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Update

House proposal would simplify Section 89 non-discrimination rules

WASHINGTON—The House Ways and Means Committee last week tentatively approved simplifying the complex non-discrimination rules for welfare plans contained in the 1986 tax law.

However, the proposal itself is quite complicated and was still being negotiated last week, congressional observers say.

Under one provision of the new proposal, welfare plans must pass the prescribed tests at a certain date each year

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Antitrust attack

McCarran repeal poses dangers, industry warns

By DEBORAH SHALOWITZ

WASHINGTON—A House subcommittee proposal that would virtually wipe out insurers' current limited exemption from federal antitrust law actually would reduce competition in the insurance industry, insurers and brokers contend.

Particularly hard hit by the proposal to gut the exemption would be smaller insurers, which lack the resources to perform some of the data-analysis activities that the proposal would prohibit, experts say.

The proposal, which so far has moved quickly through Congress, "would hinder competition" and "the smaller companies are the ones that will be affected the most," said Paul Baiocchi, president of the American Assn. of Insurance Services in Bensenville, Ill. AAIS provides ratemaking, policy forms and statistical services to approximately 400 small and medium-sized U.S. property/casualty insurers.

The proposal to amend the McCarran-Ferguson Act approved by a House Judiciary subcommittee earlier this month would "present problems for smaller insurers" who don't have the resources to project loss trends themselves, said a spokeswoman for the Insurance Services Office Inc., the New York-based group that provides ratemaking, policy forms and statistical services to most U.S. property/casualty insurers.

Property/casualty actuaries must analyze

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Illustration: Roger Schillerstrom

Proposal's impact less onerous for life/health insurance industry

By DONNA DiBLASE

Life/health insurance industry officials vehemently oppose stripping insurers of their current limited immunity to federal antitrust laws, although they rely less on the exemption than property/casualty insurers.

Life/health insurers are not even certain how amending the McCarran-Ferguson Act would affect their business practices.

As a result, the life/health insurance industry has been relatively quiet during debate over changes to the act, including the legislation passed by a House Judiciary subcommittee earlier this month (see related story).

Because life/health insurers set their rates individually, instead of using an industrywide rating bureau like the Insurance Services Office Inc., proposals to subject insurance price fixing or the development of recommended rates to antitrust law would not hurt life/health insurers.

However, some observers point out that a provision in the House legislation that would subject to antitrust laws the tying of the sale of insurance to the sale of any

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Judge restricts discovery process in states' suits

By DONNA DiBLASE

SAN FRANCISCO—The discovery process in the massive antitrust litigation filed by state attorneys general against the property/casualty insurance industry initially will be limited to whether the defendants' alleged conspiracy was exempt from antitrust laws.

"My whole effort here is directed at handling this case with economy and efficiency," U.S. District Court Judge William W. Schwarzer remarked Thursday during the first status conference in the litigation (see story, page 34).

"The fundamental question for all defendants is whether the joint action on policy forms violates state and federal antitrust laws," the judge said, directing attorneys for both plaintiffs and defendants to limit their discovery to this question.

Discovery is the pretrial process in which attorneys for one party can obtain facts and information about the case from the other side. This information can include depositions, written interrogatories, documents and on-site inspection.

"We will not at this point go into discovery that will be necessary to prove things such as pressure and coercion. Do not conduct discovery on matters that you have reason to believe will raise issues of fact that are reasonably disputable," Judge Schwarzer said. "I am trying here to avoid having the plaintiffs conduct discovery that

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NAIC to disclose IRIS statistical data

By MEG FLETCHER

NEW YORK—In a major policy change, the National Assn. of Insurance Commissioners will release annual statistical analysis of the financial condition of most insurers operating in the United States rather than fight to keep the information confidential.

The decision is a partial victory for consumers who had demanded that the NAIC release the results of its financial analysis of property/casualty and life/health insurers.

Beginning later this year, the NAIC annually will release financial ratios for insurers and insurance groups whose finances are analyzed under its Insurance Regulatory Information System. The data analyzed is provided to the NAIC in separate mandatory filings by nearly all insurers that operate in the United States on any basis.

The NAIC annually will release for each of more than 5,000 insurers IRIS ratios—11 for property/casualty insurers and 12 for life/health insurers—accompanied by an industry average for each ratio and basic information about how the ratio is calculated.

Historically, 15%-25% of insurers tested under IRIS produce results outside the expected range.

The first release will involve 1987 financial data.

However, the NAIC will continue to keep confidential its financial examiners' analysis of an insurer's statistical data. That analysis previously resulted in companies being categorized as requiring "immediate regulatory attention," "targeted regulatory attention" or "no regulatory attention."

The ratings now will be four numerical classifications.

Several months ago the NAIC ceased publishing for public release detailed descriptions of how the ratios are calculated and ratio ranges an observer can use to analyze whether an insurer's ratios are unusual.

The new policy on releasing insurers' statistical information was approved by the nation's insurance commissioners at the end of the NAIC's summer meeting in New York earlier this month.

"We decided to bifurcate the two types of information" and separate statistical data, which are a matter of public record, and the NAIC's own analytical work product, which should be kept confidential, said David Gates, NAIC vp. Mr. Gates chairs the NAIC's Data/Systems Management Task Force.

"While the IRIS financial ratios have proven to be effective in distinguishing between financially sound and potentially troubled companies, misclassifications do occur, and misimpressions can be obtained without further review by an experienced analyst familiar with insurance company operations,

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Competition among primary insurers reduces reinsurers' first-quarter premiums
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Adjusting past sex-based pension benefits is unnecessary, U.S. Supreme Court rules
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Update

Proposal simplifies Section 89

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to be considered non-discriminatory.

Currently under Section 89 of the Internal Revenue Code, which governs non-discrimination rules, it is unclear over what period of time welfare plans must be in compliance with the tests. Section 89 only says the plans have to be in compliance continuously (*BI*, April 18).

The new Section 89 proposals are part of a broad bill designed to correct drafting glitches in the Tax Reform Act of 1986.

Purchasing group ruling upheld

NEW YORK—The New York Insurance Department can require insurers that write coverage for members of purchasing groups in the state to follow New York's policy form and rate requirements, the U.S. Court of Appeals in New York ruled last week.

The decision upholds a September 1987 ruling by U.S. District Court Judge John F. Keenan in a suit filed by the Insurance Co. of the State of Pennsylvania, a unit of American International Group Inc., against the New York Insurance Department. The suit contended that insurers issuing policies to purchasing group members are exempt from state rate and form filing requirements under the federal Risk Retention Act (*BI*, Oct. 5, 1987; Sept. 7, 1987).

The insurer has not decided whether to appeal the latest decision to the U.S. Supreme Court, said Patrick J. Foley, AIG vp and associate general counsel.

Storm losses total $293 million

NEW YORK—A rash of wind, hail and tornadoes in May caused an estimated $293 million of insured damages in 23 states.

The most extensive damage occurred in the Oklahoma City area May 15 and 16, where insured property losses are estimated at $72 million. The same storm caused $3 million of losses in West Virginia. The Property Claim Services division of American Insurance Services Group Inc. assigned the storm Catastrophe No. 58.

Kentucky sustained $30 million of insured storm losses May 6-10. Other states that sustained a total of $100 million of insured losses in the storms, assigned Catastrophe No. 57, were: Nebraska, Iowa, Missouri, Illinois, Colorado, Texas, Wisconsin, Indiana, South Dakota, Kansas, Tennessee, Ohio and Alabama.

In addition, storms assigned Catastrophe No. 59 caused an estimated $33 million in damage in Texas between May 19 and 21.

Storms in seven Southern states May 23-24 were assigned Catastrophe No. 60. The most extensive damage occurred in Georgia with insured loss estimates of $8 million. The storms also caused $27 million of insured damages in Mississippi, South Carolina, North Carolina, Louisiana, Florida and Alabama.

In New Mexico, storms on May 30-31—assigned Catastrophe No. 61—caused $20 million of insured property damage.

MARAD opens hull market

WASHINGTON—Operators of ships subsidized or financed by the U.S. government will be able to purchase hull coverage from insurers outside the United States and London under new regulations finalized by the U.S. Maritime Administration.

The MARAD ruling eliminates requirements that called for 75% of the hull insurance required under subsidized programs to be written by U.S. insurers. The remaining 25% of the coverage was written mostly by London insurers.

In a summary explaining the new regulations, MARAD said "there is no compelling reason to preclude participation by additional financially sound underwriters simply because they are not in the American or London markets."

However, the agency stated U.S. insurers must have similar access to business in the foreign insurer's domicile and, "consistent with sound business judgment, owners will be expected to place their insurance with the American market to the maximum extent possible."

The regulations become effective 30 days after publication in the Federal Register, which is expected this month.

Asset reversion vote expected

WASHINGTON—Employers terminating overfunded defined benefit pension plans would be temporarily barred from taking asset reversions under legislation heading to the Senate floor.

The Senate Appropriations Committee last week approved a proposal that would require any pension plan assets not distributed to plan participants following the termination of an overfunded plan to be held in escrow until Oct. 1, 1989. The legislation would be effective retroactive to June 21.

The Senate is expected to vote this week on the measure, which is attached to a bill approving appropriations for federal agencies for fiscal year 1989.

Howden judge disqualified

LONDON—The judge hearing the pretrial criminal proceedings against four former executives of Lloyd's of London broker Alexander Howden Group Ltd. revealed last week that she is married to a Lloyd's member and, thus, disqualified herself from the case.

Magistrate Ann Mallinson disqualified herself on Friday because her husband, Terence Mallinson, has been a Lloyd's member since

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Errors & omissions

- Although submitted by the company prior to the deadline, FLX Corp.'s listing for the directory of employee benefit information systems in the May 30 issue was never received by *Business Insurance*. The listing appears on page 33.

Resignations rattling traditions at Lloyd's

By STACY SHAPIRO

LONDON—Leaders at Lloyd's of London are urging radical changes—including limiting members' liability for losses—at the 300-year-old market to stave off the increasing number of members who are resigning.

At least 1,000 names are expected to notify Lloyd's by the June 30 deadline that they will drop their membership next year, said Robert R. Hiscox, chairman of Lloyd's underwriting agency Roberts & Hiscox Ltd., and other underwriting agency officials.

Some underwriting agencies expect as many as 10% of Lloyd's 33,540 current members to resign this year, which alone would reduce Lloyd's capacity next year.

However, a Lloyd's spokesman pointed out that just as many—and perhaps more—people are expected to become Lloyd's members for the first time next year, diminishing the impact of the resignations.

The spokesman also said Lloyd's cannot estimate the number of member resignations until the Thursday deadline.

About 280 of Lloyd's 31,484 members resigned in 1987, in line with the historic pattern of about 1% to 1.5% of Lloyd's members resigning since 1980.

Current Lloyd's members who plan to resign say investing at Lloyd's is no longer profitable because premium volume is down, the British government has reduced tax incentives and syndicate overhead has grown.

Members also are resigning because they fear the risk of unlimited liability for losses outweighs the rewards, the syndicate executives add (*BI*, June 6).

As a result, several top executives working in the Lloyd's market, including top Lloyd's underwriting agency officials, last week called on Lloyd's to:

- Limit members' liability for losses.
- Restructure Lloyd's management to make the outside chief executive the market's top regulatory official, while the chairman of Lloyd's serves as a figurehead.
- Do away with the market designations—marine, non-marine, aviation and motor—and allow all syndicates to write all classes of business.
- Allow underwriting agencies to accept business from other sources besides Lloyd's brokers.

These suggestions were made before 100 leading Lloyd's underwriting agency executives, member agency executives, brokers, underwriters, accountants and corporation staff members at a conference last week on the future of Lloyd's, sponsored by Insurance & Reinsurance Research Group Ltd. in London.

The conference—which was chaired by Peter Rawlins, managing director of Sturge Holdings P.L.C., Lloyd's largest underwriting agency group—became a forum for radical ideas to change Lloyd's.

The recommendations stem from fears that members —who contribute Lloyd's capital—are losing faith in Lloyd's and may resign in droves, causing the capacity of Lloyd's to fall from about 11 billion pounds ($19.6 billion at current exchange rates) this year.

While underwriting executives are not concerned about losing 1% or 2% of the market's capacity because of a soft market, they are worried that mass

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Committee proposes relief from COBRA penalties' bite

By DEBORAH SHALOWITZ

WASHINGTON—Employers would receive some long-awaited relief from the Consolidated Omnibus Budget Reconciliation Act's massive tax penalties in legislation expected to be approved this week by a House committee.

However, the legislation still contains an onerous provision that would require employers to extend COBRA coverage to beneficiaries who have obtained health care coverage under another employer's plan.

The House Ways and Means Committee last week tentatively approved a package of COBRA-related proposals that generally would fine an employer $100 for each day it fails to extend or errs in extending COBRA health care continuation coverage to a beneficiary. Also, employers would be given a grace period during which penalties could be waived if a COBRA mistake were inadvertent and quickly corrected.

Currently, an employer can lose its entire annual tax deduction for health care expenses for a single COBRA violation, regardless of the length or severity of the violation.

More good news for employers is a provision that would impose a special minimum penalty of at least $2,500 if an Internal Revenue Service plan audit uncovers a COBRA violation that was not corrected before the employer received notice that the IRS would be auditing the plan. The House previously had proposed slapping employers with an excise tax of at least $18,000 for each COBRA violation uncovered in an IRS audit (*BI*, May 23).

However, the technical corrections bill still contains a provision that would require employers to allow beneficiaries to maintain COBRA coverage even if they become covered under another employer's health care plan (*BI*, April 11).

Employer groups have objected to that proposal, contending that employees taking advantage of the "double coverage" allowed by the provision could sock their former employers with costly health care claims and that the proposal would result in big administrative hassles involving coordination of benefits.

