the risk managers at companies with sales of $501 million to $1 billion reported direct responsibility for their companies' pension and profit-sharing plans, while slightly more—12%—said they advised or supervised.

Approximately 15% of the risk managers at companies with sales of $201 million to $500 million said they had direct involvement, while 21% said they played supervisory or advisory roles.

At companies with sales of less than $200 million, 28% reported direct involvement in pension and profit-sharing administration, while 29% said they had supervisory or advisory roles.

•

Copies of the survey are available for $60 from Logic Associates, 170 Broadway, Suite 1708, New York, N.Y. 10038; 212-227-8000.

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EFS at companies with sales of $2 billion to $4 billion reported responsibility for benefits administration in 1985, up from 3% a year

More RMIS going on line at small firms

By JOANNE WOJCIK O'HARE

More risk managers at small companies are using risk management information systems, a new survey shows.

The increasing sophistication of risk management and insurance functions at these companies has contributed to this growth, according to Bill Perry, a partner in Logic Associates Inc., a New York-based recruiting firm that annually surveys risk managers' compensation and responsibilities.

"The smaller department was forced into growth, which automatically led to an RMIS," explained Mr. Perry.

Also, the cost of setting up an computerized RMIS is declining as both hardware and software become less expensive, added Richard Meyers, another partner at Logic Associates.

"The cost of computers has really gone down significantly," Mr. Meyers said.

Approximately 31% of the risk managers responding from companies with sales of $200 million or less reported use of a risk management information system in 1985, compared with just 25.8% the previous year.

However, RMIS use was down at the largest companies surveyed.

The survey showed 62% of the risk managers responding from companies with sales of $7 million or more reported RMIS use in 1985, compared with 76.9% in 1984.

The survey also found:

- The use of an RMIS by risk managers at companies with sales of $201 million to $500 million remained relatively stable, with 23.7% reporting access to an RMIS in 1985, compared with 23.9% the previous year.
- Forty-one percent of the risk managers at companies with sales of $501 million to $1 billion said they had risk management information systems in 1984, down from 45.6% in 1984.
- At companies with sales of $1 billion to $2 billion, 61% of the risk managers reported having an RMIS in 1985, compared with 62.3% a year earlier.
- A total of 61% of the risk managers responding from companies with $2 billion to $4 billion in sales also reported having an RMIS in 1985, compared with 62.7% in 1984.
- An increase in risk management information systems was discovered at companies with sales of $4 billion to $7 billion, where 62% of the risk managers reported having an RMIS in 1985, up from 51.5% the previous year. ■

31% of risk managers involved with captives

Corporate risk managers' involvement with captives appeared to wane somewhat in 1985, despite the tightening commercial property/casualty insurance market, according to a new survey.

A total of 30.6% of the risk managers responding to Logic Associates Inc.'s 1985 Risk Management Compensation Survey said their companies had captives in 1985, down slightly from 33% in 1984.

However, the real change in the number of companies with captives could well be negligible because more risk managers responded to the 1985 survey than the 1984 poll, the survey's authors point out.

Logic Associates, the New York-based recruiting firm that conducted the survey, received 1,022 responses in 1985, compared with only 917 in 1984.

Risk managers' involvement with captives was more prevalent at larger companies, the survey found.

While the percentage of risk managers reporting captives at companies with sales of more than $7 billion increased only slightly—58% in 1985 compared with 57.7% in 1984—the number of captives operated by each company surged to an average of 1.6 from 1.27 in 1984.

But captive involvement dropped dramatically at companies with sales of $2 billion to $4 billion. Twenty-six percent of the risk managers from these companies reported their company operated a captive, down from 45.8% in 1984. However, the companies with captives reported an average of 1.3 captives each in 1985, compared with an average of 1.15 captives in 1984.

The survey also found:

- Captive involvement was reported by 13% of risk managers at companies with sales of less than $200 million, compared with 12.9% in 1984. All these companies reported using one captive during both years.
- A smaller percentage of risk managers at companies with sales of $201 to $500 million said their companies had captives in 1985, although the number of captives reported increased to an average of 1.3 in 1985 from 1.21 in 1984. A total of 13% of the risk managers responding said their companies had captives in 1985, down from 15.2% the previous year.
- Twenty-two percent of the risk managers at companies with sales of $501 million to $1 billion reported captives in 1985, up from 20% in 1984. These companies had fewer captives, however, with risk managers reporting an average of 1.1 per company in 1985, compared with 1.28 a year earlier.
- A similar change was found at companies with sales of $1 billion to $2 billion. A total of 26% of the risk managers said their companies had an average of 1.3 captives in 1985, compared with 27.3% reporting 1.19 captives in 1984.
- In the $4 billion to $7 billion in sales category, 55% of the risk managers responding reported 1.7 captives per company in 1985, compared with 54.5% reporting 1.78 captives the previous year. ■

Vermont law alters taxes on captives

MONTPELIER, Vt.—Gov. Madeleine Kunin has signed legislation that alters the premium tax structure for captive insurance companies chartered in Vermont.

The new law, H. 631, which is now in effect, imposes a tax of 0.3% on the first $15 million of reinsurance premiums assumed by a captive and a tax of 0.2% on reinsurance premiums exceeding $15 million.

The law also cuts the previous flat 1% tax on direct premiums written by a captive to 0.8% on the first $15 million of direct premiums, while the tax on direct premiums exceeding $15 million now is 0.6%.

The law also provides that any changes Congress makes in the federal Risk Retention Act will automatically be incorporated into Vermont's captive statute.

"With changes to the Risk Retention Act pending in Congress, it was deemed desirable to maintain Vermont's risk retention provisions as up-to-date as possible," said the Vermont Captive Insurance Assn. ■

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NAEHCA conference

War on rising costs not over yet, expert says

By DONNA DiBLASE

PALM BEACH, Fla.—Despite their past success, employers must continue to be aggressive and informed purchasers of health care to keep the lid on rising costs, one expert warns.

"Unless we check and change the medical care delivery system, most of the corporations in America will be swallowed up" by health care costs, predicted Calvin A. Michaels, director of personnel administration at Burlington Industries Inc. in Greensboro, N.C.

Mr. Michaels, who coordinates health benefit cost management programs for Burlington, delivered the keynote address at the 10th Annual Conference of the National Assn. of Employers on Health Care Alternatives, held May 29-30 in Palm Beach, Fla.

However, a physician also addressing the conference warned that quality health care should not be sacrificed to save money.

"The finest medical system in the world is being systematically dismantled because it allegedly costs too much," said Dr. Rufus K. Broadaway, chairman and chief of staff of surgery at Cedars Medical Center in Miami and a trustee of the American Medical Assn.

But Mr. Michaels contended the current delivery system requires some alteration to keep costs in line.

"The passive attitude of consumers and employers has developed a medical care delivery system costing $450 billion a year. This system, while delivering sophisticated technology, has made irresponsible consumers," he said.

While optimistic about the future of cost-containment efforts, "There are still many who are laying back thinking the problem of rising costs is going away," Mr. Michaels said.

"I think corporate America can make a difference. The question is, will we?" he asked. "Medical care cost management requires a long-term commitment."

One of the ways employers can reduce medical costs is to develop and maintain a health care data base available to both employers and providers, Mr. Michaels said. Such a data base will enable employers to aggressively and successfully negotiate with providers, he added.

"Employers must move aggressively to develop a data base which identifies care and treatment patterns by intensity and severity. This is important for providers and employers," he said.

Mr. Michaels is currently involved with a joint task force of the Washington Business Group on Health and the Group Health Assn. of America that is working with employer and provider representatives on developing a standardized national health care data set.

"Personally, I think this type of data source is of more value to providers in terms of competition," he added. When hospitals and physicians can see cost and utilization data of their competitors, they may also be able to competitively negotiate with employers, he explained.

Mr. Michaels also said that for cost containment to be successful, employers must develop and maintain a comprehensive cost management program.

Employers can make several immediate changes in benefit plans to encourage employees to be more cost-conscious, he said, citing utilization review, increases in employee cost-sharing, and incentives for outpatient treatment.

But Dr. Broadaway warned that employers should not jeopardize the quality of care received by their employees when attempting to contain costs

"There are great ethical and moral questions that need to be addressed in cost containment," said Dr. Broadaway

"Somebody must speak for the patient. Are we providing cheaper or less expensive care? Don't fail to provide adequate, quality care in seeking cost-effective care," he added.

But Dr. Broadaway said the AMA "believes that costs can be controlled," noting discharge planning on the day of hospital admission and home health care are useful cost-containment techniques.

Mr. Michaels agreed it is important for employers to obtain quality health care services for employees.

"The role of the employer is to communicate and negotiate with providers for quality as well as price," he said. "And, the corporate role is to facilitate information on health care to employees. They have a right to know and to make choices. But, they need the right information."

In his keynote speech, Mr. Michaels noted that one problem with the current health care system is that too much emphasis is placed on sickness and not enough on wellness.

"We need to separate health care and medical care. They are two different things—health care being the prevention of illness and injury and medical care being treatment or cures after illness or injury occurs," he said.

"Our medical system is geared to sick care. We do not concern ourselves with wellness; intervention is the magic word here. We must concentrate on well care and not sick care," he urged.

One of the cost management programs at Burlington, which operates about 70 plants and employs 40,000 people, is called "Good For You" and concentrates on wellness.