A committee staffer said legislators did not discuss the provision when the COBRA issues were addressed. However, she noted that the proposal could be brought up at the end of deliberations.

The new COBRA penalties are based on a proposal stripped last year from a House-passed budget bill (*BI*, Dec. 14, 1987). They are now part of a bill to correct drafting glitches in the Tax Reform Act of 1986 that the Ways and Means Committee is expected to approve this week.

During closed-door discussions of the technical corrections bill, committee members last week amended a newly drafted provision that would have made employers, insurers, health maintenance organizations and third-party administrators jointly and severally liable for COBRA violations (*BI*, May 30).

Under the new amendment, insurers and others would not be jointly and severally liable for COBRA violations unless an employer specifically had a contract that specifically included such a liability provision, according to a committee staffer.

Currently, only employers are directly liable for COBRA violations. ■

Inside

- Whether you are a risk manager or a concerned consumer, write to your state representatives urging the prohibition of car rental collision damage waivers, this week's editorial suggests. **PAGE 8**
- California is recommending a rule that would require ceding insurers to write off reinsurance recoverables not paid after 150 days. **PAGE 12**
- In Speaking Out, Howard C. Alper, president of Audit-Rate Inc., says that while market cycles do exist, the biggest problem with sound underwriting appears to be the property/casualty accounting system. **PAGE 21**
- Approximately 60% of U.S. employees covered by employer-sponsored group health insurance plans are subject to at least some sort of utilization review, a new survey shows. **PAGE 27**
- A judicial advisory committee recommends major changes in the English civil justice system. **PAGE 31**

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Reinsurers' volume declines in 1st quarter

By JUDY GREENWALD

Competition among primary property/casualty insurers and continued high ceding company retentions are cutting U.S. reinsurers' premium volume.

However, despite first-quarter declines in premium volume, officials of major U.S. reinsurance companies say they do not expect their combined ratios to deteriorate significantly this year.

And, reinsurers generally say they were not surprised by first-quarter results.

"Fundamentally, it's on target," said William G. Clark, president and chief executive officer of Stamford, Conn.-based Transamerica Reinsurance Co., discussing his company's 1.7% first-quarter premium decline.

Constitution Reinsurance Co.'s results were "about as expected," said Bard E. Bunaes, chairman and chief executive officer of the New York-based reinsurer whose volume rose 4% in the quarter. "Ours was in line with our plans."

While reinsurers admit there is some softening in facultative reinsurance rates, nearly all agree that competition in the primary market is responsible for the lion's share of the decline in premium volume.

Competition exists "more on a primary company level than it does for reinsurers competing with one another," said Steve Bensinger, senior vp and chief financial officer of Skandia America Reinsurance Corp. in New York.

"We have found while some of our clients are writing less business, we don't see any real softness in the reinsurance business," Mr. Clark pointed out.

According to a survey of 78 reinsurers by the Reinsurance Assn. of America, the U.S. reinsurance industry's net written premium volume declined 4.6% to to $3.2 billion in the first quarter of 1988 from $3.3 billion in last year's first quarter, when net premium volume increased by 15.7%.

The 20 largest reinsurers in terms of net premium volume surveyed by the RAA reported that volume declined 6% to $2.5 billion in this year's first quarter from $3.3 billion in the first three months of 1987, when the Top 20's premium volume rose 13.5%.

However, these results do not include Transamerica Re, which ranked as the 14th-largest U.S. reinsurer as of March 31. The reinsurer was formed after Transa-

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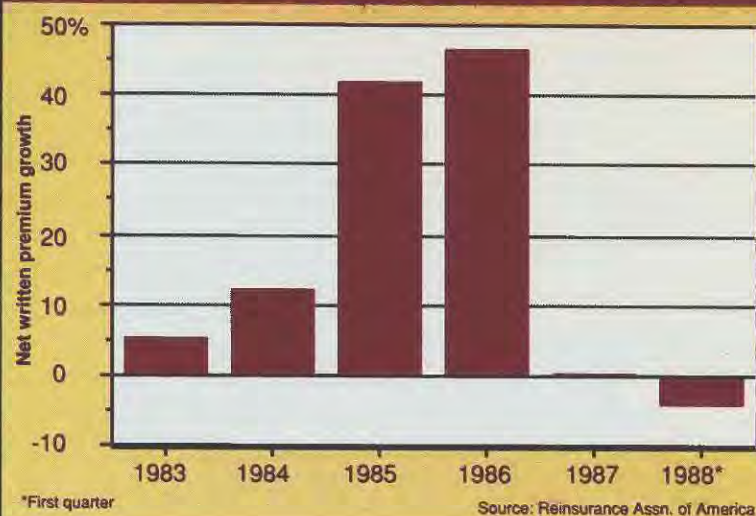

Pollution rulings

Decisions illustrate schism in policy interpretation

By STACY ADLER

SAN JOSE, Calif.—Two recent U.S. District Court rulings exemplify how state and federal trial courts nationwide continue to be sharply divided on the issue of whether government-mandated cleanup costs are insurable under comprehensive general liability policies.

In a lengthy decision on the subject, the U.S. District Court for the Northern District of California has ruled that Hartford Accident & Indemnity Co. must reimburse Intel Corp. for costs incurred in a government-mandated hazardous waste cleanup.

Meanwhile, the U.S. District Court for the Western District of Washington, in a seven-page decision, held that Travelers Insurance Co. does not have to reimburse Ross Electric of Washington Inc. for costs incurred in a government-mandated hazardous waste cleanup.

While both the California court and the Washington court—which are in the same federal judicial circuit—examined the same precedential appellate decisions, they arrived at opposite interpretations of the law.

Indeed, courts nationwide are interpreting the law in pollution cases differently, according to attorneys.

"There is a split in the various federal and state trial courts," said Roger Warin, an insurer attorney with Steptoe & Johnson in Washington, D.C. "The best arguments from each side have been made and there has not been a consensus among the courts."

Although court decisions are split, both insurers and policyholders claim the majority of the decisions are in their favor, said Mr. Warin. "However, I get the impression that the trend more recently is in favor of insurers."

"Nationwide, about two-thirds of the decisions favor insureds, but the most recent cases and the higher court cases favor insurers," said attorney John A. McKerricher, of Baker, Paroutand, Mano, McKerricher & Scheibmeir in

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Judge questions policyholder rulings

By DOUGLAS McLEOD

MORRISTOWN, N.J.—Numerous liability insurers engaged in a coverage dispute with Agent Orange producer Diamond Shamrock Chemical Co. are encouraged by a state judge's suggestion that pollution exclusions may have been interpreted too broadly in favor of policyholders in previous court cases.

In denying Diamond Shamrock summary judgment on several coverage questions, New Jersey Superior Court Judge Reginald Stanton said that the "sudden and accidental" exception to a pollution exclusion may have been misread in a precedent-setting New Jersey ruling and that the case may need "correcting."

However, Judge Stanton also noted the need for additional facts before deciding on the applicability of pollution exclusions in this case and ordered Diamond Shamrock and its insurers to present their arguments at a trial.

In a June 6 letter ruling on the summary judgment motions, Judge Stanton noted that he may be bound by "intellectually disturbing" New Jersey precedent in interpreting the "sudden and accidental" exception, but that a trial on the issue will establish a record on which insurers, if they lose, may appeal.

Stephen D. Cuyler, a lawyer for several of Diamond Shamrock's excess insurers, called the judge's statement "extremely significant." But he added that it does not necessarily indicate the court's ultimate ruling on the issue.

"We're still a long way from the fat lady singing," said Mr. Cuyler, a partner with the Morristown firm of Cuyler & Burk. "There are still a few innings left."

"All he has done is invite the defense to make their case," observed Michael P. Tierney, a lawyer with the New York firm of Cahill, Gordon & Reindel, representing Diamond Shamrock.

In 1984, Diamond Shamrock sued

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Benefit coalition hopes to influence health care policy

By BRIGITTE MAXEY

CLEVELAND—Disgruntled with federal health care policies and proposals they call "perverse" and "overpriced," Cleveland businessmen are bypassing existing lobbyists to bring their opinions about health care legislation to Congress.

Beginning as a local group in November 1987, the Health Policy Coalition since has opened its membership nationwide and currently includes between 40 and 50 companies.

"We hold the distinguishing factor of being the coalition that focuses on health policy and presents our alternative methods to the appropriate bodies at the federal, state and local levels," said Steve Smith, one of the group's founders and vp of human resources at Ameritrust Co. in Cleveland.

While he said most health care coalitions focus on fighting legislative proposals, rather than offering alternatives, the Health Policy Coalition already has presented to Congress a proposal for providing health insurance to uninsured Americans.

Members of the coalition do not plan to hire an outside lobbyist and instead will rely on their own representatives to carry their ideas for controlling the cost of health care benefits to Congress.

"We will do it ourselves," said Powell Woods, another founder and vp of human resources at Nestle/Stouffer Corp. in Cleveland. He says that the business community, for too long, has not been active in creating solutions to America's social problems.

The Health Policy Coalition was begun by Mr. Smith; Mr. Woods; Jack Evans, vp of human resources at Eaton Corp. in Cleveland; and attorney Charles D. Weller of the Cleveland-based law firm of Jones, Day, Reavis & Pogue, who serves as counsel to the coalition.

There is no fee for membership, but the group accepts donations.

"All the company has to do is have a common interest in current health legislation. Members are not restricted to the state of Ohio; we have members as far away as Texas," Mr. Woods said.

The group was drawn together late last year by a common concern: developing legislation to provide health coverage for the uninsured. "That was in November and the issue

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Pension decision benefits employers

By DOUGLAS McLEOD

WASHINGTON—Employers are relieved by last week's Supreme Court ruling that employers are not required to adjust sex-based differences in pension benefits retroactively to the date of an earlier ruling that ended discrimination in pension contributions.

Reversing two lower court rulings, the high court ruled 5-4 that Florida's Retirement System did not violate the Civil Rights Act of 1964 by offering sex-based retirement benefit options after the court's ruling in *Los Angeles Dept. of Water & Power vs. Manhart*.

In the 1978 *Manhart* decision, the high court concluded that unequal pension plan contributions for male and female employees based on actuarial tables reflecting women's longer lifespans violated sex discrimination provisions of the Civil Rights Act.

The court in 1983 extended the non-discrimination requirement to retirement benefits.

Since its formation in 1970, Florida's defined benefit plan for state and local government employees has provided for equal contributions and equal normal retirement benefits for men and women.

Before the 1983 ruling, though, the system also offered employees three benefit options under which monthly payments to male retirees were reduced on the basis of sex-based actuarial tables.

After the 1983 ruling, Florida adopted unisex actuarial tables that equalized pension benefits under all options for men and women retiring after Aug. 1, 1983.

However, a class-action lawsuit against Florida was filed on behalf of male participants in the system who retired after March 24, 1972—the effective date of the Equal Employment Opportunity Act—but before the 1983 Supreme Court decision, and who had chosen a sex-based benefit option.

A U.S. District Court judge in Tallahassee granted summary judgment to the retirees in April 1986, ordering that:

- Pension benefits for those retiring after the high court's 1978 ruling but before its 1983 ruling be retroactively increased to the prevalent unisex levels from the date of the *Manhart* decision until the date of the district court's order.
- Future benefits paid after the court order be increased to the unisex level for participants retiring between 1972 and 1983.

The 11th U.S. Circuit Court of Appeals affirmed the award.

However, the Supreme Court reversed the appeals court ruling last week in an opinion written by Justice Anthony Kennedy.

Justice Kennedy wrote that the *Manhart* decision did not place Florida on notice that optional sex-based pension benefits violated the Civil Rights Act, noting the 1978 ruling was limited to unequal pension contributions and did not deal with unequal benefits.

Observing that Florida acted immediately after the court's 1983 decision to correct discrimination in its pension plans, the court also concluded that there is no need to impose retroactive liability to enforce the Civil Rights Act's provisions. Such liability also would be inequitable, since it could threaten the financial solvency of retirement systems and their beneficiaries, the majority held.

The majority also threw out the award of future benefit increases to all class members, finding that the ongoing increased benefits would be "essentially retroactive" in their disruption of past funding assumptions. ■

Pennsylvania to compile health care data

By GLENN HUNTLEY

Benefit beat

Pennsylvania state officials have embarked on a major project to gather information on the cost and quality of health care in the state and make it widely available to employers, labor unions and the public.

The state contracted with Health Risk Management Inc. of Minneapolis last month to compile a data base composed of all medical claims incurred in the state in 1988 and 1989.

The state will pay the firm $2 million to gather information on cost and quality of health care from all hospitals and ambulatory care facilities in Pennsylvania.

The effort may be the first time any state has attempted to create an information base that measures both the cost and effectiveness of health care services provided by various parties like hospitals and physicians, said Bruce Kelley, vp of analytical services at Health Risk Management.

"It will be especially valuable to purchasers of health care, such as employers and labor unions, and to the general public because the data will help people become better informed health care consumers," Mr. Kelley said.

The result should be "comparison shopping" for health care, he said. "The better purchasing decisions could save millions of dollars a year for Pennsylvanians."

Data on length of hospital stays, severity of illness upon hospital admission and health at hospital discharge will be combined with cost information to determine effectiveness of treatment, said Fred Bodendorf, assistant director of the Pennsylvania Health Care Cost Containment Council.

Members of the council, which was established by the state Legislature to oversee the data base, include labor and business representatives, consumer groups, insurers and the medical community.

"Quality is the most important part of what we're doing," said Mr. Bodendorf, who called the program "very ambitious."

The first results should be available at the end of 1988, when information from the first of eight regions of the state is compiled, he said. By late next year, data from all regions will have been compiled and statewide statistics will become available.

The results will be available in several forms:

- Quarterly reports that detail costs and quality of care. The results will be publicly available.
- Special reports that include specifics such as utilization patterns as requested by insurance buyers.
- On-line access to the data base, which will be available to employers, labor unions and the public.

Health Risk Management will test the data it receives to detect errors and then will edit the consistent results into quarterly reports.

New York Times pact

The New York Times will resume making all contributions toward health care benefits for about 2,000 union employees under a new labor contract ratified June 15.

News, advertising, circulation and business employees represented by Local 3 of The Newspaper Guild had each been contributing a total of $13 per week—$10 from salary and $3 from their pension fund—to maintain health insurance benefits since Empire Blue Cross/Blue Shield of New York, which underwrites medical and dental care benefits for the employees, increased rates in August 1987, explained Jim Madden, the union's local representative.

The insurer attributed the higher rates to increased medical care costs.

However, under terms of the new contract, The New York Times will make a special weekly contribution of $18.35 per employee to the plan retroactive to March 1987, according to Mr. Madden.

In addition, The New York Times will continue to contribute 3% of straight-time payroll to a fund that pays premiums to Blue Cross/Blue Shield for medical and dental coverage. The fund also is used to pay claims under the newspaper's self-insured vision plan.

The retroactive payments also will be deposited into the insurance fund; the employees will not be reimbursed.

The six-year contract also includes a clause that allows the union to re-open negotiations after three years, Mr. Madden said.

The union's health benefit plan, which did not change under the new labor contract, covers 80% of major medical and hospitalization expenses after annual deductibles of $200 for individuals and $500 for families. The annual maximum out-of-pocket cost is $2,000 for both individual or family coverage.

The agreement, which is consistent with contracts negotiated with seven other unions representing New York Times employees, also includes pay raises that average 4.6% per year over the length of the contract, according to Mr. Madden.

Drug testing policies

Drug testing policies are in place at almost half of American companies surveyed by TPF&C, a division of Towers, Perrin, Forster & Crosby Inc.

Of the 249 U.S. companies surveyed by the benefits and actuarial consulting firm, 45% have a drug testing policy in effect. And, a further 25% are considering implementing a drug testing policy, the survey shows.

At those companies with drug testing policies, 84% pair their testing program with an employee assistance program, which involves counseling and treatment for substance abuse.

Three-fourths of companies with a testing program check for drug use prior to hiring employees, according to the survey. And, 66% tests employees they suspect of drug abuse, while 11% conduct random tests in the workplace.

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Benefit beat keeps insurance and employee benefit managers informed on what other companies are doing and of current developments in the employee benefit field. We'd like to know if you've made any changes. Write Glenn Huntley, Business Insurance, 6404 Wilshire Blvd., Los Angeles, Calif. 90048; 213-651-3710.

Landmark Studies Confirm What Hundreds of Companies Already Know.

Medco's Mail Service Can Reduce Drug Costs by 25%.

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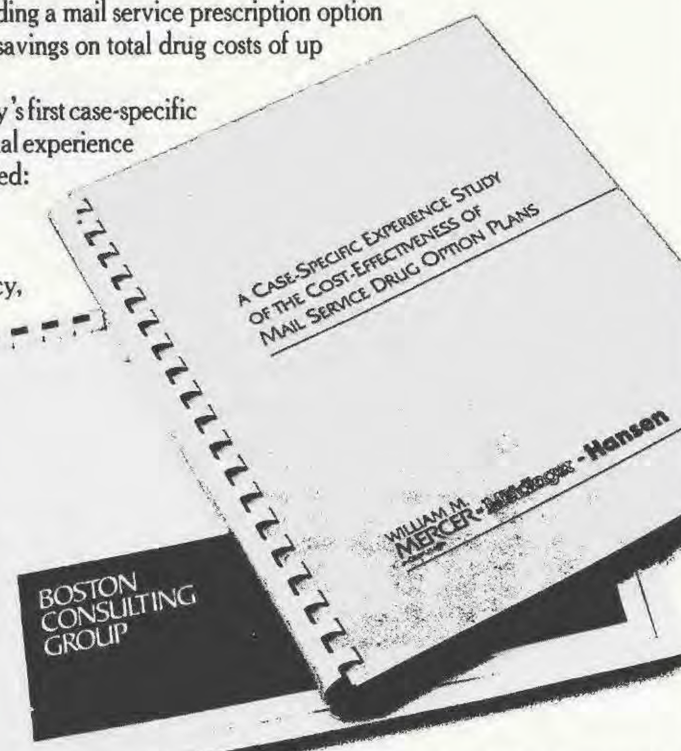

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PRIMEX, Weavers team to offer higher limits

LONDON—PRIMEX Ltd., a Barbados-based facility that writes excess liability insurance for 20 small to medium-size chemical companies, is changing its limits and its policy wording now that H.S. Weavers (Underwriting) Agencies Ltd. is offering additional coverage as part of the PRIMEX program.

Last week, PRIMEX and Weavers finalized an agreement whereby PRIMEX will reduce the coverage limits it offers to $5 million excess of $1 million for general liability exposures and excess of $2 million for auto liability exposures. PRIMEX had offered up to $15 million in capacity.

Under the agreement, Weavers now will offer PRIMEX members up to an additional $20 million in excess liability coverage in $5 million layers excess of the $5 million PRIMEX layer, said PRIMEX Chairman Mark F. Wilson, corporate risk manager of First Mississippi Corp. in Jackson, Miss.

The entire $25 million in coverage—including the coverage underwritten by Weavers—is written on a new PRIMEX claims-made policy, which is a "unique" version of Weavers claims-made form, said Robert Polack, who becomes chairman of PRIMEX on July 1, replacing Mr. Wilson.

While all layers of the PRIMEX/Weavers program will provide coverage for sudden and accidental pollution incidents, only the $5 million layer written by PRIMEX provides coverage for cleanup costs on non-owned sites.

In addition, in a change from Weavers' usual practice, the Weavers coverage will respond to claims if the $5 million PRIMEX layer is exhausted by defense costs. Normally, a Weavers policy will not respond to claims until indemnity payments exhaust the limits of underlying coverage.

The development of the PRIMEX/Weavers program took more than a year, said Mr. Polack, vp and general counsel for Reilly Tar & Chemical Corp. in Indianapolis. Others involved in the negotiations included Johnson & Higgins (Barbados) Ltd., which manages PRIMEX, and London broker Willis Faber & Dumas Ltd.

"We see this as a long-term solution to a very thorny problem," Mr. Polack said.

—By Stacy Shapiro

IRIS ratios

Continued from page 1

financial reporting procedures as well as a knowledge of the IRIS financial ratios," NAIC officials have said.

For example, "if a company strengthens loss reserves to correct a previous inadequacy, the change may identify this company as exceptional when in fact the company has been strengthened," the officials have said.

The property/casualty IRIS ratios compare surplus to premium, surplus aid, agents' balances, estimated current reserve deficiency as well as reserve development. Other ratios include liabilities to liquid assets or relate to change in premiums written and investment yield.

The life/health IRIS ratios examine changes in: capital and surplus, premium, product mix, asset mix and reserving ratios. In addition, life/health ratios examine the relationship between net gain to total income, commissions and expenses to premiums and deposits, surplus relief and several investment-related computations.

'The ratios will help people to evaluate their insurance companies,' says the AIA's Mr. Schwartz.

NAIC officials decided to release the statistical information in hopes of stemming challenges to the confidentiality of its IRIS-based analyses of insurers.

For example, a District of Columbia Superior Court judge last fall ordered the release of some NAIC statistical and analytical information sought by Joseph Belth, a professor at the University of Indiana and the editor of an insurance industry newsletter (*BI*, Nov. 23, 1987).

Previously, the Montana Supreme Court had ruled that the NAIC could deny Mr. Belth access to that financial data (*BI*, July 20, 1987).

Mr. Gates, who is the Nevada insurance commissioner, said regulators from two other states he would not identify feared they could not protect the confidentiality of the IRIS information because of the wording of their states' laws granting public access to government records.

The NAIC had adopted an interim policy of not providing IRIS information to states that could not protect it. However, that interfered with regulators' ability to perform their jobs.

NAIC officials believe the new policy to release statistical information involving already public data makes it more legally defensible for the NAIC to protect the analytical information resulting from financial examiners' evaluations, an NAIC spokesman explained.

"We don't advise a buyer using this information to decide whether or not to buy from an insurance company," Mr. Gates said, referring to the statistical information.

But, if a buyer sees that an insurer's ratios are significantly different from the norm, "it will give you some hint that you want to look at the company closer," Mr. Gates added.

"The ratios will help people to evaluate their insurance companies," said Phillip Schwartz, vp-financial reporting and associate general counsel of the American Insurance Assn., which represents property/casualty insurers.

"I certainly welcome the approach," said Jon Harkavy, governmental affairs director for the Risk & Insurance Management Society Inc.

The inclusion of average ratios in the material released may make the information "somewhat meaningful" to consumers, he added.

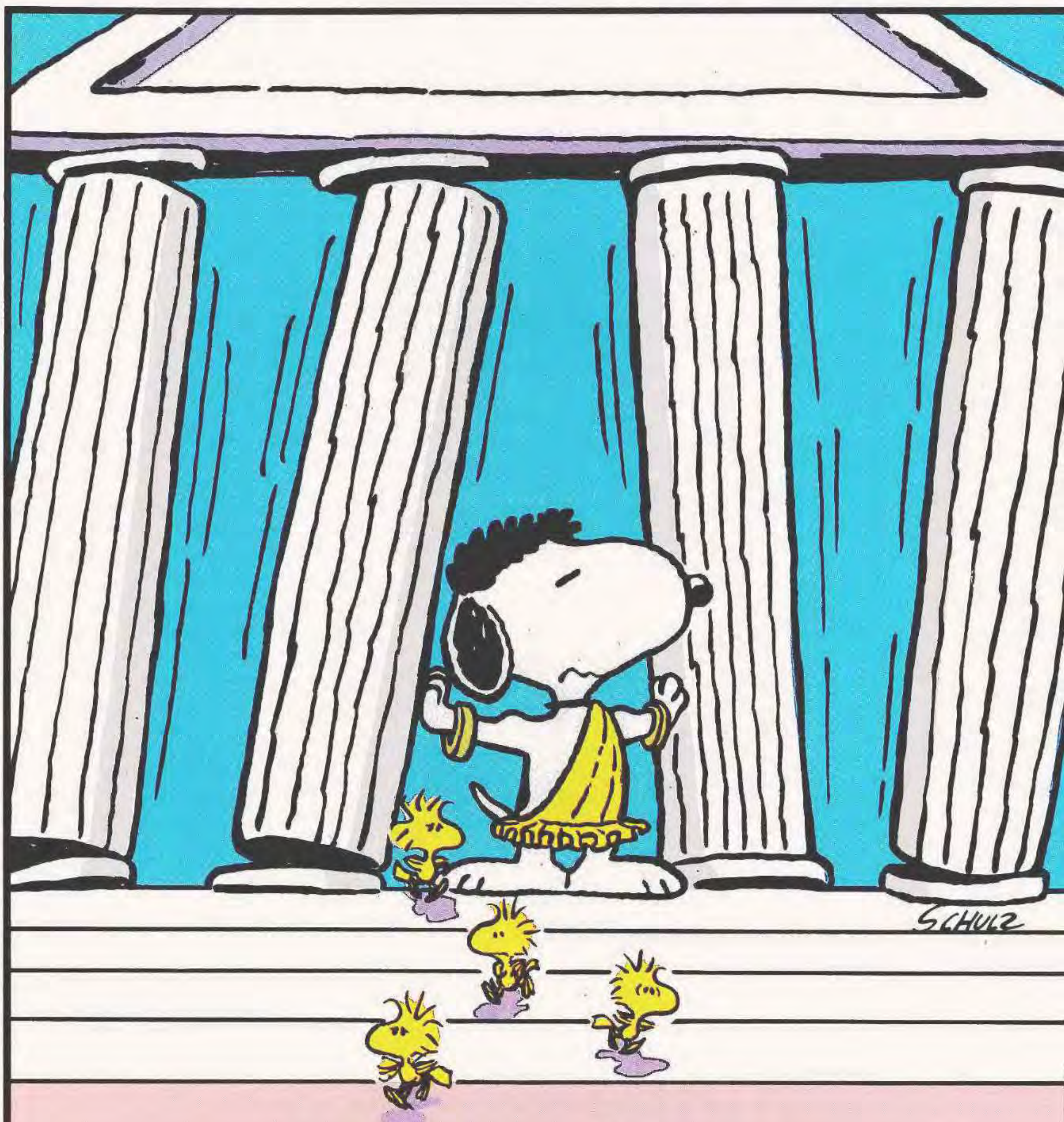
However, the analyses that are not being released contain the most vital information, he pointed out.

Still, having the mean ratio as a benchmark "is better than nothing," Mr. Belth said.

The difficulty in interpreting the information may place independent agents and brokers, who must evaluate insurers on behalf of their clients, "probably in even worse a quandary than ever before," said Patricia Borowski, vp-government and industry affairs for the National Assn. of Professional Insurance Agents.

"The question arises: What does the information really tell you?" she asked.

"The information is probably hard to interpret, but there is no easy answer to evaluating companies'—including insurance companies—financial condition," Mr. Schwartz said. ■



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Opinions

Wave good-bye to CDWs

FED UP WITH THE CONFUSION and high cost of collision damage waivers sold by car rental companies?

It's up to you to do something about it now.

The National Assn. of Insurance Commissioners adopted a model law earlier this month that prohibits car rental companies from selling CDWs. Instead, car rental companies would have to assume the risk of physical damage to their vehicles as a cost of doing business (*BI*, June 20).