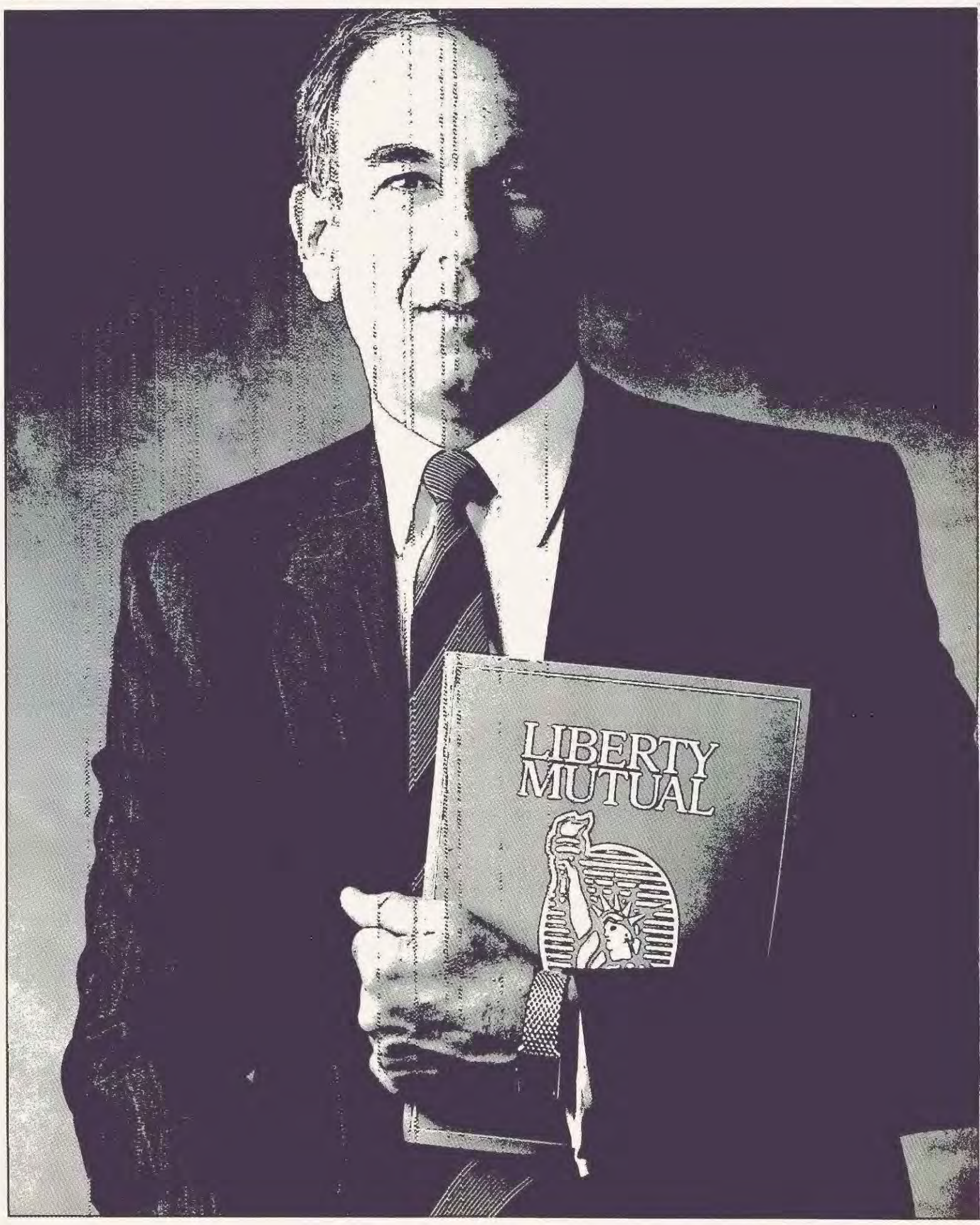
The program was implemented last year, after about six months of planning that involved employees and health care providers. It includes a smoking cessation course, nutrition counseling, emphasis on off-the-job safety and fire prevention in the home. Employees also are offered stress management courses and an employee assistance program.

As part of the program, the company is now working on a health risk questionnaire that will be distributed to seven plants in a pilot program. The questionnaire will help the company identify other wellness needs, as well as make employees aware of their own health status.

"Why can't we take occupational safety programs into the health risk management area? We believe that intervention is the way to go to contain costs," said Mr. Michaels.

But, while preventive programs can help employers to encourage their employees to lead healthy lifestyles, it is difficult to assess

Continued on next page



Continued from previous page
whether the programs really contain health costs, Mr. Michaels said.

"The research on these programs is not adequate. It's too premature to assume whether prevention is cost-effective," he said.

"But, although the programs cost us more money initially, as time goes on, employees use less and less medical services."

Dr. Broadaway of the AMA agreed that prevention "can help costs. Our traditional system is to take care of acute illness."

However, John Lowe, a vp at the American Hospital Assn. in Chicago, said wellness programs were not intended to be cost-containment. "Prevention is not going to save you that much money. The programs started as life-improving tools, not cost-savers," he said.

The speakers also disagreed about the role uninsured patients will have on business' health costs.

"One of the major issues in policy-making circles is to assure access to available benefits to everyone in our society," Mr. Michaels said. "Eighty percent of our society has access to health care benefits through public or private means. But there is another 20% that does not have access to benefits.

"And, there are some policymakers who feel that business and industry should become the welfare system for that remaining 20%," he said.

However, Dr. Broadaway replied, "I think that assuming business and industry will become the welfare system for the medically indigent is a little paranoid." ■

Wellness 'programs started as life-improving tools, not cost-savers,' says John Lowe.

Hewlett-Packard discovers savings with PPO contract

By DONNA DiBLASE

PALM BEACH, Fla.—A preferred provider arrangement directly negotiated between a Silicon Valley employer and a local hospital is substantially lowering hospital costs, the company's benefit manager says.

Palo Alto, Calif.-based Hewlett-Packard Co. negotiated its own preferred provider contract with an area hospital in 1984, explains Arthur Young, corporate benefits manager for the company.

"The system—which has been labeled a PPO—is different because the employer deals directly with the provider. And, it's information-driven. It's a total health care system—not just a set of negotiated rates," Mr. Young told the 10th National Conference of the National Assn. of Employers on Health Care Alternatives last month.

The company's contract with El Camino Hospital in Mountain View, Calif., reduced the cost per hospital admission to $2,099 in May 1985 from $2,888 in June 1984, he said. In addition, the average length of stay for that period decreased to 3.51 days from 4 days.

The contract with the hospital includes a set of negotiated per-diem rates for particular illnesses and an inflation ceiling.

But, "probably the most important part of the whole program is the utilization review," he said.

Pre-certification is required for all elective admissions. A concurrent review is performed daily that focuses equally on both the medical and financial aspects of the patient's hospitalization, he said.

Retrospective reviews also are performed, Mr. Young said.

Under the program, employees are not required to use El Camino Hospital for medical services, but their copayment is reduced to 10% from 20% if they do, he said.

The contract has proved more cost-effective for Hewlett-Packard than for other employers whose employees use the same hospital on a non-contracted basis, he noted.

"The fees Hewlett-Packard have negotiated with El Camino are lower than those for non-Hewlett-Packard patients," Mr. Young said.

For example, the negotiated cost per case at El Camino in 1984 was $2,956 for Hewlett-Packard employers and $3,329 for other patients, he said. And, in 1985, the negotiated fee for Hewlett-Packard patients was $2,494, compared with $3,476 for other patients.

Hewlett-Packard is not the only employer now negotiating PPO arrangements with providers.

"About 10 other companies in the American Electronics Assn. have gotten together and formed their own data network," he said.

Some of those employers—like Apple Computer Inc. and Xidex Corp.—are now in the process of negotiations, according to Mr. Young and Joseph Rosmann, a principal with Deerfield, Ill.-based benefit consultant A.S. Hansen Inc.

Hansen is assisting those employers in setting up a data base and advising them on contractual considerations, Mr. Rosmann said.

Employers on the East Coast also report similar PPO success stories.

"The success we've had with our PPO is a good example of what can happen when employers, the medical community, insurers and labor get together," said Susan Weiner, assistant superintendent in the office of risk management of Dade County Public Schools in Miami.

After compiling data on area providers through the South Florida Health Action Coalition in 1979, "we found that members of the employer coalition were being charged different amounts from the same hospitals," she said.

"We felt that employers were the victims of Medicare cost shifting," as hospitals were paid prospectively determined amounts according to diagnosis-related groups developed for the Medicare program.

So, in 1983, the coalition asked area providers for proposals concerning any negotiated preferred provider products they offered.

"The idea was called a farce and anti-competitive by hospital administrators, but by early November, 18 hospitals had met our criteria," she said.

MetElect, the PPO slected by the Dade County Schools, is administered by Metropolitan Life Insurance Co. Under the plan, employees are not required to use preferred providers, but a 20% copayment is waived if they do.

At first, five hospitals belonged to the PPO. Now, 14 hospitals and 1,500 physicians have contracted with MetElect, she said.

The school system experienced an 11.4% decline in hospital admissions and a 15.4% reduction in length of stay in 1985, she said. In addition, hospital payments declined 6% in the first six months of 1985, she said.

And, "because we have had so much success with the medical PPO we started a dental PPO this year," she said. ■

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Employers seek data to study HMO use

By DONNA DiBLASE

PALM BEACH, Fla.—Employee benefit managers say they want a data collection system to evaluate health maintenance organizations, but they admit they need to determine what kind of data they want.

"We're asking for more data than we can deal with—and it's the wrong type," said Laird Miller, corporate manager for provider relations at Minneapolis-based Honeywell Inc. "We're not asking for information that we as managers need to evaluate HMOs," he added.

Mr. Miller discussed his company's experience with health maintenance organizations at last month's 10th National Conference of the National Assn. of Employers on Health Care Alternatives.

HMOs are as interested in providing data to employers as employers are in receiving that data, according to Jeanne Kardos, director of employee benefits at Southern New England Telephone Co. in New Haven, Conn.

"HMOs want to cooperate, but they are just having a hard time getting the data together. I can't emphasize enough that they need help with this," she said. "We need an agreement on a data collection method that is accurate, complete and comparable."

Ms. Kardos explained HMO participation at her company jumped to 33% last year from 12% in 1984, partially due to a 1985 change in the company's medical benefits plan from first-dollar coverage to a comprehensive plan requiring deductibles and copayments in 1985.

As a result of the increased participation, the company's contributions to HMOs rose to $12 million in 1985 from $4 million in 1985.

'HMOs want to cooperate, but they are having a hard time getting the data,' says Southern New England Telephone's Jeanne Kardos. 'We need an agreement on a data collection method that is accurate, complete and comparable.'

"There was $12 million going into a black box that I didn't see," Ms. Kardos explained. So, SNET began negotiating this year with its HMOs to obtain data on cost and utilization, she said.

The company's goals going into the negotiations include:

- Thorough data analysis, identifying the characteristics of employees moving to HMOs and studying claims.
- Establishing "a negotiating environment for dialogue between us and the HMOs. We also want to exchange data, negotiate our HMO contributions and resolve other benefit issues," she said.