We commend the NAIC for its action on this issue.

Now, it's up to each state legislature to use the model law to pass legislation outlawing CDWs in its state.

That is where you come in—whether you are concerned about CDWs as a risk manager trying to protect your corporation from the potential liability of uninsured damage to vehicles rented by your company's employees without recommending the company pay the high price of CDWs, or whether you are confused and concerned when you rent cars as an individual consumer.

Write to your state insurance department and to your state elected representatives urging them to promote enactment of the NAIC model law prohibiting the sale of CDWs in your state.

As we have said before, the best solution to the problem of car rental companies gouging consumers for the cost of collision damage to rented cars is to abolish the CDW (*BI*, May 9).

While we urge professional risk management and insurance organizations to support this lobbying effort, we strongly recommend that letters of support for outlawing CDWs be written on your personal stationery.

Your opinion as a voter will do more to sway a legislator's opinion on this issue than leaving the lobbying to professional and business organizations.

Letters

Flex plan costs, savings questioned

To the editor: Stop! Hold it! Someone put the brakes on! Just how stupid do you think the average employer is? I keep viewing articles in *Business Insurance* informing me of the increasing number of employers offering flexible benefits plans. Many individuals pushing these plans have an administration company that "just happens" to handle flex plan administration.

In *BI*'s May 30 issue, you quote a flex administration cost per employee per month of $18. Currently, our TPA can handle administration of your average major medical plan for about $8 per employee per month. Has anyone asked where the other $10 goes?

My favorite sales pitch is that flex plans can save you premium in reduced taxes and overall benefit costs. The fact is you can obtain the tax advantages with a simple premium conversion plan or, at most, the implementation of FSAs. Cafeteria plans simply muddy up the waters, making it difficult for competing brokers to implement a cost effective plan.

And, don't forget our national deficit and our friends who work for the Internal Revenue Service. Don't be surprised if the tax loopholes of flex plans get plugged or severely limited in the near future.

Last, but certainly not least, are those dirty words: adverse selection. Insurance Class 101 teaches any idiot that when you give an employee a choice of benefit plans to choose from, he or she is going to pick the plan that they intend to use. Bingo! No more healthy policyholders to offset the unhealthy. . .no more "spread of risk". . .no more "group" insurance. It's that simple.

Dave Rodas
Account Executive
Ruland & Mattingley
San Diego

■ *Editor's note: As stated in the May 30 article, the $18 charge per employee per month covers the complex administration involved in providing a flex plan, including enrollment, claims processing, monitoring and compliance with government regulations. As also stated, charges for administering a simple flexible spending account can be as little as $5 per employee per month.*

The purpose of the May 30 article was to review developments in software used to administer flexible benefit plans. Other articles in Business Insurance *reporting on the growth of flexible benefit plans also have addressed the cost, administrative and regulatory problems inherent in offering such plans, most recently in the Feb. 15, 1988, and Nov. 2, 1987, issues.*

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.

Lauding defense tactic sidesteps real issue

To the editor: The recent surge of publicity with respect to the consolidated defense of the San Juan Dupont Plaza Hotel fire properly lauds the group for its efforts in reducing defense costs through such tactics, among others, as the utilization of fewer attorneys, the hiring of joint experts and the sharing of data processing information (*BI*, May 30).

Plaintiffs' lawyers also gleefully applaud this approach since they have stated for the record that the reduction of legal expenses will put more money into the victims' pockets.

However, there has been little attention, except in *Business Insurance*, directed to the fact that this unfortunate catastrophe resulted from a criminal action with the hotel's liability insurance limited to $1 million for the occurrence. Typically these days, the matter of legal liability has been quietly put aside, once again demonstrating that our civil justice system is neither civil, nor will there be justice.

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

Case management not cost control device

To the editor: I read with interest the May 30 Ask a Benefit Manager column, "Case Management Cuts Psych Care Cost." I agree with Mr. Duva that psychiatric case management—done properly—can help achieve the goal of good patient care in appropriate settings.

However, the article does perpetuate one myth. Mr. Duva wrote that the "guaranteed" cost savings being touted by some case management companies imply that unnecessary services are widespread. This is simply false. Guaranteed savings simply means that needed services will be denied employees. Currently, the major culprits preventing patients from obtaining such critical resources are halfway house services, partial hospitalization, poor benefit design and/or arbitrary limits and caps.

While some cost savings may be seen initially, case management should not be used as a cost control device. Its effectiveness is its ability to help all parties involved—payers, patients and providers—work out mutually agreeable alternatives in difficult cases to ensure that patients get the level of care they require.

The National Assn. of Private Psychiatric Hospitals has developed a booklet to help employers understand psychiatric case management. Called "Ensuring Good Psychiatric Benefits," this booklet includes a detailed checklist for evaluating a psychiatric case management program. We would be happy to send a free copy to any of your readers. Write to the National Assn. of Private Psychiatric Hospitals, Socioeconomics Department, 1319 F St. N.W., Suite 1000, Washington, D.C. 20004.

Robert L. Thomas
Executive Director
The National Assn. of Private Psychiatric Hospitals
Washington

Rules for HMO rates, contributions differ

To the editor: Your response to my previous letter to the editor regarding community rating requirements and federally qualified HMOs (*BI*, June 6) quotes an unidentified spokesman at the U.S. Department of Health and Human Services Office of Prepaid Health Care as saying that federally qualified HMOs may negotiate "a mutually acceptable rate other than a community based rate."

Your reporter must have misunderstood the OPHC spokesperson, as this interpretation has never been the position of OPHC and runs contrary to the clear requirements of the federal HMO Act and its implementing regulations. I would appreciate your accurate clarification on this matter.

James F. Doherty Jr.
Michaels & Wishner P.C.
Washington

■ *Editor's note: Under the federal Health Maintenance Organization Act of 1973, federally qualified HMOs and employers can negotiate the employer's portion of the premium contribution for employees enrolled in the HMO, according to the U.S. Department of Health and Human Services Office of Prepaid Health Care, which regulates federally qualified HMOs. However, federally qualified HMOs must set their premiums based on the health care costs of their entire enrollee population, a practice known as community rating. Therefore, employers and federally qualified HMOs cannot negotiate premiums, but they can negotiate the employer's share of the total premium charged to employees enrolled in the HMO. A federally qualified HMO can establish a separate, non-qualified benefit plan, which can use rates negotiated with employers.*

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Rule to expose slow-paying reinsurers

By MEG FLETCHER

The new disclosure proposal 'is going to highlight those assuming companies that delay in making payments,' says Vincent Laurenzano, assistant chief of the New York Insurance Department's property companies bureau.

NEW YORK—Slow-paying reinsurers will be more identifiable if an accounting proposal that received preliminary approval from a panel of the National Assn. of Insurance Commissioners is adopted later this year as expected.

The proposal increases the annual statement disclosure requirements for property/casualty insurers that cede business to reinsurers.

The change requires the ceding company to disclose disputed reinsurance recoverables in footnotes, if the amount is "material."

An amount is considered material "if the amount or amounts in dispute exceed 5% of the cedant's surplus, if one reinsurer, or 10% if more than one reinsurer," the proposal states.

The proposal also would require that ceding insurers disclose the length of time amounts recoverable from reinsurers have been outstanding.

The proposal would amend Schedule F, Part 1 A, Section 1 of the annual convention statement, which lists ceded reinsurance. It would be amended to include an "aging" schedule that would categorize reinsurance recoverables on paid losses into four categories: one for recoverables currently due; one for recoverables overdue 30-90 days; one for recoverables overdue 90-180 days; and one for recoverables overdue 180 days.

The determination of when a reinsurance payment is "due" would be based on the terms of the contract, said Kenneth W. Smith, who heads the NAIC's Study Group on Property and Casualty Reinsurance.

Reinsurance contracts provide for monthly, quarterly and even annual reconciliation of accounts, including payment of earned premiums and losses.

The new disclosure proposal was developed because some ceding insurers have trouble collecting reinsurance on a timely basis, said Mr. Smith, who is deputy director for the Illinois Insurance Department's property/casualty division.

"It is going to highlight those assuming companies that delay in making payments," said Vincent Laurenzano, assistant chief of the New York Insurance Department's property companies bureau.

That will make regulators and buyers more aware of slow-paying reinsurers and "should encourage more timely payment of reinsurance balances," Mr. Laurenzano said.

In addition, the proposal recommends that the accounting manual should include a provision denying a ceding company credit for reinsurance recoverable in dispute with an affiliate.

The study group's proposals were adopted by the NAIC's Accounting Practices and Procedures Task Force. They will be presented to the Blanks Task Force for final action in October. If the task force adopts them, as expected, the measures would go into effect for 1989 annual statements that insurers file in March 1990.

Edmond F. Rondepierre, senior vp and general counsel of General Reinsurance Corp., said he "very much" supports the proposals that will make information about slow paying reinsurers available to regulators and consumers. "It would give them a reference list for who pays on time and who doesn't," he said.

Gen Re's policy is to pay claims within 10 days, he said.

This proposal expands the new disclosure categories added to the 1987 annual statement blanks. Those disclosure categories require ceding companies to footnote reinsurance recoverables if the reinsurer: is in conservation, rehabilitation or liquidation; is in arbitration or litigation with the ceding insurer; or if the reinsurance recoverable is more than 90 days overdue under the terms of the reinsurance contract.

In addition, the study group deferred action on proposals that would require ceding insurers to write off overdue reinsurance recoverables, Mr. Smith said.

One proposal recommends an increasing percentage write-off, whereby the longer the reinsurance is delinquent, the greater the percentage of write-off.

The write-off could be against operating income or directly against capital and surplus.

California regulators also are considering a proposal to reduce reported policyholder surplus by overdue reinsurance recoverables (see story, page 12).

The NAIC study group plans to submit a proposal on this issue to the Blanks Committee by July 1, which is the cut-off date for items that will be considered at the October meeting.

Commissioners at the summer meeting held June 12-17 in New York also examined proposals including:

Data reporting

The NAIC adopted a model regulation governing how licensed property/casualty insurance companies should report specific financial and statistical information to state insurance departments.

The goal of the model is to standardize the information provided by insurers as well as the way in which it is reported.

However, "this regulation shall not be interpreted to limit the powers granted the commissioner by any laws or part of laws of this state," the model says.

Each property/casualty insurer is required to provide insurance departments with an annual statement, expense information and other supplemental information. The amount of supplemental information required has increased recently, especially in states that wedded new insurer data reporting requirements to tort reform.

The model gives commissioners authority to engage qualified data collection services to compile and analyze information collected from insurers, including information

Continued on next page

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Continued from previous page

about the insurer's lines and classes of insurance, premiums and losses.

The model act also calls for insurers to report loss ratio, claims cost and claims severity data for use in "fast track" data reports and for the information to be submitted to statistical agents within 45-75 days of the end the calendar quarter, depending upon the line of insurance.

In addition, the model calls for "accelerated" data reports, to be submitted within 60 days of the close of each quarter.

Some commissioners have said that these reports are essential to regulating insurance companies, especially during hard markets.

The model also establishes a reporting schedule for general liability insurers that varies according to an insurer's market share.

The model also alerts commissioners about the need to consider the confidentiality of the information collected.

To protect buyers of claims-made professional liability insurance policies, the NAIC 'strongly' urges each state jurisdiction to adopt guidelines that would 'provide for greater predictability and affordability' in tail coverage pricing.

"Each state must determine what arrangements will be necessary to handle requests for data by outside parties in view of its statutes regarding the release of public information," it says.

"Depending on a state's public records law and the nature of the data collected under the agreement, it may be difficult to keep certain company-specific data confidential," according to the model. If that is the case, a state may wish to amend its statutes to ensure confidentiality.

Insurers have supported uniformity in data collection to reduce compliance cost and time.

In related action, the NAIC:

- Approved a resolution urging all states to require insurers to file currently required statistical information for 1988 on computer diskettes. That type of computerized filing had been done only in six states where the NAIC's new computer system was being tested.
- Approved some minor changes to the NAIC Examiners Handbook to help clarify certified public accountants' reports of insurers' loss reserves. However, Joseph Waldbaum, an accountant in North Hollywood, Calif., who raised the issue of "phantom" CPA reports, said he was "completely disappointed" by the NAIC's action.

Tail coverage

Buyers of claims-made professional liability insurance policies should be protected by minimum pricing guidelines on tail coverage, according to a resolution adopted by the NAIC.

The NAIC "strongly" urges each state jurisdiction to adopt two guidelines to "provide for greater predictability and affordability" in the pricing of tail coverages:

- The premium for the extended reporting period shall be quoted at the inception of the coverage and each renewal thereafter.
- The premium quote for the extended period may not be altered during the policy period except when the policyholder requests changes in coverage or limits.

The NAIC adopted the resolution to protect "a sizable variety of professional consumers" in light of "ever increasing" premiums for claims-made insurance and tail coverage. The NAIC believes the problem may cause some professionals to cease providing services due to the unaffordability of insurance.

Depending upon state law, some insurance commissioners may be able to adopt the resolution as administrative policy without legislative approval, regulators say.

Insurers typically oppose this type of measure because it does not allow them to pass on cost increases to policyholders.

Survey results

The NAIC reported 68 representatives of insurers, trade groups, government leaders, consumer groups and the media responded to an NAIC survey conducted over the past six months on state insurance regulation (*BI*, Feb. 8).

The 68 confidential respondents urged:

- A strengthened NAIC central office.
- A greater emphasis on securing legislative adoption of NAIC model laws.
- Expansion of technical development programs for commissioners and staff.
- A tighter focus for NAIC meetings.
- More uniform rating laws.

They also criticized relations between regulators and the insurance industry as adversarial and said regulators are not sufficiently receptive to critical needs of the insurance industry.