Honeywell's Mr. Miller, who is co-chairman of the Community Buyer System of the Minnesota Coalition on Health Care Costs, has worked on developing a standardized data set for HMOs and employers near Minneapolis-St. Paul.

The data set is serving as one of the models for a national data set being developed by a joint task force established by the Washington Business Group on Health and the Group Health Assn. of America, an HMO trade group.

Once employers evaluate HMOs and other health care delivery systems, "your goal should be to purchase comprehensive, quality care in the most cost-effective setting," he said.

Mr. Miller predicted changes in alternative health care delivery systems over the next five years and suggested necessary actions by employers.

"Right now, there are approximately 300 HMOs with about 13 million participants. I think we'll see a movement toward for-profit plans and an increased need for funding," he explained.

"But, these won't be HMOs as we know them now," he said. "They're going to evolve. And, there will be increased price competition, more risk sharing and more employer participation in benefit plan designs," he predicted.

"And, from the purchaser's perspective, there will be more support of HMOs as an alternative to fee-for-service plans."

Mr. Miller also noted that employers are concerned about growth of HMOs in their current form.

Two main concerns are adverse selection in indemnity plans as a result of increased HMO enrollment and community rating—a practice by which HMOs base their premium rates on their total enrollment population.

Some employers contend that community-rated premiums do not accurately reflect the ages or health of their employee populations in HMOs and that, therefore, the premiums they pay can be unfairly calculated.

Another employer concern is a practice many employers refer to as "price-following." Employers contend that after HMOs learn how much an employer contributes toward coverage under a fee-for-service plan, the HMOs set their premiums according to these amounts, Mr. Miller explained.

But, "at Honeywell, we don't tell the HMOs our indemnity premium," he said.

Finally, employers are concerned they are not seeing the savings that HMOs say they produce, he explained.

Mr. Miller warned both employers and providers that they must cooperate in the competitive purchasing environment.

"Providers—you've got to sit down with your customers and go over everything with them. You have not done this before," he said.

When negotiating, he said both parties should review:

- The design of the plan.
- The quality of the health care services rendered.
- Cost-containment procedures.
- Costs of services.
- The financial stability of the provider.
- Accessibility of facilities.
- Grievance procedures.
- Utilization reporting.
- Payment mechanisms.
- Utilization and cost information provided to the employer.

"The big providers will stay large forever if they cooperate like this," he said.

In the future, Mr. Miller said he believes "we can reduce the cost of care by 25% in this country."

"Health management systems in the future will involve risk assessment and reduction, health promotion, disease prevention and early intervention, case management and the employer as the purchaser of health care," he added.

And, Ms. Kardos suggested other changes that may help employers to contain their costs.

"Legislative or regulatory changes are needed which will make negotiations more flexible or (allow more) non-federally qualified HMOs because they have more flexibility," she said.

"The evolution in our relationship with HMOs has changed from one of sponsorship in the 1970s to one of partnership in the 1980s. You have to do business with HMOs just like you do business with anyone else," she added. ■

Cost containment efforts lauded

PALM BEACH, Fla.—Two employers and a Boston doctor have been honored by the National Assn. of Employers on Health Care Alternatives for contributions to health care cost containment.

RJR Nabisco Inc., Xerox Corp. and Boston University Medical Center's Dr. Richard Egdahl received the awards at the NAEHCA's 10th national conference, held in Palm Beach last month.

Winston-Salem, N.C.-based Nabisco, a charter member of NAEHCA, began operating a prepaid group health plan in 1976, the same year that NAEHCA began operations, said Patricia Nazemetz, president of the Key Biscayne, Fla.-based employer group.

The Winston-Salem Health Care Plan Inc. covers more than 38,000 employees and dependents at the company's headquarters, she said.

And, the company introduced the Winston-Salem Dental Care Plan Inc. in 1978. Under this prepaid plan, employees receive preventive care along with endodontia, orthodontia and oral surgery services.

The company also has implemented other cost containment measures such as pre-admission certification, a pre-admission testing requirement, on-site concurrent review in the hospital and a mandatory second surgical opinion program.

Nabisco is now in the process of developing its own case management program, she said.

Xerox, which moved from a first-dollar medical benefits plan to a comprehensive plan with copayments and deductibles in 1984, has been able to reduce hospital utilization by about 20% as a result of cost-containment efforts, said Ms. Nazemetz, who is also manager of benefits development of the Stamford, Conn.-based company.

Xerox also offers employees a comprehensive wellness program, which was established in 1978. The company has fitness facilities at 11 of its major offices, and employee-volunteers who coordinate health seminars, contests, and distribution of wellness materials.

Xerox is now in the first stages of developing a managed-care system in which the company will negotiate provider contracts with physicians and hospitals.

Dr. Egdahl, a practicing surgeon and director of the Boston University Medical Center, was honored for his contributions to cost containment as a health care provider.

Dr. Egdahl is the founder and director of the Health Policy Institute of Boston University. The institute includes three smaller groups: the Center for Educational Development in Health, the Center for Strengthening Health Delivery and the Center for Industry and Health Care.

In his role as director of the Center for Industry and Health Care, he has worked to make employers aware of the importance of their role in the medical care delivery system.

He also is involved in a utilization management program, in which corporations, hospitals and physicians work together to achieve cost-effective utilization of health care services while maintaining quality. ■

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Three Gen Re execs quit to join Olla Industries Inc.

By AVRA WING

NEW YORK—Three senior executives from General Re's North Star Reinsurance Corp. have left the reinsurer to join Olla Industries Inc., which on June 30 will become Re Capital Corp.

Donald E. Chisholm, formerly chairman and president of North Star in Stamford, Conn., was named president and chief executive officer of Olla.

Mr. Chisholm replaces Paul-Louis Durand-Ruel, who resigned after serving two years as head of Olla. Mr. Durand-Ruel, managing director of MM. Worms & Cie. Group of France, which owns a 44% stake in Olla, remains a director of Olla.

In addition, James E. Roberts and David C. Smith, senior vps at North Star, were appointed senior vps of Olla. Both posts are new.

"What we're doing is putting together a company to operate in the brokered property and casualty treaty reinsurance market," commented Charles E. Harris, chairman and chief executive officer of the Lexington Group Inc., which worked with Worms in setting up Re Capital Corp.

Re Capital hopes to raise a total of $100 million by the end of the year, says Charles E. Harris.

Re Capital will be traded on the American Stock Exchange.

After June 30, Lexington will own 10,200 shares of Re Capital and warrants to buy another 200,000 shares at $28 a share which, together, would give Lexington about a 25% stake in Re Capital. Mr. Harris said he will serve on the reinsurer's board.

Mr. Durand-Ruel's resignation was part of the plan for converting Olla into Re Capital, Mr. Harris noted.

Messrs. Chisholm, Roberts and Smith, along with an as-yet-unnamed chairman, chief financial officer and corporate secretary, will comprise the entire management of Re Capital, which will be a holding company, Mr. Harris said.

He added that "fewer people are needed" to manage the brokered treaty business.

"We wanted to position the company not only for the current market but for the next soft market," he said. "When the market dies, we won't have to retrench, but can continue to expand."

On May 23, Olla bought Fester, Fothergill & Hartung Ltd. of New York in exchange for 105,758 Olla shares at $28 a share. The agreement to buy the reinsurance managing general agent provides for another 42,282 shares to be exchanged depending on FF&H's performance, making the deal worth between $3 million and $4 million.

In addition, on that same date, Olla set up Regal Re, which FF&H manages, investing $15 million in the new reinsurance carrier.

Olla also owns a share in the New York Insurance Exchange's J&H WF Syndicate B, managed by Johnson & Higgins/Willis Faber (USA), for which it paid $250,000 (*BI*, Feb.24).

Re Capital plans to make other acquisitions, Mr. Harris said, but he declined to provide details.

Olla currently has $25 million in capital. Most recently, it received $3 million from Conning Funds of Conning & Co. in Hartford in exchange for 80,000 shares of Olla common stock representing an 11% interest in Olla.

Re Capital hopes to raise a total of $100 million by the end of the year through private placements and public offerings, Mr. Harris said.

At General Re, general counsel Edmond Rondepierre said Messrs. Chisholm, Roberts and Smith would be replaced "fairly soon." ■

ODECO fraud charges

Continued from page 2

into a series of three "excess aggregate reinsurance" agreements with Pinnacle Reinsurance Co. Ltd. in Bermuda during the years 1982, 1983 and 1984, the answer denies that ODECO at the time knew or ever approved side letter agreements to the contracts which provided that no payments would be made for 10 years.

ODECO's answer also maintains that "Mentor underwrote and set prices for its insurance and administered claims on its own without the influence or control of ODECO."

In addition, ODECO's answer denies that ODECO President Hugh J. Kelly was told by former Mentor Chairman Douglas Higley in early 1985 that "everybody knew" of the side letters to the Pinnacle Reinsurance Co. contracts.

Officers of ODECO who were named in the liquidators' suit, including Mr. Kelly, also have filed answers denying the allegations in the complaint.

However, the plaintiffs have asked the court to strike certain responses filed by former Mentor Chairman Mr. Higley, who also denies any fraudulent actions. The plaintiffs contend that certain answers are not responsive to the allegations contained in the complaint.

"Higley has elected to improperly avoid—evade is the more accurate characterization—a response," the plaintiffs contend.

Pinnacle, also named in the complaint, has asked the court to be dismissed by the action for a lack of jurisdiction. The contracts between Mentor and Pinnacle were initiated in Bermuda by Mentor and signed in Bermuda by Pinnacle, the company said.

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NAIC report

Continued from page 1

John B. Crosby, senior vp and general counsel of the NAII.

There is no need for more "onerous regulation. I don't think we need to go to JUAs or state funds or other administrative mechanisms in order to get the private market to respond to the problem risks. I think MAPs are as far as we need to go," Mr. Crosby said.

However, the report notes that "while there is good evidence that voluntary responses may be meeting most of the basic coverage needs for these problem risks, the amount of coverage and its price may still not be satisfactory to insureds."

However, when those conclusions were presented to the NAIC's Commercial Line-Property/Casualty Insurance Committee last Wednesday, state regulators bristled not only at the findings, but also at the fact that they were given to the media before the committee.

The committee tabled any action on the report and would not even "receive" it for fear that consumers would misinterpret their action as sanctioning some of the trade association's conclusions.

Arizona Insurance Director S. David Childers said the conclusions are "extremely misleading" and cannot be based just on MAP results.

He also took the three trade associations to task, saying "these are the same people who say when tort reform is discussed that there is a severe crisis."

"One thing that has to be kept in mind in looking at these MAPs . . .is what they're set up for. I mean, several of them aren't even for general liability," said Paul A. Synnott Jr., a deputy commissioner from Virginia.

Some lines of insurance specifically were not included in Virginia's MAP program "because we knew there was no market at all," Mr. Synnott said, adding, "We don't have directors and officers (liability coverage) in our state."

"This isn't a fair analysis," Mr. Synnott said, referring to the conclusions drawn by the three associations. "Many of those MAPs were set up with full knowledge that they would be totally useless for a large number of classes of business."

"You can't on one hand say that we have a real problem out there and need tort reform, and then on the other hand, when it comes to regulation, say the crisis is not as bad," said Jon Harkavy, director of governmental affairs and general counsel for the Risk & Insurance Management Society in New York. RIMS is represented on several NAIC advisory committees, but not on the property/casualty panel.

"It's a very, very dangerous conclusion to even minimize the extent of the crisis," Mr. Harkavy said.

Representatives from other groups on the advisory committee also voiced objection to the strong conclusions reached by the three trade associations.

"I think the problem is one of having statements in a narrow context," said Patricia Borowski, vp of government and industry affairs with the National Assn. of Professional Insurance Agents in Alexandria, Va.

Ms. Borowski said that because the market changed drastically in early 1985, agents and brokers were unable to rely on their previous sources of insurance and still are having trouble placing coverage.

For the NAII, AIA and Alliance to assume the availability crisis has subsided because MAPs are working is a "fairly large jump," said Karl W. Koch, executive vp of the NAIC.

"That the report was released prior to the discussion in here . . .may certainly infer that there might have been some differences of opinion . . .on the committee," he said.

However, the data concerning MAPs contained in the report can serve as a valuable tool to state regulators, said Maryland Insurance Commissioner Edward J. Muhl, NAIC vp and chairman of the Property/Casualty Committee.

The MAP data was produced in a survey of the 24 states in which MAPs are operated. The report concludes:

- Normal operation of the insurance market, efforts by state regulators and special mechanisms like MAPs have taken much of the sting out of the availability problem.

According to the survey, 2,614 applications for various lines of coverage were made to the 24 MAPs. Of that number, 1,265, or 48%, received quotations for coverage.

- MAPs put into effect by insurance regulators and the insurance industry have been extremely valuable in identifying market problems and facilitating voluntary responses to market needs.

"MAPs in general do a pretty good job in obtaining quotations and placing these risks," said the AIA's Mr. Chittenden.

The report, however, did single out governmental liability as a line with continuing availability problems, which the report blamed on the erosion of the sovereign immunity doctrine and courts' liberal interpretation of insurance policies.

"Legislation placing caps on noneconomic damages and reform of joint and several liability are primary tort reform solutions," the report noted. "Other long-term solutions include formulating more effective risk management guidelines and developing employee safety programs."

For the short term, insurance department hot lines and MAPs are the best means of alleviating troubles, the report noted.

Besides looking at MAPs in general, the advisory committee focused on three specific lines: day-care liability, liquor liability and governmental liability.

It found that the public perception of serious shortages of day-care coverage was "an exaggeration of the true market condition."

Availability problems were confined to home day-care providers that care for more than three children and smaller commercial operations, the report said.

In the liquor liability line, the report said, "There is an insurance availability problem but perhaps not one of crisis proportions. The shortages varied widely among the states and among the types of liquor establishment.

"The fear of litigation has caused liquor vendors who traditionally did not purchase insurance to seek insurance protection," the report said. "In the past, specialty companies or surplus lines insurers were able to meet the need of the liquor industry. Unfortunately, as demand for this type of insurance increased, the general supply of insurance capacity had diminished."

The survey also found that there is a market for directors and officers liability insurance, "even though the terms and conditions of D&O coverage may be somewhat limited."

"For D&O we found 15 markets out there," Mr. Crosby said.

Other members of the NAIC advisory committee besides the NAII, AIA, Alliance and PIA include representatives from the National Assn. of Casualty & Surety Agents, the National Assn. of Insurance Brokers, the National Assn. of Professional Surplus Lines Offices Ltd., American International Group Inc., CNA Insurance Cos., Lloyd's of London and the Institute of London Underwriters.

Mr. Crosby expects the advisory committee to continue its study of MAPs and update the report. It also is expected to look at other lines of liability insurance, including nurse midwives and recreational liability coverage.

Representatives on the advisory committee also noted that this survey deals specifically with availability problems—not affordability.

"It would be difficult for us to address affordability questions," Mr. Crosby said. "The rates being charged were a very subjective thing on a company basis. . .With antitrust concerns, we could not sit around the table and discuss rates and determine what is appropriate or not in a particular setting.

"Therefore, to a certain extent, we have not dealt with affordability deliberately. The fact that many people translate affordability into availability problems has not been lost on the advisory commitee and again we think the evidence speaks for itself," Mr. Crosby said. ■

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FGIC planning initial public offering

NEW YORK—FGIC Corp., whose wholly owned subsidiary Financial Guaranty Insurance Co. insures municipal bonds, plans to raise $88 million to $96 million in an initial public offering.

FGIC has filed a registration statement with the Securities and Exchange Commission seeking to offer 4 million shares of common stock with a probable offering price of $22-$24 a share.

FGIC's current owners include General Electric Credit Corp., General Re Corp., Lumbermens Mutual Casualty Co., a Kemper company, Merrill Lynch & Co. Inc., Shearson Lehman Bros. Inc., J.P. Morgan & Co. and Gerald L. Friedman, FGIC's chairman and president. They will not sell any of their stock in the public offering, and will continue to hold more than 80% of the corporation's equity once it is completed.

According to FGIC, uncertainty over the continued tax-free status of municipal bonds lowered FGIC's net premium volume to $5.7 million in the first quarter from $19.3 million for the comparable period a year ago. ■

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Regulators

Continued from page 1

immediately criticized the study as fundamentally flawed.

• Sen. Mitch McConnell, R-Ky., said he will leave no stone unturned in an attempt to get Congress to enact a comprehensive civil justice reform bill, S. 2046, that he introduced earlier this year (*BI*, Feb. 17).

Sen. McConnell is considering attaching his bill to legislation, S. 2129, now on the Senate floor that would expand the Risk Retention Act, or to a product liability reform measure being hammered out by the Senate Commerce Committee.

However, supporters of the risk retention legislation are urging Sen. McConnell to drop his plan to merge the two proposals.

"I would hope the two proposals would remain separate. I don't think the cause of either would be served by such a joining together," said Jim Anderson, director of government relations for the National Assn. of Wholesaler-Distributors in Washington.

Meanwhile, in his letter to the NAIC, Rep. Florio also said he wants the NAIC to respond to concerns that regulators have the proper resources to supervise the liability insurance market.

"It is almost universally acknowledged that inadequate staffing and funding of state insurance departments is a key problem for state regulation," he said.

He noted that regulators and insurers have questioned the ability of the states to identify financially troubled insurance companies because of unreliable data.

Rep. Florio also is asking whether there should be more regulation of the reinsurance industry.

While Rep. Florio said it is premature for the federal government to assume primary regulation of the industry, he said the public's patience with rate hikes and policy cancellations is growing thin.

Rep. Florio said his subcommittee will continue to examine a number of proposals that have been suggested to ease the liability insurance crunch. Those include a proposal by the Risk & Insurance Management Society to establish a federal agency to provide reinsurance for hard-to-place risks and other proposals to require insurers to report more financial information to the federal government (*BI*, April 21; April 28).

He also said legislation pending before his subcommittee to expand the Risk Retention Act may deserve early action. To date, the panel has not acted on the legislation, which has been pending before the subcommittee for months.

A similar bill was passed by the Senate Commerce Committee in late March (*BI*, March 31).

Meanwhile, Rep. Rodino last week released a study conducted by the House Monopolies and Commercial Law Subcommittee's staff that says property/casualty insurers have been collecting far more premiums for certain liability lines than they have paid out in claims and expenses.

The study was based on data supplied by the Insurance Services Office.

Among the nine liability lines surveyed for the period between 1975 and 1984, insurers reported a total of $4.3 billion in earned premium and $1.7 billion in paid claims and expenses.

Insurers during the same period collected a total of $1.6 billion in earned premiums for product liability and completed operations coverage, while paying out $478 million in actual losses and expenses, according to the survey.

And in 1984, product liability premiums amounted to $311.5 million, while paid claims and expenses totaled only $21.9 million, the survey reports.

The fact that premium volume far exceeds paid losses and expenses "undermines the companies' claims of massive losses and raises the specter of price-gouging and bloated prices," Rep. Rodino said.

But Tom O'Day, assistant vp in the Washington office of the Alliance of American Insurers, said the Rodino study "ignores fundamental financial common sense."

"It's so fundamentally wrong that insurers are laughing at it," he said.

For insurance, the study does not take into account insurers' contributions to reserves for unpaid losses, Mr. O'Day noted. Instead, he said the study is just a cash-flow statement that is meaningless in an industry where it may take years for a claim to paid.

"What you paid out in a year has little relevance for long-tailed lines. An insurer can look fine on a cash-flow basis and be broke," Mr. O'Day said. ■

Pension plan surplus

Continued from page 3

belong to the three Exxon plans: about 40,000 current employees and 30,000 former employees and retirees.

Exxon proposes to use what is known as a "spinoff termination" to recover the excess plan assets.

In a spinoff termination, an employer splits an existing defined benefit plan into two plans, one for retirees and one for employees. Excess assets are typically placed in the retirees' plan, which is then terminated. The company then usually buys annuities to pay promised benefits to retirees and recaptures whatever assets are left over. The other plan, which covers current employees, is retained.