"Many of the concerns expressed about the regulatory system are valid," said NAIC President John Washburn, who is director of the Illinois Insurance Department. "Many of the responses identified problems for which we are already studying or are developing solutions."

These include enhancing the NAIC central office's ability to gather and analyze data through a new computer system, adding staff to assist with financial analysis and evaluating market trends and conducting special commissioner and staff training programs.

Copies of the survey report are available from the NAIC office in 120 W. 12th St., Suite 1100, Kansas City, Mo. 64105; 816-842-3600.

Trust agreement

Regulators and bank officials are continuing to discuss one major issue blocking consensus on the standard form trust agreement, NAIC regulators were told.

The standard agreement exists between non-admitted alien insurers and the banks in which they have deposited at least $1.5 million in a trust account, which insurance regulators require before alien insurers can write business in the United States.

At issue is whether bank trustees or state insurance regulators should have first claim on the money in the trust account if the insurer does not fulfill its obligations, said John Mulhern, an attorney with LeBoeuf, Lamb, Leiby & MacRae who is helping the Surplus Lines Task Force Advisory Committee draft the measure.

A compromise under review would give insurance regulators priority to the first $1.5 million, while the bank trustee would have access to larger sums, he said.

Exposure drafts

Various NAIC subgroups have released for comment exposure drafts on the following:

- Notice and consent forms for AIDS virus testing.
- Actuarial guidelines on structured settlements and substandard annuities.
- The expansion of the NAIC's model immunity act, which generally excludes regulators and investigators from civil liability. ■

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California may limit credit for overdue recoverables

By KATHRYN J. McINTYRE

NEW YORK—The California Insurance Department's staff is recommending the state strengthen regulations governing reinsurance transactions, including a rule that would encourage more prompt payment of reinsurance claims.

Among the recommendations made by the department staff to Insurance Commissioner Roxani Gillespie is to require ceding insurers to write off all reinsurance recoverables not paid within 150 days of when the ceding company paid the underlying claim.

This requirement goes much further than new disclosure proposals regarding reinsurance recoverables pending before the National Assn. of Insurance Commissioners (see story, page 10).

Norris Clark, chief of the financial analysis division of the California Insurance Department, discussed the department's staff proposals during an American Bar Assn.-sponsored National Institute on International Reinsurance Collections and Insolvency held June 11-12 in New York.

Permitting ceding companies to take credit on their annual statements for reinsurance recoverables unpaid long after the underlying claim has been paid allows "surplus to be overstated," Mr. Clark explained.

Unlike the disclosure proposals before the NAIC, which would consider reinsurance payments due according to the terms of the contract, the California proposal would consider amounts overdue based on when the ceding company paid the claim.

Mr. Clark explained that some reinsurance contracts give the reinsurer up to 120 days after a pre-determined settlement date to pay reinsurance claims and the settlement date might be Dec. 31 on a contract that began Jan. 1.

With that long a lag time to pay claims, "is the reinsurer still going to be around?" he asked.

The 150-day limit anticipates quarterly settlement of accounts with a 30-day period to pay claims, he said.

In addition, unlike the NAIC disclosure proposal under consideration, the California staff proposals would not exempt amounts in dispute, arbitration or litigation from the write-off requirement, Mr. Clark said.

"Why exempt amounts in dispute, arbitration or litigation?" Mr. Clark asked. "From the department's perspective, how long do you have to give before they pay?"

The write-off could be reported against operating income or as a penalty against surplus, such as for unauthorized reinsurance.

If the California staff proposal were enforced, it could force insurers authorized in California to write off $4 billion out of aggregate surplus of about $100 billion, Mr. Clark estimated.

The aggregate surplus of insurers authorized in California is about 95% of the aggregate surplus of all U.S. insurers, he noted.

Responding to the suggestion that such write-offs would reduce the insurance industry's capacity and, therefore, its ability to underwrite insurance, Mr. Clark said: "From a regulator's standpoint, that's illusionary capacity."

He also noted later that the estimated impact on surplus is only 4% of surplus.

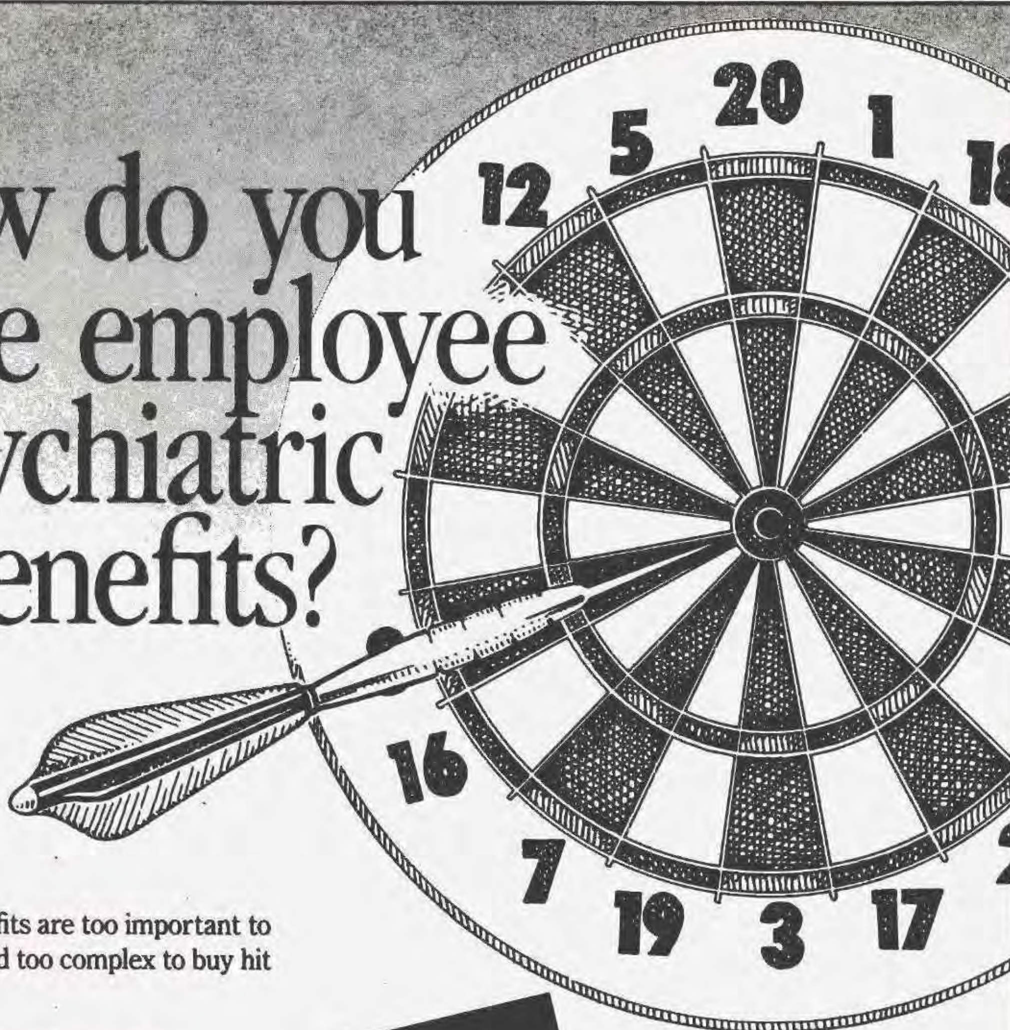
A ceding company that withheld funds from the reinsurer or held a letter of credit for the reinsurance recoverables overdue by more than 150 days would not be required to write off the overdue amounts, Mr. Clark said later.

The staff also has recommended that the department license and regulate reinsurance intermediaries and managing general agents.

Commissioner Gillespie is expected to respond to the staff proposals by the end of the summer.

If she agrees with the staff recommendations, it might be necessary for the department to seek new rule-making authority to implement these requirements, Mr. Clark said.

A state's rules supersede the NAIC's rules governing the annual statement, which otherwise are effective in every state. ■



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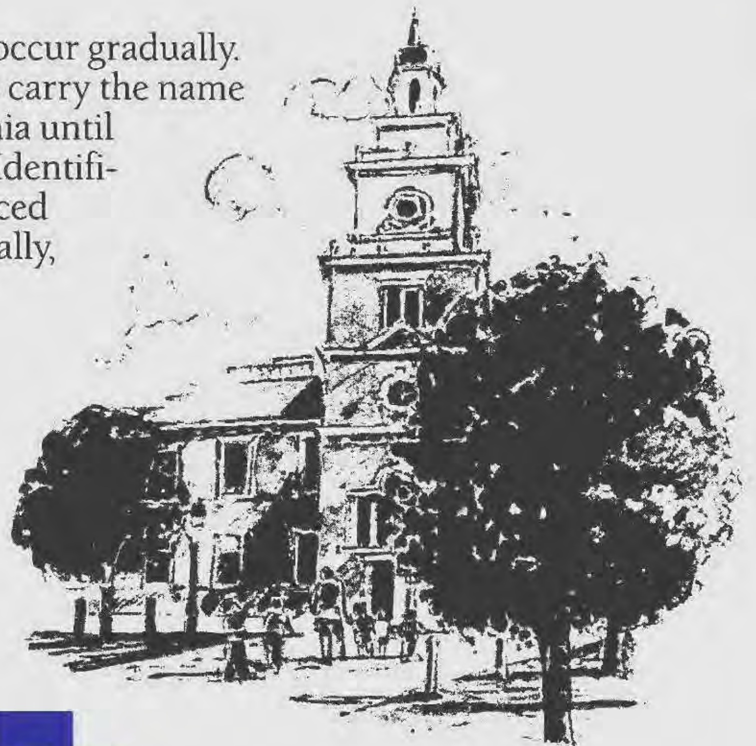

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Global market tests regulators' mettle

By MEG FLETCHER

NEW YORK—While the growth of a worldwide financial services market creates new opportunities for consumers, it also creates new challenges for insurance regulators, experts say.

A panel discussed the merging of insurance, banking and investment services during the third annual International Conference of Insurance Regulatory Officials, sponsored by the National Assn. of Insurance Commissioners as part of the NAIC's summer meeting June 12-17 in New York.

Panelists told U.S. regulators and 22 foreign officials that the worldwide market for financial services is changing because of:

- Globalization of financial services.
- Breakdowns in barriers between different types of financial institutions.
- Modification or elimination of regulations, which often follow increased competition between financial service companies.

"The world is becoming a single marketplace," said James W. McLane, president and chief executive officer of Citicorp Insurance Group Inc., a New York-based subsidiary of Citicorp.

"Intense" globalization has occurred in many financial services because of new communications technology, said James H. MacNaughton, managing director of Salomon Brothers Inc. in New York.

Some countries, like those in Europe, are positioning themselves well, Mr. McLane said.

"For example, the European Economic Community has a target of removing all barriers to the free flow of financial services in its member countries by 1992," said Meredith M. Fernstrom, senior vp-public responsibility with American Express Co. (*BI*, May 16).

However, some have argued that the United States is not as well-prepared, Mr. McLane said.

And, the U.S. insurance industry has been more cautious about expanding beyond its borders, added Mr. MacNaughton.

That is due, in part, to "an inventive array of protectionist devices (by dozens of countries) denying the U.S. and other foreign insurers a level playing field in the world insurance market," said Henry G. Parker III, senior vp and managing director of Warren, N.J.-based Chubb & Son Inc.

As a result, although the United States is the world's largest insurance market, only 1% of all U.S. insurance companies have overseas underwriting and servicing capabilities, Mr. Parker said.

"The ultimate loser is the insurance buyer," he said. "He is denied freedom of choice; he cannot select the covers he wants and receive reliable service he desires at a price he can afford to pay."

The globalization and blending of financial services offer new opportunities for clients who want to buy from one single source, Mr. McLane said. And, institutions offering multiproduct lines, like insurance as well as banking services, can be more secure.

However, not all segments of the marketplace applaud this trend.

U.S. consumer leaders have opposed the U.S. banking industry's efforts to obtain authority to sell insurance. The consumer spokesmen see the need "for adequate safeguards to protect the consumer from 'tie-ins,' for example, selling insurance as a condition of obtaining a loan," Ms. Fernstrom said.

The greatest threat to innovation in financial services lies in keeping regulation of those services rigidly segmented, Mr. McLane said. He urged regulators to:

- Study market trends so they can measure the direction, depth and consequences of the changes.
- Dismantle artificial barriers between products.
- Support the functional regulation of financial services by an appropriate general regulator.
- Expand the work of the international conference of regulators to define policies.

In addition, Chubb's Mr. Parker called for development of an international set of rules liberalizing insurance trade. He also called "for the NAIC to build a bridge between the state regulatory system and the federal trade negotiating system." That is necessary because the U.S. itself cannot guarantee that states will comply with an international agreement through the federal government, he said.

New York Insurance Superintendent James Corcoran said in a separate address at the conference: "Regulators are now working with the industry as well as state and federal legislators to expand and facilitate the free flow of insurance capacity globally. Such collaboration is in everyone's best interest as long as it's done responsibly."

Ms. Fernstrom urged members of the financial service industry and regulators to remember individual consumers as these trends develop. She recommended the industry continue to design new products and services, provide adequate information to consumers and work closely with consumer leaders and public policy makers to ensure fair and efficient regulation.