Bartlesville, Okla.-based Phillips last week said it intends to recapture $400 million from a plan that had a $508 million surplus at year-end 1985. A Phillips spokesman said the company would use the recaptured assets to reduce the company's debt, which totaled $6.7 billion at the end of first quarter.

Phillips proposes to split its current defined benefit plan into two separate plans, one covering about 25,000 active employees and one covering about 30,000 retirees. The company would then terminate the retiree plan and buy annuities to guarantee retirees' benefits.

Neither Exxon nor Phillips had filed details of their proposed reversions with the Pension Benefit Guaranty Corp. as of last week.

Meanwhile, another employer, Revere Copper & Brass Inc. of Stamford, Conn., also announced last week it intends to recover an estimated $30 million in surplus pension funds.

Companies like Exxon, Phillips and Revere that complete asset reversions this year may not recover as much as they would have last year.

Both the tax bill passed by the House last December and the proposal now before the Senate contain provisions that would place a 10% excise tax on reversions from overfunded pension plans completed after Dec. 31, 1985 (*BI*, May 19).

However, an amendment to the Senate bill offered by Sen. David Boren, D-Okla., and approved by the Senate Finance Committee would exempt Phillips from the excise tax.

No similar provision is included in the House bill. ■

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BI CLASSIFIEDS WORK!

Florida legislation

Continued from page 1

Public Medical Assistance Trust Fund in wrongful death and personal injury cases or to the general revenue fund in other types of cases.

USF&G is taking the most sweeping action in response to the bill and previous underwriting losses in the state.

USF&G last month stopped writing last month any new policies in Florida, including personal lines and workers compensation insurance. The insurer has lost $75 million in Florida in the past five years, including investment income.

Aetna Life & Casualty Co. also stopped writing new commercial policies in May, in anticipation of the passage of the legislation. Aetna says it controls about 5% of the commercial property/casualty market in Florida.

Since the bill passed, CIGNA Corp., Transamerica Corp. Continental Corp., Cincinnati Insurance Co. and Travelers Corp. have announced they will not issue new commercial property and liability policies for the foreseeable future.

In addition, Chubb Group said last week it would not issue any new liability policies in Florida, pending a review of the legislation.

Transamerica said as of late last week it had not decided whether to also stop renewing commercial accounts.

Travelers is the leading insurer of allied lines in Florida, with 6.7% of the market in 1984, followed by Aetna with 6.4%, according to A.M. Best Co. 1984 statistics. Travelers also is the second-largest underwriter of fire insurance in Florida, with 7.5% of the market, and the third-largest property/casualty insurance underwriter with 3.8% of the market.

CIGNA is the third-largest underwriter of general liability insurance in the state with 5.7% of the market, behind Crum & Forster and American International Group Inc.

CIGNA also is the third-largest writer of medical malpractice insurance in Florida, with 6.9% of the market, behind The St. Paul Cos. Inc. and Evanston Insurance Group.

CNA Financial Corp. and Fireman's Fund Insurance Cos. both denounced the legislation last week but had not taken any action.

Insurance buyers were just as outspoken as underwriters.

"I don't like paying what I do, but I don't want to lose what I've got," said James Matthews, risk manager at Knight-Ridder Newspapers Inc. in Miami and treasurer of the Florida Chapter of the Risk & Insurance Management Society.

"None of it is in favor of the buyers," except for small buyers that would be grateful for a 40% cut in premiums but "don't understand what this is doing," Mr. Matthews said. The Florida Chapter of RIMS, he added, unanimously agreed not to support the legislation.

"It's going to drive insurance companies out of the state, at least for the moment," predicted William Logie, risk manager for Racal Corp., a communications equipment manufacturer in Boca Raton. "We have to be concerned that there will not be enough capacity."

Richard Hinds, risk manager for Florida Power & Light Co. in Miami, says the bill's tort reform measures are "exciting to a risk manager" and will have long-term beneficial effects. But, "as for the other portions of the bill, I think it will make it difficult to get commercial insurance for a while, particularly for the average-sized corporation," he said.

The bill, which passed 37-2 in the state Senate and 108-3 in the House, would become effective July 1 and calls for an immediate freeze on commercial property/casualty rates. Through Jan. 1, no business could be written or renewed at rates higher than the rates the insurer "had in effect" on May 1, the legislation states.

Premiums, however, could be increased on existing business if coverage changed and exposures became greater.

On Oct. 1, insurers would be required to give policyholders a 40% refund or credit on premiums due or paid on liability coverage for the remainder of the year. The credit would actually amount to around a 10% premium rollback for a 12-month policy. If a policy is in force for less than the full three months, a prorated premium refund or credit would be due.

To stop insurers from canceling or not renewing policies to avoid the rate freeze or premium rollback, the legislation prohibits insurers from exceeding their monthly average of cancellations or non-renewals by more than 30%.

Also on Oct. 1, insurers would be required to file new liability rates for use in 1987, and the legislation's intention is for those rates to be the same as those filed for Jan. 1, 1984. Legislators chose 1984 rates because they viewed those as the last filings before prices began to climb dramatically, lawmakers say.

"The intent is to hold the liability rates to Jan. 1, 1984 levels," said an Insurance Department spokeswoman. That intent does not extend to property rates, she added, but applies to commercial liability lines.

Under the new legislation, insurers can attempt to demonstrate in a Sept. 1 filing why they consider 1984 rates inadequate.

Insurers would be allowed to deviate from the rates if they could show the rates would be "clearly inadequate" to provide a reasonable rate of return or would lead to insolvency, she said.

Commissioner Gunter said, "Companies have every right to present all the data, including what the policies actually cover today as to what was covered in 1984, what interest rates are today compared with 1984" and information on changes in laws that could affect profitability and could indicate 1984 rates would be inadequate in today's market.

Mr. Gunter said the Insurance Department was not the architect of all pieces of the legislation.

"It was our idea that insurers file the rates and justify them, but it was not our idea to go back and use the base 1984 rates," said Mr. Gunter, noting the bill is a compilation of several pieces of legislation drafted by the department, Gov. Graham's administration and the Legislature.

Under current Florida regulation, commercial property/casualty insurers file rates according to the "use-and-file" system, meaning they use rates and file them with the department up to 30 days later. The department can declare the rates excessive only if it can prove there is a lack of competition among insurers in the same lines.

In addition, insurers are not now required to notify the department of rate deviations, such as discounts or surcharges.

Under the new legislation, commercial property/casualty insurers would have the option of using the same method of using and filing rates, but rates could be rejected by the department for reasons other than lack of competition. And, the department has the authority to consider investment income in ratemaking.

Insurers also could file rates prior to their use, and the department would have 60 days to initiate any rate changes. If no changes are sought, the rate would be considered approved.

The department also could order rates lowered, but refunds could only be ordered on rates used and later filed.

Franklin Nutter, president of the Alliance of American Insurers, said the Alliance is opposed to the new filing requirements.

"We're not proponents of file-and-use or the statute that provides the option," said Mr. Nutter. "It's a step backward from the open marketplace. It's not an insurmountable barrier, but it adds another bullet to the attack on the insurance marketplace."

Although no precise figures are available, the January 1984 rate levels probably were higher than actually charged. Insurers are believed to have heavily discounted rates in Florida in early 1984.

"There is no doubt they were not charging ISO advisory rates," commented a spokesman for the Insurance Services Office in New York.

Robert B. Morgan, president of Cincinnati Insurance Co. in Springdale, Ohio, said his company and probably many others were likely discounting filed rates as much as 35% in Florida in January 1984.

But while insurers are attacking the rate filing provisions, the rate freeze and premium refund or credit are the "lightning rods," Mr. Nutter contends.

"The freeze and the rollbacks are the most onerous and punitive," he said. "They are the most counterproductive."

Although both insurers and risk managers have fought for tort reform, they question if the amount of reform in the Florida legislation is worth the consequences that could be brought by the rate freeze and liability premium rollback.

Mr. Matthews of Knight-Ridder said tort reform measures in the bill "might cut 1% out of an insurer's loss column. It's supposed to help cut 40%. It won't work . . . They can't trade 1% for 40%."

A spokeswoman for the American Insurance Assn. in Washington said of the tort reform: "Basically, it gives us nothing."

And an Aetna spokesman said, "The tort reform package is weak."

He added that in other states where tort reform measures have been more meaningful, Aetna is planning to increase its writings. "Where there is excellent tort reform, we have reconsidered our market presence and expect to write more in those states."

Other major provisions of the legislation include:

- Establishing a joint underwriting association that guarantees the availability of commercial property/casualty coverage to any business required by law to have insurance but unable to find it in the conventional market. The JUA would also accept some risks that are not required by law to have coverage, but can't find insurance elsewhere.

The risk would have to be first rejected by

Continued on next page

Washington tort reform makes insurer reconsider

NOVATO, Calif.—Responding to tort reforms recently enacted in Washington state, Fireman's Fund Insurance Cos. is accepting coverage requests for three types of risks it previously deemed uninsurable.

The company announced last Monday that, effective immediately, it will consider issuing commercial general liability insurance policies in Washington state to professional day-care centers, school districts and municipalities with populations of 100,000 or less.

It last wrote liability coverage for these risks in late 1982, a spokeswoman for Fireman's Fund in Novato, Calif., estimates.

The company, which has only 2% to 3% of the state's commercial market, also says it is freezing CGL base rates in the state for one year until more information about tort savings is available.

The insurer is unable to predict how many school districts, municipalities or day-care centers it might insure. The spokeswoman says the risks will be considered individually, and stresses that Fireman's Fund doesn't intend to be a major underwriter.

The company made its decision following passage of S.B. 4630, which caps non-economic damages at a maximum of $573,000 and determines them according to a sliding scale based on the plaintiff's life expectancy with adjustments for inflation. The law was signed April 4 by Gov. Booth Gardner (*BI*, March 31).

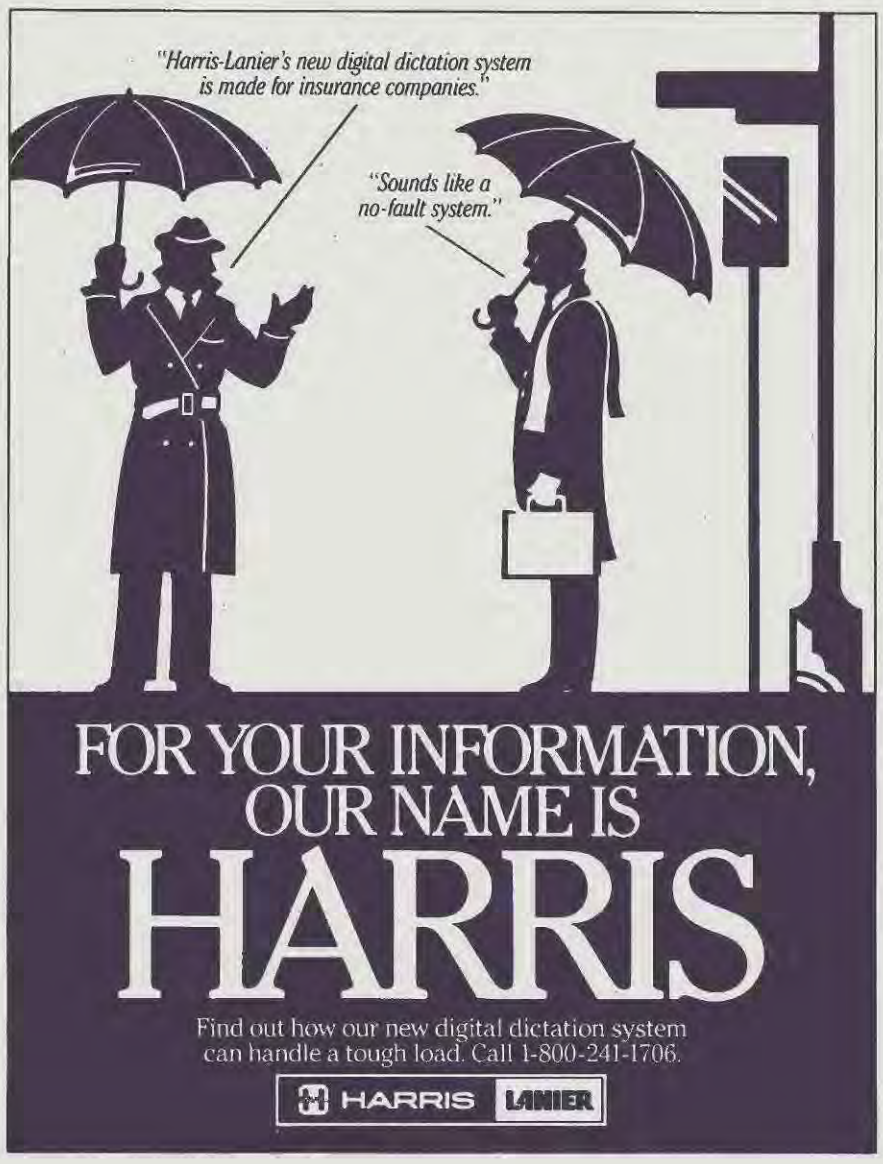
The legislation also establishes a periodic payment plan for future loss-of-earnings awards, authorizes the state's insurance commissioner to form a market assistance plan for consumers unable to find liability coverage and limits defendants' liability for pain and suffering awards to their percentage of fault (*BI*, May 19).

Fireman's Fund also is one of several insurers the California Insurance Department recently cited as willing to play a more active underwriting role in the wake of the passage of Proposition 51, the state's hotly debated tort reform measure (*BI*, June 9).

The company spokeswoman says municipalities are the only California risks it will look at more aggressively now, and that it cannot guarantee it will write any of these. It hasn't written municipal liability business in California for about a year.

"It's more an act of good faith than anything else," she explains. Compared with the steps taken by Washington, she characterizes Proposition 51—which repeals the application of joint and several liability to non-economic damage awards in third-party liability lawsuits—as "minor."

"It does very, very little to solve the problems in California."



Florida legislation

Continued from previous page

the conventional market and refused under the state's Market Assistance Plan. The JUA will be implemented before year-end, the department spokeswoman said.

- Creating an excess profits law pertaining to all commercial property/casualty insurance, except windstorm coverage. Excess profits—defined as underwriting profits over a four-year period that exceed estimates when the rates were filed by more than 4%—would be returned to policyholders that meet risk management guidelines and loss ratio tests that will likely be developed by the insurance buyer and the insurer.
- Requiring a 45-day notice of cancellation, non-renewal or premium increase for property/casualty coverages. Policies would have to be delivered to the policyholder within 60 days.
- Broadening the types of groups eligible for formation of self-insurance trusts. Currently, only attorneys and physicians can form self-insurance pools. The new legislation would allow their formation by architects, engineers, veterinarians, land surveyors, pharmacists, dentists, chiropractors, psychologists, optometrists, nurses, physicians' assistants and insurance agents.

The legislation also authorizes not-for-profit trade associations that weren't formed to obtain or provide insurance to form self-insurance funds for "pooling and spreading liabilities of their members in any commercial property or casualty risk or surety insurance." The associations would have to be at least one year old, and the funds would fall under department regulation.

- Permitting businesses to form groups to buy property and casualty insurance.
- Permitting banks to own and control reinsurers.
- Requiring insurers to supply the Insurance Department by Sept. 1 with data on personal injury claims for the last five years.

"One of the major aspects of this legislation is that we have deregulated self-insurance" of property/casualty risks, Mr. Gunter said. Employers in Florida already are allowed to group self-insure workers comp risks.

The commissioner added that commercial insurers "need to take that into account," referring to the self-insurance provisions.

"This saber-rattling tactic is a two-edged sword," he remarked, meaning insurers threatening to pull out of the state could lose a chunk of business they might never regain if they do decide to stop writing.

"Of course," he added, "Florida being a growth state, the sixth-largest state in casualty insurance premium in the U.S., it's a gamble I suggest they don't want to take."

Oregon Insurance Commissioner Josephine M. Driscoll, who also is president of the National Assn. of Insurance Commissioners, said the Florida move to roll back rates is "appalling, a terrible thing to do.

"I feel it's not the way to go," she said. "You're going to kill the markets."

Ms. Driscoll said some rate-structure abuses warrant tough solutions, but added the Florida legislation "is setting a precedent and other states will follow."

Regulators in other states also are concerned about the ramifications of the new legislation.

Illinois Insurance Director John E. Washburn said, "The question truly is, 'Are the rates excessive?' How do we know? Are they overpricing? The problem with property/casualty is that you don't know for 10 years."

One commissioner, who asked to remain anonymous in order not to rile his Legislature, said, "Legislative ratemaking is not a panacea."

In another response to the Florida action, Salomon Brothers Inc. in New York released a statement expressing concern that if states like California, New York, Illinois and Pennsylvania adopt similar legislation, the "still-emerging industry recovery would be threatened."

The bulletin recommended investors avoid purchasing stocks in insurers that could be affected by the legislation until other states react to Florida's action. ■

Illinois lawmaker's suit charges three insurers with collusion

CHICAGO—While Florida lawmakers tied lower insurance costs to tort reform, an Illinois legislator is bringing a class-action lawsuit against three insurers in his state because they said they would lower rates if tort reform were passed.

The suit, filed in Cook County Circuit Court last week by Rep. Alan J. Greiman, D-Skokie, names CNA Insurance Cos. and its general counsel, William Courtney; Governmental Interinsurance Exchange, an underwriter specializing in municipal coverages, and its president, James I. Bliss; and Kemper Group and its chief insurance officer, Rudi J. Landolt.

Charging them with conspiring to raise insurance rates and reduce coverage in violation of state antitrust laws, the suit cites letters that the defendants sent to the General Assembly and governor that said if civil justice and tort laws are changed, the defendants would charge lower rates and premiums and make available coverage that has been unavailable.

According to the suit, the letters imply that unless the conditions set forth in the letter are met, insurance rates will not be reduced or changed, regardless of possible changes in market conditions.

The sending of the letters at about the same time constituted "a combination of persons who would be competitors" and effectively "fixes, controls or maintains a rate charge of insurance for commercial and business customers" in violation of state antitrust laws, the suit says.

In a prepared statement, Mr. Landolt of Kemper said the suit was "outrageously frivolous and without merit" and "an attempt to grab headlines and intimidate our participation in the current debate over the lawsuit crisis."

Mr. Bliss of Governmental said supporters of tort reform have made reference to a plague of frivolous lawsuits and that "this is a good example of that."

He called the suit "totally baseless" and said it ignores the principle that political action is absolutely privileged in the United States.

By Stephen Tarnoff

update

Greyhound sues D&O insurers

Continued from page 2

The suit was filed June 4 in Maricopa County Superior Court in Phoenix by Greyhound and an overseas subsidiary.

Briefly noted

Some 819 property/casualty and life insurance companies may be headed for financial trouble, according to a report by an examiners team of the **National Assn. of Insurance Commissioners**. The report cited 234 property/casualty insurers and 191 life insurers for immediate regulatory attention and 267 property/casualty and 127 life insurers for targeted regulatory attention. . . .Claims stemming from the December 1984 gas leak in Bhopal, India, may be litigated in Indian courts within 10 months, following **Union Carbide Corp.'s** formal acceptance last week of a district court judge's conditional order that dismisses the case from U.S. courts. However, Carbide reserved the right to appeal. . . .The Senate last week rejected efforts to retain tax deductions for contributions to **Individual Retirement Accounts** for those covered by private pension plans.