The panel was moderated by Lyndon L. Olson Jr., former chairman of the Texas State Board of Insurance, who resigned last year. He is now president of National Group Cos. in Waco, Texas. ■

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STATUTORY SURPLUS (000 Omitted)	COMBINED RATIO
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1984 — $16,739	1984 — 97.0
1985 — $37,037	1985 — 99.7
1986 — $53,063	1986 — 84.1
1987 — $57,243	1987 — 84.2

5 YEAR COMBINED RATIO 89.8 (1983-1987)

ASSETS (000 Omitted)	LOSS RESERVES (000 Omitted)
1983 — $ 35,156	1983 — $ 4,985
1984 — $ 48,719	1984 — $ 9,150
1985 — $105,993	1985 — $22,784
1986 — $159,568	1986 — $46,243
1987 — $168,859	1987 — $59,712

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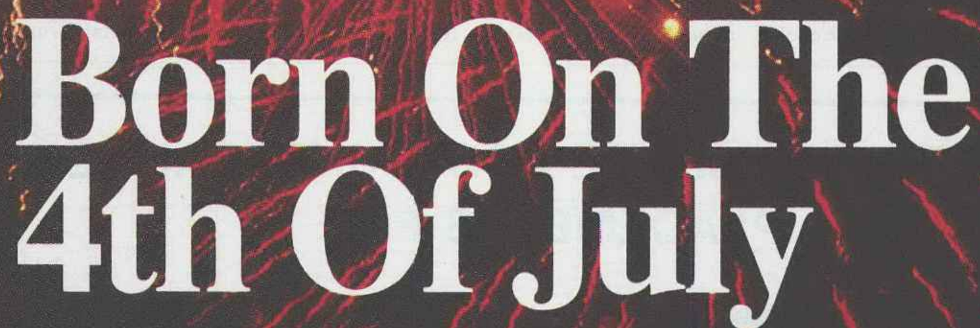

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Johnson Wax names Hodnik risk manager

Comings & goings: buyers

James S. Hodnik, 44, has been named director of corporate risk management at S.C. Johnson & Son Inc. in Racine, Wis. In this position, he oversees the worldwide risk management program for Johnson Wax, including property/casualty coverages, self-insurance and captive insurance company operations. He replaces **David H. Ellis**, who left the company. Mr. Hodnik reports to John L. Clark, vp and corporate treasurer. Mr. Hodnik joined Johnson Wax in 1984 and has served as corporate insurance manager for four years. Prior to joining Johnson Wax, he was corporate insurance manager at Bucyrus-Erie Co. in South Milwaukee, Wis. Mr. Hodnik received a bachelor of science degree in business administration from Southern Illinois University in Carbondale. In addition, he is a member of the Captive Insurance Companies Assn. and is a deputy member of the Risk & Insurance Management Society.

Mr. Hodnik

* * *

Wayne C. Pachol, 33, has been named corporate insurance and risk manager at McCormick & Co. Inc. in Hunt Valley, Md. In this position, he oversees general liability and property insurance. He replaces **Dan Hanifen**, who died. Mr. Pachol reports to James A. Hooker, vp and controller. Prior to joining McCormick, which produces seasonings, flavorings and speciality foods, Mr. Pachol was assistant risk manager for DynCorp in McLean, Va. Mr. Pachol holds a bachelor of science degree in accounting from Waynesburg College in Waynesburg, Pa., and he is a deputy member of the Risk & Insurance Management Society. In addition, Mr. Pachol just completed the final examination leading to the Chartered Property & Casualty Underwriter designation.

* * *

Bryce E. Farmer, 36, has been named vp-human resources at Ranger Insurance Co. in Houston. In this position, he oversees employee benefits, salary administration and other personnel activities for the property/casualty insurer. He replaces **Joan Taylor**, who left Ranger. Mr. Farmer reports to President Richard F. Harris. Prior to joining Ranger Insurance, Mr. Farmer had been senior vp and manager of human resources for Western Bancorporation in Houston. He holds a bachelor's degree from Dallas Baptist College. In addition, Mr. Farmer is a member of the American Compensation Assn., the Houston Personnel Assn. and serves on the personnel committee of the Assn. of Fire & Casualty Companies.

Mr. Farmer

* * *

Douglas R. Schedeler, 38, has been named manager of the Brighton, Mich., workers compensation claims office of Ryder System Inc. of Miami. In this position, he oversees claims administration for 10 states. He replaces **Mark Hanner**, who left the company. Mr. Schedeler reports to Susan L. Drake, senior manager-workers compensation. Prior to joining Ryder, Mr. Schedeler was corporate workers compensation supervisor for Tecumseh Products Co. in Tecumseh, Mich. Mr. Schedeler holds a bachelor of science degree in labor relations and personnel management from Michigan State University in East Lansing.

Also at Ryder: **Lucille D. Johnson**, 38, has been named workers compensation systems coordinator in Miami. In this newly created position, Ms. Johnson is responsible for the flow of workers compensation claims information, functioning as a coordinator among Ryder's data processing department, risk management department, field operations and data processing vendor. Ms. Johnson also reports to Susan L. Drake. Prior to joining Ryder, Ms. Johnson was self-employed, operating a word processing service.

* * *

Martin J. Eichler, 37, has been named corporate benefits administrator for Tracor Inc. in Austin, Texas. In this newly created position, he reviews and analyzes Tracor's benefit plans, assuring compliance with federal and state legal requirements. Mr. Eichler reports to J. David Baird, vp-financial services. Prior to joining Tracor—which produces technological products and services including sonar, military telecommunications and electromechanical components—Mr. Eichler served as credit analyst for First Republic Bank in Austin. He holds a bachelor of business administration degree in accounting and finance, as well as a master of business administration degree in finance from Baylor University in Waco, Texas.

* * *

Frank Aaron, 45, has been named manager of business risk insurance at Valero Energy Corp. in San Antonio, Texas. In this newly created position, he will oversee property/casualty and marine insurance for the natural gas concern. He reports to Gary W. Spangler, director of risk management. Mr. Aaron joined Valero in 1981 as a claims analyst and has served as risk management coordinator since 1985. He received a bachelor of science degree from Oklahoma State University in Stillwater and holds the Associate in Risk Management and Chartered Property & Casualty Underwriter designations.

Also at Valero, **H.F. Campbell**, 43, has been named manager of safety for the company's natural gas and refining divisions. He replaces **Frank Hiett**, who retired, and reports to Mr. Spangler. Mr. Campbell, who joined Valero in 1977, most recently served as technical trainer. He received a bachelor of science degree in education from East Tennessee State University in Johnson City and holds the Certified Occupational Health & Safety Technologist designation.

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Court rejects Dona Paz class action

Worldwide

MANILA, Philippines—More than 3,000 survivors of victims of the Dona Paz shipwreck cannot file a $60 million class-action suit against the owner of the vessel, the Philippine Supreme Court has ruled.

However, the ruling does not stop plaintiffs from filing individual suits.

Relatives of the victims of the world's worst maritime shipping disaster had asked the court to allow them to form a class action against Sulpicio Lines, the owner of the ferry that sank Dec. 20, killing an estimated 3,500 people (*BI*, Jan. 18). They also asked the court to waive the cost of filing the suit —about $303,000—because they said they were too poor to pay the fee.

However, the Supreme Court late last month ruled that although the claimants can file separate lawsuits against Sulpicio, the claimants cannot file a class-action suit. The court also ruled that there was insufficient financial evidence to support the plaintiffs' allegation that they are too poor to pay the filing fee.

The court said in an eight-page opinion: "Sympathy and commiseration, however well-deserved, are not considerations that would justifiably argue for bending or dispensing with the observance of the rules which prescribe how such vindication may be obtained in the courts of law."

Attorneys for the relatives of the victims of the Dona Paz were unavailable for comment.

Meanwhile, Rosario Macasigan, director for the claims division of the Philippines' Department of Social Welfare and Development, said that the claims filed on behalf of 1,350 victims have been settled with Sulpicio.

Ms. Macasigan, whose department is coordinating the relief efforts for the relatives of the victims, said that some of the relatives had settled for less than the 30,000-peso ($1,428) government-mandated settlement per victim because some claimants were unable to prove their relatives were on board the Dona Paz.

Sen. Alberto Romulo, chairman of the Filipino Senate Committee on Social Justice, warned Sulpicio Lines in a letter that non-compliance with the $1 438 minimum settlement set by the government shortly after the disaster would result in further lawsuits.

A Coast Guard board of inquiry has determined that the Dona Paz was grossly overloaded with Christmas holiday travelers when it sank after colliding with a domestic oil tanker. A ship's manifest listed 1,593 people aboard, but officials say there were about 3,500 people aboard. Only 26 passengers survived the disaster.

Sulpicio has only 31.86 million pesos ($1 54 million) of liability insurance to respond to Dona Paz claims.

—By Kathleen Barnes

Insurer takeover

BRUSSELS, Belgium—A five-month unfriendly battle for control of Belgium's third-largest insurer, Assubel Vie S.A., waged by Belgium's largest insurer, Groupe A.G., has come to an end.

The two companies last month agreed to a plan whereby Groupe A.G. and French "white knight" Assurances Generales de France will control 51% of the shares of Assubel through a joint holding company.

The remaining shares will be held by independent companies and Assubel affiliates.

The parties to the new agreement said they will continue to treat each other as competitors and that their agreement will not affect their operations.

—By Denise Claveloux

Saudi market

RIYADH, Saudi Arabia—Insurers in Saudi Arabia say insurance regulations must be drafted to allow the Saudi insurance market to grow responsibly.

Until a serious initiative is taken by the government to hire an insurance commissioner and impose regulations on the industry, Saudi insurers say that the present chaotic state of affairs in the country will continue indefinitely.

Although a draft law regulating underwriting agents has been introduced, there is no pending legislation to register insurance companies. And, it is unlikely that insurance regulations will be considered in the near future.

Religious authorities object to officially recognizing insurance companies by law because the Saudi legal system is based on Islamic law, which does not recognize insurance, Saudi insurance observers say.

However, they contend the country needs a law to legitimize the market and to get rid of "cowboy" insurance operators, who have established questionable operations in the country.

At the moment, the Saudi government is reviewing the latest draft of a law for the estimated 200 Saudi underwriting agents that write an estimated $400 million in annual premium volume. Under the proposed legislation, each agent must have:

- A claims guarantee of at least 3 million rials ($801,000) from a Saudi bank deposited at the Ministry of Commerce.
- Minimum paid-up capital of 10 million rials ($2.67 million)
- An obligation by the insurer to pay all claims underwritten by the agent.

However, this legislation will not regulate insurance companies, Saudi sources point out.

And, one Saudi insurer said "the minimum bank guarantee of 3 million Saudi rials will not stop the cowboys because anyone can afford that kind of money. You must at least make sure that people (the agents) have 10 to 15 million Saudi rials of assets in the company."

Regulatory relief could come from the Gulf Cooperation Council, which is made up of six Persian Gulf countries including Saudi Arabia.

At a GCC meeting in Abu Dahbi last December, members discussed the possibility of establishing a GCC reinsurance company and unifying insurance regulations throughout member countries.

"It will take two or three years to discuss this," said a Saudi insurer who attended the meeting, adding: "One day we will have a law similar to those in the United Arab Emirates or Bahrain."

—By Maria Kielmas

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Outsmarting brilliance

Sharp underwriter sticks to pricing principles despite cycle

By Howard C. Alper

IT DOESN'T MAKE MUCH sense to assume a commercial risk for $100,000 one year and for $30,000 another year, particularly when the risk is larger and the liability climate worse in the latter year. Yet that is exactly what has happened—again and again—in the soft commercial property/casualty insurance market of the early 1980s, and it is where we're heading now unless we instill some sanity into our business. If we don't, the government will.

Yes, I'll concede there are market forces and the hard/soft market cycles appear to be inevitable, but insurers certainly should be able to moderate the "swings" and not massacre themselves. Let's not forget Mission Insurance Co., Ideal Mutual Insurance Co. and others.

The cycle is peculiar to commercial lines. Personal lines has no such phenomenon because personal lines insurers make decisions based on books of business, not on individual account transactions. The regulators check personal lines closely to make sure they are conforming to their filings, which don't have 40%-50% judgment factors.

There are few "new" accounts born to appease property/casualty insurers' insatiable appetite for volume in the soft market, nor do accounts evaporate when insurers abandon them in the hard market, except for those attractive risks that find or develop alternatives to commercial insurance. By and large, the same risks are churned between insurers, at a very expensive processing and re-underwriting cost.

In reality, many insurers have great difficulty pricing their business; losses are difficult to project and rate adequacy is elusive. But these problems are the essence of the insurance industry's existence. The biggest detractor to stability of operations and sound underwriting seems to be property/casualty insurers' accounting system. Let's illustrate by spinning a fairy tale:

There was a time—although I can't remember it—when rates were steady and good underwriting profit—let alone investment profit—was produced.

One underwriter—let's call him Brilliant Underwriter, or BU for short—conceived the brilliant idea that if he cut rates in half, he'd attract more business, have better selection, spread fixed costs and make more money. Writing $12 million in premium a year, or $1 million per month, BU doubled his monthly volume to $2 million, albeit at 50% rates, by assuming four times as much risk. At the end of that month BU still showed a profit. So he decided to do it again (see Chart 1).

The next month, BU wrote $3 million of volume at 33% rates and still showed a profit. So BU continued at the 33% rates. He figured he didn't have to cut rates any more, and he wouldn't unless his competitors decided to play the same game. And, of course, they will!

It wasn't until four months later that BU found he was losing money (see Chart 2). His loss ratio was so bad he doubled the rates. After a month, BU's results weren't much better, so he doubled them again.

Looking at Chart 1, it looks like BU increased annual underwriting profit to $1.63 million from $1.2 million. Very commendable, except for three flaws:

- BU's operating figures include many months of higher-priced business, thereby continuing to flow previously developed profit through to the last 12 months' results.
- BU assumed claims would continue at 60%, the same as his seasoned book of business. Of course, they won't because he is underwriting more units at lower premiums. But it takes time for the pigeon to come home to roost.
- BU thought he'd be a better underwriter than most. There are few "better" underwriters and, during volume-building periods, underwriting procedures are de-emphasized.