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Largest U.S. reinsurers' first-quarter 1986 results

(All amounts in thousands of dollars) (Ranked by net reinsurance premium written)

Reinsurer	Policyholders' surplus (reinsurers only)	Net reinsurance premiums written 1986	Net reinsurance premiums written 1985	Net reinsurance premiums earned	Losses & loss adjustment expenses	Loss ratio	Underwriting expenses	Expense ratio	Combined ratio 1986	Combined ratio 1985
General Re	$1,503,102	$602,758	$322,865	$454,844	$369,263	81.2%	$149,805	24.9%	106.1%	113.4%
Employers Re	575,975	267,508	142,293	216,866	177,501	81.8	59,370	22.2	104.0	116.2
American Re	314,232	208,957	143,466	199,469	152,575	76.5	50,649	24.2	100.7	127.4
North American/Swiss Re	329,774	188,267	106,634	140,700	116,899	83.1	55,200	29.3	112.4	118.9
Munich Re	203,061	145,999	82,138	133,324	103,939	78.0	42,345	29.0	107.0	115.0
Prudential Re	275,951	133,975	123,312	115,329	95,945	83.2	40,787	30.4	113.6	134.2
Kemper Re	152,547	100,793	58,681	93,125	84,867	91.1	20,077	19.9	111.0	116.1
National Re	129,208	73,931	30,931	68,857	65,120	94.6	11,472	15.5	110.1	126.6
Continental Re	103,874	68,402	54,823	57,905	51,032	88.1	16,428	24.0	112.1	110.9
Transatlantic Re	102,484	66,341	27,877	51,683	45,812	88.6	16,988	25.6	114.2	137.6
Skandia America Group	147,720	63,967	71,512	62,160	53,235	85.6	19,243	30.1	115.7	133.7
St. Paul Re	N/A	59,057	23,151	47,512	32,400	68.2	16,506	27.9	96.1	119.0
Continental Casualty	N/A	50,124	27,573	32,556	26,851	82.5	11,133	22.2	104.7	117.1
INA Re	141,591	48,537	48,574	48,537	35,229	72.6	15,714	32.4	105.0	132.7
Constitution State Mgt.	N/A	46,891	18,399	41,354	35,741	86.4	11,604	24.7	111.1	113.3
PMA Reinsurance Corp.	28,297	45,242	20,990	22,923	18,659	81.4	8,958	19.8	101.2	93.1
Buffalo Re	109,307	41,939	33,780	42,201	44,041	104.4	7,904	18.8	123.2	145.6
Constitution Re	85,424	40,055	32,267	34,772	27,502	79.1	10,261	25.6	104.7	115.3
Metropolitan Re	56,587	33,746	18,995	26,942	18,728	69.5	9,457	28.0	97.5	119.5
Home Re	50,005	33,122	23,970	25,886	21,468	82.9	5,455	16.5	99.4	97.6
Total for top 20	**4,309,139**	**2,319,611**	**1,412,231**	**1,916,945**	**1,576,807**	**82.3**	**579,356**	**25.0**	**107.3**	**120.4**
Total for all companies	**5,440,875**	**2,873,838**	**1,812,806**	**2,400,378**	**1,976,380**	**82.3**	**730,154**	**25.4**	**107.7**	**121.1**

Source: Reinsurance Assn. of America

Good times for reinsurers

Continued from page 3

by one much-improved quarter," says Michael G. Fitt, chairman and chief executive officer of Employers Reinsurance Corp. in Kansas City, Mo.

Already, there are some "very preliminary signs" of market softening, particularly in property lines, he says.

Discussing Employers Re's results, Mr. Fitt says, "I'm pleased with the trends, but not entirely pleased with the results and won't be until our combined ratio is below 100%. I don't think the first quarter is any great indication as to how 1986 will end up."

Employers Re's combined ratio improved to 104.0% in the first quarter of 1986, compared with 116.2% in last year's first quarter.

While he expects Employers Re's results to continue to improve, he does not anticipate an underwriting profit this year, although "we could reach that point in 1987."

"I still think that there has been enough blood spilled in the last couple of years that we have at least got to look forward to two or three more years of good results before we see a downturn," says James F. Dowd, chairman of Skandia America Group in New York.

Skandia American reported a 115.7% combined ratio for the first quarter, compared with a 133.7% combined ratio in last year's first quarter. Net premiums written, according to the RAA survey, declined to $64 million from $71.5 million.

Mr. Dowd says the apparent decline in Skandia's first-quarter premium volume reflected intragroup reinsurance, noting that, in reality, the company posted a "good premium increase," particularly in facultative business.

The biggest contribution to Skandia's loss ratio, he says, was surety business. The company has reduced its participation in this line to a certain extent, he adds.

Richard Hopkins, president of St. Paul Reinsurance Management Corp. in St. Paul, Minn., which manages the reinsurance business of St. Paul Fire & Marine Insurance Co., observes that if the hard market does not last "at least three years, reinsurers will be in a lot of trouble" because of the huge losses they have accumulated over the last five years.

But, Mr. Hopkins says, "we were very pleased" with St. Paul Re's first-quarter results. The company turned an underwriting profit with a 96.1% combined ratio, compared with a 119.0% combined ratio in the first quarter of 1985.

St. Paul Re's results were better than the average, he says, partly because it is a relatively new player and does not have to run off old business.

"We expect the balance of the year to be good if we don't have any catastrophes such as a hurricane or an earthquake," he says, noting St. Paul Re is very active in property lines.

Another reinsurer that posted a first-quarter underwriting profit is New York-based Metropolitan Reinsurance Co., which reported a first-quarter combined ratio of 97.5% in 1986, compared with a 119.5% combined ratio in 1985.

"I would say Met Re benefits from having been very realistic on its loss reserving and its IBNR policies," comments Frank Haftl, president and chief operating officer, who attributes the reinsurer's improved numbers to higher rates.

The third reinsurer to post a sub-100% combined ratio, Home Reinsurance Co., actually saw its underwriting results deteriorate slightly in the first quarter as its combined ratio rose to 99.4% from 97.6% in the first quarter of 1985. Home Re President Martin Jackson says there was no particular reason for the increased combined ratio.

However, Mr. Jackson says there are "one or two spots" where competition among reinsurers is already increasing, particularly in facultative lines. Some direct reinsurers are writing more facultative reinsurance, and companies that accept business from brokers are seeing fewer offerings.

Edward Jamison Jr., chairman and president of Buffalo Reinsurance Co. in Woodland Hills, Calif., comments that the industry's first-quarter results are surprising since they indicate that reinsurers generally did not boost their reserves.

While he would not say how much Buffalo Re had added to its reserves, he noted that the company traditionally does much better on an annual basis than it does during the first quarter.

Buffalo Re reported a 123.2% combined ratio in the first quarter of 1986, compared with a 145.6% combined ratio for 1985's first quarter. ■

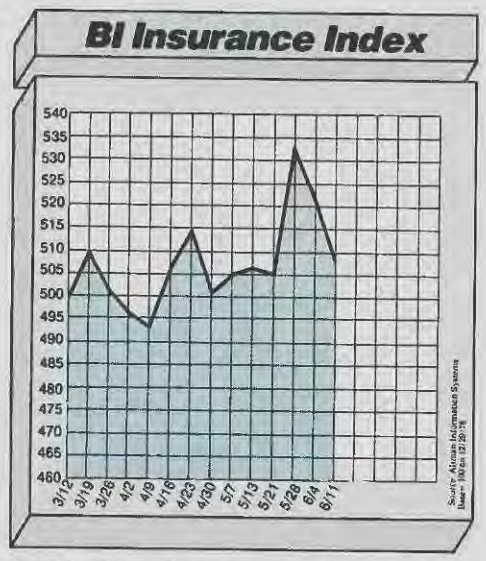
BI Industry Stock Report

June 11, 1986 6/5/86 thru 6/11/86

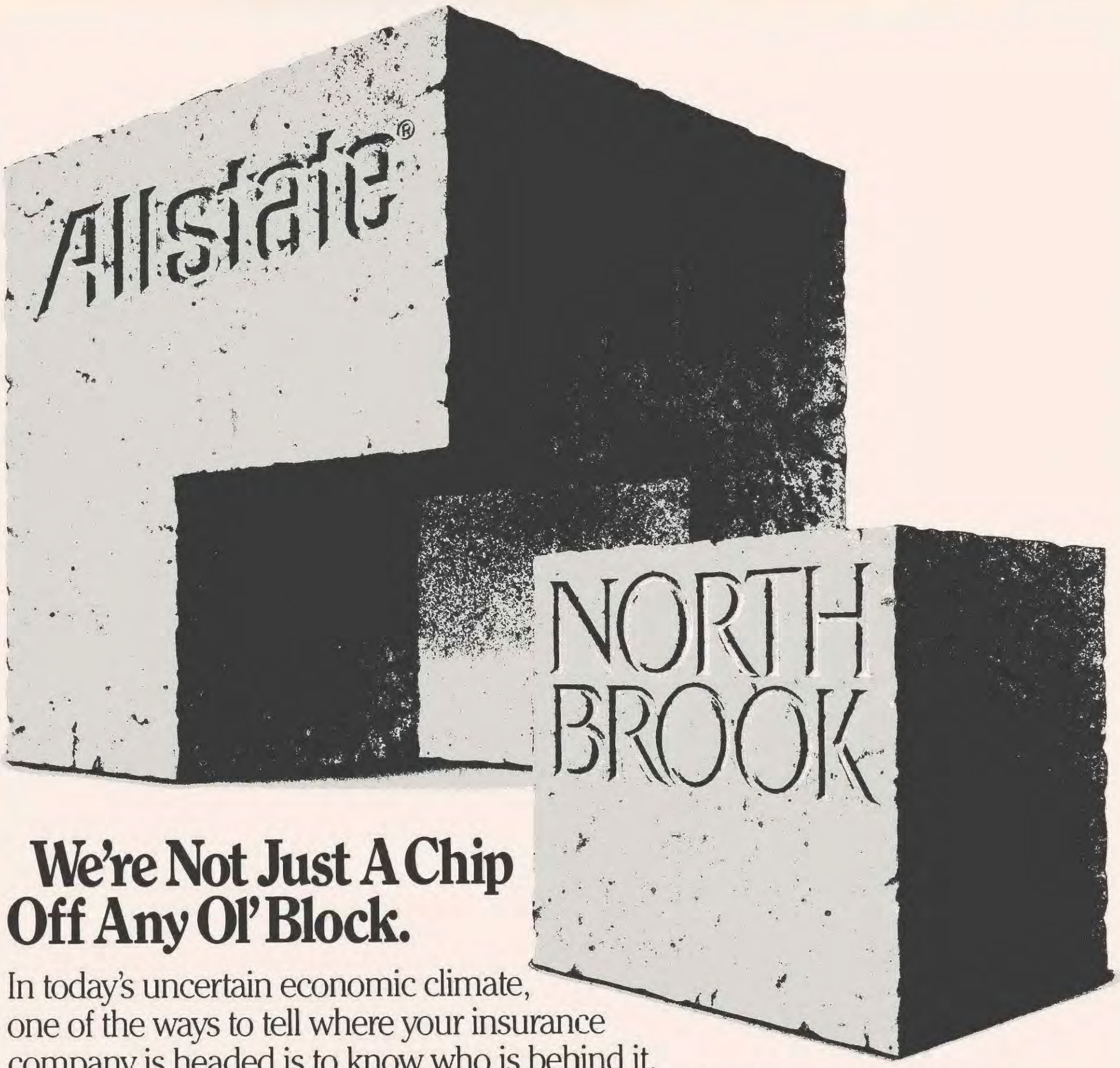
		Price	% Chg.	P/E	$ Div.	% Yld.	High	Low	Vol.(000)
Brokers									
Alexander & Alexander Svcs	NYSE	37.13	-4.8	0.4	1.00	2.7	39.25	36.63	251.1
Baldwin & Lyons Inc	OTC	107.00	-0.9	53.8	0.80	0.7	108.00	100.00	0.1
Corroon & Black Corp	NYSE	37.50	-1.3	20.1	0.65	1.7	37.50	35.00	212.0
Crump E H Cos Inc	OTC	26.00	-1.9	22.0	0.25	1.0	26.38	25.50	122.6
Emett & Chandler Cos Inc	OTC	18.75	0.0	25.3	0.00	0.0	0.00	0.00	0.0
Gallagher Arthur J & Co	OTC	50.00	1.0	21.6	0.40	0.8	50.50	49.50	51.0
Hall Frank B & Co Inc	NYSE	27.25	-2.2	0.0	0.00	0.0	29.13*	27.13	401.0
Marsh & McLennan Cos Inc	NYSE	56.63	-4.0	22.5	1.50	2.6	58.25	56.00	464.0
Poe & Assoc Inc	OTC	11.50	4.5	0.0	0.53	4.6	11.50	11.50	15.8
AGENTS/BROKERS	AVERAGE			3.8		1.4			
Conglomerates & Holding Cos.									
American Express(Fireman's Fd)	NYSE	58.50	-5.3	13.7	1.36	2.3	61.88	58.50	3,776.2
Anderson Clayton(Ranger/PanAm)	NYSE	55.88	-9.5	31.9	0.00	0.0	0.00	0.00	0.0
Armco Inc	NYSE	9.00	-5.3	0.0	0.00	0.0	9.50	9.00*	470.9
Berkley W R Corp	OTC	51.25	-7.2	26.4	0.36	0.7	56.00	51.25	396.3
CIGNA Corp	NYSE	59.63	-6.3	0.0	2.60	4.4	63.13	59.38*	2,563.6
CNA Finl Corp (CNA)	NYSE	55.25	-10.9	17.4	0.00	0.0	62.50	55.25*	374.1
General Re Corp	NYSE	114.00	-4.2	35.1	1.76	1.5	117.50	112.25	907.7
ITT (Hartford Group)	NYSE	45.13	-3.5	24.5	1.00	2.2	47.25	43.88	4,564.6
Sears Roebuck & Co. (Allstate)	NYSE	46.38	-2.6	13.4	1.76	3.8	48.25	46.00	5,260.4
Teledyne Inc (Argonaut)	NYSE	334.88	-2.3	8.1	0.00	0.0	342.75	333.50	66.9
Transamerica Corp (Occidental)	NYSE	33.63	-5.6	16.1	1.68	5.0	35.75	33.50	801.7
CONGLOMERATES/HOLDING COS.	AVERAGE			16.8		1.2			
Insurers									
Aetna Life & Cas Co	NYSE	57.00	-6.9	12.6	2.64	4.6	60.75	56.50	4,360.4
American General Corp	NYSE	38.75	-0.6	11.7	1.12	2.9	39.88	37.75	1,662.9
Amern Heritage Life Invt Co	NYSE	42.38	0.6	15.6	1.32	3.1	42.38	42.13	1.8
American Indty Finl Corp	OTC	19.00	-3.8	0.0	1.12	5.9	20.00	19.00*	8.7
American Intl Group Inc	NYSE	120.00	-4.6	22.3	0.44	0.4	124.00	119.38	1,330.7
Aneco Reins Ltd	OTC	2.50	0.0	0.0	0.00	0.0	2.50	2.50	5.5
Avemco Corp	NYSE	28.75	-0.4	16.0	0.50	1.7	28.88	28.75	21.7
Business Mens Assurn Co Amer	OTC	28.50	-0.9	17.2	1.10	3.9	29.50	28.50	369.5
Chubb Corp	NYSE	66.88	-8.2	131.1	1.56	2.3	72.25	66.75	1,378.7
Combined Intl Corp	NYSE	55.88	-3.5	11.2	2.24	4.0	56.75	54.75	415.5
Continental Corp	NYSE	44.75	-6.5	0.0	2.60	5.8	47.50	44.00	1,660.7
Crown Life Ins Co	OTC	300.00	-3.2	3.0	0.00	0.0	310.00	300.00	0.1
Durham Corp	OTC	46.50	0.5	12.5	1.36	2.9	47.00	46.25	15.9
Farmers Group Inc	OTC	42.00	-1.9	15.1	1.00	2.4	42.50	40.00	1,276.2
Fairmont Finl Inc	AMEX	29.13	-1.3	21.9	0.00	0.0	29.25	28.13	146.1
Fireman Fd Corp	NYSE	34.25	-4.5	0.3	0.30	0.9	36.13	33.63	1,257.9
Fremont Gen Corp	OTC	26.38	-3.2	0.0	0.48	1.8	27.38	26.38	185.2
Great West Life Assurn Co	OTC	700.00	0.0	7.0	18.00	2.6	700.00	700.00	0.0
Home Group Inc	AMEX	26.25	-5.4	57.1	0.00	0.0	27.00	25.63	853.4
Hanover Ins Co	OTC	61.25	-0.8	32.8	0.56	0.9	62.00	61.25	22.8
Hartford Steam Boiler Insptn	OTC	90.75	1.4	14.4	2.40	2.6	90.75*	88.50	90.4
Kans City Life Ins	OTC	34.50	3.8	13.6	0.87	2.5	34.50*	33.25	16.3
Kemper Corp	OTC	88.00	-6.4	31.2	1.80	2.0	93.63	85.00	804.0
Liberty Corp S C	NYSE	40.88	-2.1	17.2	0.72	1.8	41.50	40.88	12.4
Lincoln Natl Corp Ind	NYSE	50.88	-6.2	11.5	2.00	3.9	53.13	50.38	748.0
Mission Ins Group Inc	PAC	3.13	0.0	0.0	0.00	0.0	4.38	2.88	268.0
Monumental Corp	OTC	54.00	0.0	19.2	1.40	2.6	54.25*	53.88	23.5
Nac Re Corp	OTC	37.00	-7.5	0.0	0.00	0.0	39.50	37.00	68.2
Nobel Ins Ltd	OTC	16.25	-8.5	21.4	0.25	1.5	17.75	16.00	71.1
Northwestern Natl Life Ins	OTC	29.00	-0.9	12.7	0.86	3.0	29.25	28.75	117.4
Ohio Cas Corp	OTC	83.50	-4.8	19.3	3.00	3.6	87.25	81.88	448.6
Old Rep Intl Corp	OTC	37.00	-3.3	13.6	0.78	2.1	38.25	36.50	380.5
Orion Cap Corp	NYSE	35.88	-3.7	0.0	0.76	2.1	36.25	35.88	129.0
Protective Corp	OTC	23.50	0.0	12.8	0.70	3.0	23.50	23.00	35.6
Provident Life & Acc Ins Co	OTC	28.88	-3.3	10.1	0.84	2.9	29.50	28.63	279.4
St Paul Cos Inc	OTC	42.50	-7.1	25.6	1.50	3.5	46.00	41.50	1,929.6
SAFECO Corp	OTC	54.50	-6.0	14.7	1.68	3.1	58.25	52.88	762.9
Sri Corp	OTC	22.50	-1.1	0.0	0.80	3.6	22.75	22.50	59.3
Seibels Bruce Group Inc	OTC	19.00	-6.2	0.0	0.80	4.2	20.50	19.00	50.7
Statesman Group Inc	OTC	5.38	-4.4	38.4	0.05	0.9	5.63	5.38	67.4
Tokio Marine & Fire Ins Co	OTC	405.25	13.8	76.3	1.05	0.3	405.25*	363.50	19.9
Torchmark Corp	NYSE	32.50	0.4	14.1	0.60	1.8	32.63	31.50	555.0
Travelers Corp	NYSE	48.25	-4.0	12.2	2.16	4.5	49.25	47.25	3,259.6
United Fire & Cas Co	OTC	28.00	-5.1	22.2	0.80	2.9	29.00	28.00	109.9
United States Fid & Gty Co	NYSE	38.13	-6.7	0.0	2.32	6.1	40.50	37.63*	2,562.5
Uslife Corp	NYSE	42.00	-1.2	11.2	1.12	2.7	42.63	40.88	166.1
Washington Natl Corp	NYSE	34.00	-1.1	15.0	1.08	3.2	34.00	33.50	46.2
Zenith Natl Ins Corp	OTC	26.75	-4.5	133.7	0.80	3.0	28.00	26.75	195.6
INSURANCE COMPANIES	AVERAGE			8.5		2.1			

System design: Altman Information Systems

BI Insurance Index



The *Business Insurance* index continued its downward slide last week, closing at 508.8 on June 11, down 13.9 points from 522.7 on June 6. A total of 44 stocks posted losses, while seven gained and seven were unchanged. The largest losses were posted by: CNA Financial Corp., down 10.8%; Nobel Insurance Ltd., down 8.5%; Chubb Corp., down 8.2%; NAC Re Corp., down 7.5%; and W.R. Berkley Corp., down 7.2%. Stocks posting the largest gains were: Tokio Marine & Fire Insurance Ltd., up 13.8%; Poe & Associates Inc., up 4.5%; Kansas City Life Insurance Co., up 3.8%; Hartford Steam Boiler Inspection & Insurance Co., up 1.4%; and Arthur J. Gallagher & Co., up 1.0%. The *BI* index fell 2.7%, which was much sharper than the declines in other market averages.



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