Brilliant Underwriter's operating results

(In millions of dollars)

Chart 1

	Volume	Claims	(%)	Expenses	(%)	Profits	(%)
Before brilliant idea	$12,000	$7,200	(60%)	$3,600	(30%)	$1,200	(10%)
1 month later							
BBI (11 months)	11,000	6,600	(60%)	3,300	(30%)	1,100	(10%)
First BI month	2,000	1,200	(60%)	560	(28%)	240	(12%)
Last 12 months	$13,000	$7,800	(60%)	$3,860	(29.7%)	$1,340	(10.3%)
1 month later							
BBI (10 months)	$10,000	$6,000	(60%)	$3,000	(30%)	$1,000	(10%)
First BI month	2,000	1,200	(60%)	560	(28%)	240	(12%)
Second BI month	3,000	1,800	(60%)	810	(27%)	390	(13%)
Last 12 months	$15,000	$9,000	(60%)	$4,370	(29.1%)	$1,630	(10.9%)

Chart 2

	Volume	Claims	(%)	Expenses	(%)	Profits	(%)
Six months BBI	$6,000	$3,600	(60%)	$1,800	(30%)	$600	(10%)
First BI month	2,000	1,500	(75%)*	560	(28%)	−60	(−3%)
Second BI month	3,000	3,750	(125%)*	810	(27%)	−1,560	(−52%)
Next four BI months	12,000	12,000	(100%)*	3,360	(28%)	−3,360	(−28%)
Last 12 months	23,000	$20,850	(90.6%)	6,530	(28.4%)	−4,380	(−19%)

*The emerging truth

Chart 3

	Volume	Claims	(%)	Expenses	(%)	Profits	(%)
Last 12 months BBI	$12,000	$7,200	(60%)	$3,600	(30%)	$1,200	(10%)
11 months BBI repriced	5,500	6,600	(120%)	2,200	(40%)	−3,300	(−60%)
First BI month*	2,000	1,200	(60%)	560	(28%)	240	(12%)
Last 12 months	$7,500	$7,800	(104%)	$2,760	(36.8%)	−$3,060	(−40.8%)

*Same assumptions BU made before

Charts: Amy Palmer

Speaking out

Finally realizing where he was, BU doubled the 33% rates to 66% and, after a month, doubled them again to 133%. Now, he'll make some real money (given enough time). And that established the next cycle!

While this fairy tale is obviously exaggerated, it illustrates precisely what occurs in real life, albeit at a slower pace.

The flaw in property/casualty insurers' accounting system is the use of the last 12 months'—or some other period's—operating results to measure current profitability. *The last 12 months' results have no bearing to projected future results if there have been price changes in the period!*

Insurers shouldn't keep score as they would for their stockholders. Insurers should use industry operating data—not financial reporting records—to provide themselves with the information to make sound business judgments. A score card based on past activities and rates is no projection of future results. With price changes—and what 12-month period does not have price changes—insurers need to develop a method to revalue their on-the-books business before they can intelligently project results.

Let's say that the rates Before Brilliant Idea (BBI) were 100%. After the first Brilliant Idea (BI) month, by repricing the existing book at 50%—the new rate level—the results would look like Chart 3. With those results, BU wouldn't have gone further; he probably wouldn't even have started his fiasco. But, without such a system, we've seen the illogical price-cutting again and again: For example, the $100,000 risk written for $30,000 (and sometimes less).

So how can insurers develop a repricing mechanism on existing business? The actuaries should be able to do it. Perhaps it would be something like this: Establish a parity (100%) price or rate, and every time a policy is issued enter its relation to parity. Then, to reprice the book, enter the new price level—as a percent of parity—push a button and the book is repriced.

Now insurers can experiment with different computer rate levels without the agony of real combat suffered by our BU. It's not that difficult: Just look at the prior loss experience on account, project loss costs and divide by whatever factors they want to achieve parity rates.

Continued on next page

Howard C. Alper is president of Chicago-based AuditRate Inc., an insurance cost-reduction consulting firm. Mr. Alper holds the Chartered Property & Casualty Underwriter and Associate in Risk Management designations.

Pools pose challenges for RMIS

ONE OF THE THEMES I wish to continue in this column is an occasional article on how a particular industry can benefit from risk management information systems. Earlier this year, I focused on the banking industry (*BI*, Feb. 15). This month, I would like to discuss RMIS for public entity pools.

I'm basing my observations and comments on an address given by Richard S. Betterley, president of Betterley Risk Consultants, to attendees of a conference sponsored by The Joseph Ivy Co. and Advanced Risk Management Techniques (*BI*, March 21).

Pools have unique and distinct needs for a well-designed RMIS. Unfortunately, as with the banking industry, vendors have not yet effectively quantified and tapped this burgeoning market. However, along with the captive risk retention group market, I believe that the vendors will increasingly fix their attention upon this area.

An RMIS designed for pools is much the same as it is for any other claims-oriented client, with one exception: Instead of one client, there are many within the pool. Each member of the pool desires its own specific loss information—or underwriting data information—as well as knowledge of how it compares to the rest of the pool. In this regard, a pool poses special challenges to the RMIS vendor in meeting the varied and diverse needs of some of the pools' membership.

Confidentiality of information is another challenge. One member may not desire the others to have specific information on its particular risk. This becomes difficult when the risk management information system is being designed, as we will see later.

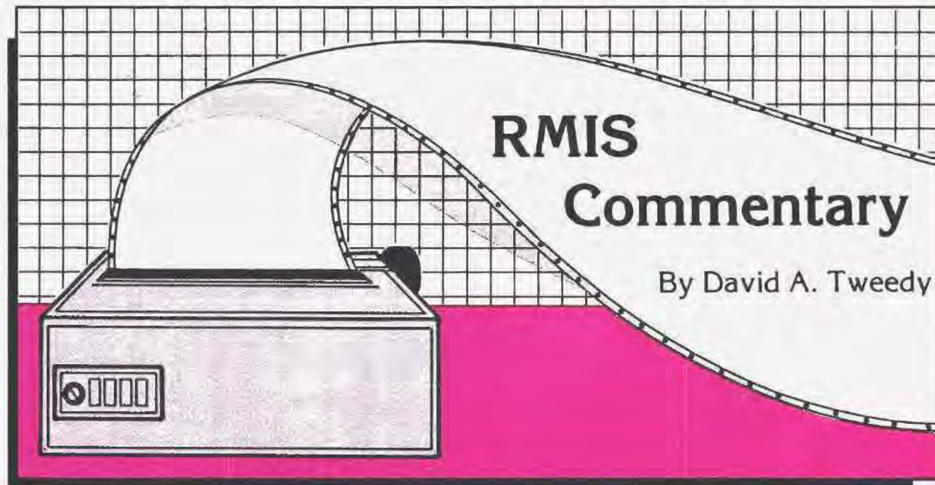
Closely related to this first problem is the common problem of data collection. An RMIS vendor, utilizing a time-sharing system that receives hundreds of loss reports or bits of data from the various members, must properly code and input the data into the system.

In the first place, that data must be correct when received and then properly coded and input into the system to generate meaningful aggregate and individual results.

However, pools have a unique slant on this problem. As mentioned above, due to the individual member makeup of the pool, each may want the RMIS to generate customized reports on data it wishes to analyze. Also, there are different levels of data confidentiality. These different needs place an extraordinary burden on system flexibility and vendor administration and communication.

One large project I worked on involved more than 20 similar companies utilizing one major time-sharing RMIS vendor. Poor planning and miscommunication among pool management, individual members and the vendor created significant dissatisfaction and frustration with what the system provided.

Indeed, inaccurate data and poor planning are the most troublesome and commonplace of all RMIS



mistakes that users experience. Software and hardware limitations are being overcome due to advances in technology, but it basically comes down to this fact: Good data must be collected and input for the RMIS to provide the answers risk managers are looking for.

In past columns, I have stressed the need for a careful needs-determination assessment (*BI*, Jan. 20, 1986) so that you are not surprised by requests for new data or new reports that are beyond your current system's capabilities.

According to Mr. Betterley, other key problems as a result of poor planning are inadequate training of system users, too much paper output in terms of meaningless reports and a poor understanding of the total costs involved in administering a comprehensive RMIS.

Assuming that proper planning of the system has taken place, all the needs have been identified, the budget has been set and approved and the specifications have been designed, what kind of output should the risk manager of the pool expect to aid in the performance of his or her job? The most useful reports to public entity pools, according to Mr. Betterley, are:

✔ Loss report. This basic report deals with loss experience. What information is necessary should be agreed upon by the pool members; they need to know what their needs are. The report should be issued monthly and sorted by categories, meeting the members' described needs (i.e., by department, supervisor or location).

Furthermore, it may be useful to describe some of this information in suitable nomenclature, such as claims cost per employee. This is particularly important to the pool management and the individual member's management as it looks at costs.

✔ Reserve analysis report. Monthly reserve change or loss disposition reports are extremely helpful in monitoring claims activity. Significant fluctuations in the reserves give a good management control, or monitoring device, on the claims administrator. The system should be able to generate such reports in as much detail as required. It also should be capable of listing the reason for each reserve change for justification purposes.

✔ Litigation analysis report. This report provides much more detail than the average loss run generated from the claims module. It indicates a specific breakdown of defense counsel, costs, lists of experts, plaintiffs attorneys, defendants, recent offers, ad damnums, state of negotiations, etc. There are many good litigation management modules available today within the RMIS industry. A pool-based RMIS needs to have such capability.

✔ Underwriting management report. This report will analyze specific causes of losses and is tailored to the needs of an individual pool. Claims dollars per 100 man-hours or some other useful member statistic is an example.

✔ Ad hoc report. Essentially, the ad hoc report allows the risk manager or pool manager the flexibility of comparing different groups of data and conclusions. For example, it may specify the number of claims that have occurred by member, or per location, or by shift or supervisor. It also can provide loss stratification reports by size of reserves, by adjuster, by state or by any other parameter desired. Furthermore, such information should be available from one time period comparing it against similar time periods in the past.

✔ Analytical report. Based on basic loss data, reports centering on loss trends, loss development and even loss forecasting are quite useful, given statistically significant claims volume. Such reports should be designed with actuarial input.

✔ Claims management reports. Last but not least, these reports monitor the effectiveness of the claims organization handling the pool's claims. Subrogation status, legal costs contracted out by the claims administrator, average number of days before the injured is first contacted by the adjuster, adjuster claim turnover per month and other useful statistics can be generated and evaluated.

To summarize, a risk management information system for pools must be heavily oriented toward claims management. It should provide some analytical capabilities in doing trend analysis and perhaps some loss forecasting, being able to provide data in a format useful to actuaries or consultants. However, it also must provide basic raw data on losses, including reserve changes, adjuster performance, underwriting data reports, litigation management reports and other useful management-oriented reports.

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

Sound underwriting

Continued from previous page

Accurate loss information is essential, but not easy to obtain. An insurer's old files—if maintained—should give it some input, since the risk probably has been submitted to it previously. But, how can an insurer overcome the unwillingness of present insurers—sometimes itself—to provide current accurate loss information to competing insurers?

Insurers are better able to price existing business, because they know it. So why do they cut prices—even below current account levels—to get new accounts when they don't know them as well as existing accounts? Sure, repricing could be a lot of work, but it's a lot better than a price war! Or, insurers can develop their own ingenious method to determine when they're *really* profitable or losing money.

Practically all property/casualty insurers showed substantial improvement in 1987 operating results over 1986 results. That is only because they overreacted to the 1979-1984 soft market and pushed prices excessively high to stop their near-death bleeding. So, they gradually reduce prices—practically month by month—and take their temperature by measuring the last 12 months' results. They are already writing some business at a loss and don't know it—or don't want to know it.

Above all, insurers should forget "market share" and "cash-flow underwriting." These are terms that belong in the advertising and carnival business. And, the new tax law makes it even more difficult to make a profit. Who needs a share of an underpriced book of business? And how will insurance company chief executives—if they still have their jobs—explain to the board why they managed the company into such a large operating loss? When are insurers going to realize what they are doing? Before or after the government takes control?

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Conflicting coverage rulings

Continued from page 3

Chehalis, Wash., who represents Ross.

Eventually the Supreme Court may resolve the issue, attorneys say.

U.S. District Judge Robert P. Aguilar for the Northern District of California said: "Costs incurred by an insured in investigating and cleaning up pollution—in particular, hazardous waste—that is damaging public property and posing an established threat to public health are covered by the terms of a comprehensive general liability policy."

The court's ruling stemmed from litigation between Intel Corp. of Santa Clara, Calif., and The Hartford Accident & Indemnity Co. of Hartford, Conn.

Hartford is requesting a rehearing of the April 26 ruling.

Intel is an international semiconductor manufacturer. During the 1970s and 1980s, at its Mountain View, Calif., production plant, Intel used cleaning solvents containing toxic chemicals.

"Despite the extremely hazardous nature of these chemicals, Intel stored them in an unsecured underground tank," according to court papers. The chemicals have since contaminated the ground and groundwater beneath Intel's plant.

In accordance with the Comprehensive Environmental Response, Compensation & Liability Act of 1980, better known as the Superfund Act, Intel entered into a consent decree with the Environmental Protection Agency in August 1985 to perform a multimillion-dollar cleanup at the site.

Intel then turned to Hartford for reimbursement of the cleanup costs, which Hartford denied. Intel had primary third-party liability coverage with Hartford from April 1976 to April 1983 with a $1 million per-occurrence limit.

Relying on California law, Judge Aguilar ruled that the term "damages" in the standard CGL policy includes government-mandated cleanup costs.

The judge said that simply because Intel's obligation is in the form of a consent decree rather than a civil judgment does not bar coverage.

In addition, Judge Aguilar refused to allow the insurer to assert a defense based on the pollution exclusion clause. The judge said Hartford waived the right to use the pollution exclusion by waiting too long to inform Intel of the applicability of the exclusion and insurers waive all defenses not mentioned in their claims denials to policyholders.

Addressing the sole exclusion Hartford did mention in its claims denial—the owned property exclusion—the court said the pollution is not confined to Intel's own property and therefore the exclusion does not apply.

"By polluting the groundwater, Intel has damaged the property of all Californians," said Judge Aguilar. He noted that Mountain View has one public water supply, within one-half mile of the contaminated area, and additional public water supply wells are within one mile of the area.

Similarly, the court ruled that there are significant issues of public policy that warrant consideration in the case.

"From the federal perspective there simply is not enough money in the Superfund and enough horsepower in the EPA to clean up first and seek potentially responsible party reimbursement later. The EPA and Congress have recognized that even with increased appropriations, industry cooperation is essential to begin to combat the nation's hazardous waste problem," said Judge Aguilar.

In making his decision, Judge Aguilar specifically rejected the reasoning of three federal courts that have held that government-mandated cleanup costs are not legal damages insurable under CGL policies:

- The 4th U.S. Circuit Court of Appeals ruled on Nov. 4, 1986, in *Mraz vs. Canadian Universal Insurance Co. Ltd.* that the insurers did not have to reimburse the policyholder for costs incurred in a government-mandated hazardous waste cleanup because response costs constitute "economic loss," which may be incurred independently of property damage (*BI*, Dec. 8, 1986).

Judge Aguilar said the *Mraz* decision is flawed because the court failed to apply the laws of Maryland.

- In a subsequent decision, the 4th Circuit in *The Maryland Casualty Co. vs. Armco* ruled that CGL polices insure "only payments to third persons where those persons have a legal claim for damages," not government-mandated cleanup costs (*BI*, July 27, 1987; July 20, 1987).

Judge Aguilar said this decision was flawed because the 4th Circuit drew its definition of damages "from a 30-year-old case in another circuit."

- Most recently, the entire 8th U.S. Circuit Court of Appeals held that Continental Insurance Co. was not obligated to reimburse the now-defunct Northeastern Pharmaceutical & Chemical Co. for cleanup costs related to dioxin-contaminated sites in Times Beach, Mo. (*BI*, March 7).

Judge Aguilar rejected the 8th Circuit ruling because it was based on Missouri law.

Meanwhile, U.S. District Judge Robert J. Bryan, in looking at the same three cases, came to an opposite conclusion.

Judge Bryan of the U.S. District Court for the Western District of Washington followed the federal precedents and ruled on May 27 that insurers do not have an obligation to reimburse policyholders for the costs of government-mandated cleanup costs.

In applying Washington law, Judge Bryan said the type of relief sought by the government against Ross Electric of Chehalis, Wash., represents equitable monetary relief—not a claim for legal damages—and, therefore, is not insurable.

"The term 'damages' has an accepted technical meaning in the law," said Judge Bryan. "That is legal damages, not including equitable relief."

The government is suing Ross for the cleanup of a TCB-contaminated site in Coal Creek, Wash., where Ross dismantled transformers. Mr. McKerricher estimates that it will cost $5 million to $16 million to clean the site.

From 1972 to 1983, Ross had primary third party liability coverage and umbrella coverage with Travelers Insurance Co. of Hartford, Conn., with a $500,000 to $1 million per-occurrence limit.

Ross may appeal the decision. ■

Diamond Shamrock litigation

Continued from page 3

Aetna Casualty & Surety Co.—its primary liability insurer for more than three decades—and dozens of other excess insurers seeking declaratory judgment on insurance coverage for liability arising from its production of the chemical defoliant Agent Orange.

The case covers two general areas of damages:

- Indemnification for Diamond Shamrock's $21.6 million share of the $180 million 1984 class-action settlement of claims brought by Vietnam veterans against producers of Agent Orange, which contains the toxic chemical dioxin.
- Indemnification for cleanup costs, bodily injury and property damage claims related to a dioxin-contaminated Newark plant site where Diamond Shamrock manufactured Agent Orange.

In ruling on earlier motions, Judge Stanton found that cleanup costs constitute "damages" under Diamond Shamrock's general liability policies (*BI*, Jan. 25).

However, he later excluded coverage for the Vietnam veterans' claims under policies incepting after Dec. 29, 1980—when the class-action lawsuit was certified—and for the Newark plant claims under policies incepting after June 4, 1983—when New Jersey Gov. Thomas Kean issued an executive order that the site be cleaned up (*BI*, Feb. 15).

Disposing of a third set of pretrial motions in his letter to lawyers in the case, Judge Stanton refused to grant summary judgment in favor of Diamond Shamrock on the applicability of pollution exclusions in its policies to the Newark plant site claims.

Diamond Shamrock said some of the exclusions related only to its oil and gas operations, not to chemical production at the Newark plant.

The chemical company also argued that the exclusions—imposed by its insurers—do not define such terms as "pollution," "sudden," and "accidental," and that the resulting ambiguity should be construed against the insurers.

Other courts have concluded that a pollution exclusion's exception for "sudden and accidental" occurrences is equal to a CGL policy's coverage of events "not expected or intended" by the policyholder, Diamond Shamrock said.

Therefore, the chemical company argued, the liability insurers should bear the burden of proving that Diamond Shamrock intended to contaminate the Newark site.

But, Judge Stanton wrote, "Absent a fuller factual record, I am not certain that I can find anything ambiguous about the word 'sudden' in the context of this case."

Judge Stanton added that he found a previous New Jersey ruling that the "sudden and accidental" exception is equivalent to "neither expected nor intended" to be "intellectually disturbing because they simply read the word 'sudden' cut of the relevant policies."

The New Jersey case, *Broadwell Realty Services Inc. vs. Fidelity & Casualty Co.*, may be one that "needs correcting," the judge wrote. "If that is so, I, as a trial judge, cannot correct it, but I think the parties to this present action should be afforded an opportunity to create a factual record which may be used to make an argument to the Appellate Division or the Supreme Court for a change of law."

Judge Stanton also denied two Diamond Shamrock motions for rulings that all claims arising from the Newark plant contamination represent a single occurrence under policies issued between 1951 and 1983 and that Vietnam veterans' claims be considered a single occurrence under policies issued between 1962 and 1981.

Insurers during those periods should be held jointly and severally liable for the claims, and Diamond Shamrock should be allowed to select which policies respond to the losses, the chemical company had argued.

Diamond Shamrock suggested two possible ways it might recover its contribution to the class action settlement:

- By tapping policies in the 1962-63 to 1970-71 period and first exhausting all primary limits during that span before proceeding layer by layer through the excess coverage.

Under this approach, Aetna would pay $1.7 million and the excess insurers would pay the remainder, with the largest contribution coming from American Re-Insurance Co., which provided first-layer excess limits of $18.2 million during the period.

- By tapping the 1970-71 policy year only. Under this approach, Aetna would pay $500,000 and excess insurers providing total limits of $25 million for the year would pay the remainder.

Insurers, however, argued that claims relating to both the class action and the Newark plant contamination represent multiple occurrences calling for application of multiple deductibles.

Judge Stanton concluded that a trial will be necessary to determine how many occurrences are involved in the two situations.

Writing separately about the Vietnam veterans' class action settlement, Judge Stanton said: "Although I have previously found that it could not be proven that a particular soldier was injured by a particular application of Agent Orange. . it does not necessarily follow that all of the Agent Orange product liability claims are a single indistinguishable mass."

Meanwhile, Judge Stanton granted a Diamond Shamrock summary judgment motion to bar insurers from denying coverage of Newark plant claims on the grounds that the chemical company had not filed timely notice of claims and had made unauthorized settlements. He also denied a motion by insurers for a jury trial, deciding instead that a judge should hear the case. ■

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Lloyd's changes

Continued from page 2

member resignations could cause Lloyd's capacity to plummet.

J. Antony Haynes, chairman of the Assn. of Lloyd's Members and a self-proclaimed "deeply concerned member of Lloyd's," pointed out that one major issue is causing anxiety among members.

"Is the risk/reward ratio becoming inadequate as seen from the capital base?" he asked, referring to the members. "Put simply, it seems to me that the prospects of reward for the Lloyd's name and the risk of loss are moving away from each other. The ultimate question is: Are they in danger of moving so far apart that the risk/reward ratio becomes unacceptable in the face of unlimited liability?"

Mr. Haynes said that members specifically are concerned that:

- U.S. long-tail liability claims continue to mount.
- Inter-syndicate disputes over reinsurance recoverables, like the disputes involving syndicates underwritten by Richard Outhwaite, are beginning to spread.
- More syndicate accounts are being left open.

Lloyd's members particularly are concerned that the disputes involving Mr. Outhwaite's syndicates will cause more damage to the reputation of the Lloyd's market than the much-publicized losses at syndicates formerly managed by PCW Underwriting Agencies Ltd.

"External names ask themselves where it will all end," remarked Mr. Haynes.

"Is the position deteriorating uncontrollably? Or could a massive and determined intervention by the Council (of Lloyd's) limit the damage before internal and external confidence in Lloyd's begins to be undermined?," he added.

Members also are concerned about the "serious shortage" of premium volume, said Mr. Haynes.

Because of increased competition, Lloyd's syndicates are writing no more than 65% of their premium capacity, other conference participants pointed out.

While Mr. Haynes said the premium volume decline can be blamed on the cyclical nature of the commercial insurance market, he added: "Are the current problems really temporary or might they be indicators of longer-term competitive weakness of Lloyd's in the market?"

And while Lloyd's premium volume is reduced, expenses are increasing because of the tremendous bureaucracy that governs Lloyd's, he said.

To solve these problems, Mr. Haynes suggested that Lloyd's consider limiting members' liability.

In addition, Lloyd's should hire a management consultant to restructure its management to make it less cumbersome and expensive and more efficient, he said.

Mr. Hiscox added that Lloyd's should hire a stronger independent chief executive, leaving the chairman to "shake hands with the queen."

Also, Lloyd's should enhance the corporation staff to replace the other two deputy chairmen and the 27 committees of volunteers, he added.

Lloyd's should give up its "obsession over secrecy," Mr. Haynes concluded.

The quality of debate could be improved within the market and better decisions made if Lloyd's published transcripts of its meetings, he said.

Other speakers who followed Mr. Haynes all agreed with his observations on why members are nervous about Lloyd's future and suggested how to improve the market and satisfy the members.

For example, many speakers agreed that Lloyd's should consider limiting members' liability, including Mr. Hiscox; Anthony G. Cooper, managing director of Wellington Underwriting Agencies Ltd., Lloyd's third-largest underwriting agency group; and David J. Springbett, chairman of Lloyd's broker PWS International P.L.C.

Others attending the conference who favor the abolition of members' unlimited liability included Richard Youell, underwriter for a marine syndicate managed by Janson Green Management Ltd., and David Robson, director of Merrett Holdings P.L.C., the second-largest underwriting agency group at Lloyd's.

Limiting members' liability also would allow Lloyd's syndicates to use a one-year accounting system rather than the current three-year system and would allow syndicate accounts to be closed on time rather than remain open, said Mr. Hiscox.

Leading Lloyd's non-marine underwriter Richard Hazell, who opposes a move to limited liability, suggested other changes to improve Lloyd's efficiency and to increase business.

For instance, Lloyd's should establish a central policy preparation office and create a marketwide central claims office to speed the drafting of policies and the payment of claims, Mr. Hazell suggested. Currently, policies are drawn up by Lloyd's brokers and issued by a central office but most claims settlements are delayed until many underwriters see the notice of claim.

In addition, Mr. Hazell strongly advocated the elimination of the four designated markets at Lloyd's. Instead, each syndicate should be allowed to write all classes of risks, he said. That would allow syndicates to write more non-marine business and more package policies for clients, he said.

"Sectional interests have to be put aside in order for the market to celebrate its 400th anniversary," said Mr. Hazell. "There is only a limited time in the market before inefficiency of (our) systems will drive business away from us. We will attract business when we have something to offer."

"I am wholly in favor of the composite syndicate," added Richard J.W. Titley, chairman of the international division of broker Sedgwick Group P.L.C.

Lloyd's underwriting agencies also advocate sources of business other than Lloyd's brokers.

Heading this movement is Merrett, which last year opened an underwriting agency in Birmingham, England, to handle small corporate risks placed by brokers outside London.

Merrett disapproves of the current proposed Lloyd's broker regulations that reinforce the tradition that producers of Lloyd's business must be Lloyd's brokers regulated by the market, says Ken Randall, managing director of Merrett.

Instead, Merrett maintains that Lloyd's should regulate the business that comes into the market, rather than those that produce the business. That way, Lloyd's syndicates could directly tap non-Lloyd's brokers and foreign brokers for business, Mr. Randall said.

"Proper consideration must be given for the underwriters who feel that the routes of business to Lloyd's are changing," he said. "My view is that we should leave the regulation of brokers to someone else" like the British Insurance Brokers Registration Council, which regulates non-Lloyd's brokers in the United Kingdom. ■

Informal vote favors limiting names' liability

By STACY SHAPIRO

LONDON—Momentum is gaining at Lloyd's of London to limit the liability of its members.

In a show of hands at a conference on the future of Lloyd's last week, more than half of the 100 Lloyd's underwriting agency executives, brokers, and corporation staff agreed that Lloyd's should abolish unlimited liability for members (see story, page 2).

Only a quarter of the conference participants opposed the abolition of unlimited liability, while the rest had no opinion, according to the poll by conference chairman Peter Rawlins, managing director of Sturge Holdings P.L.C.

And, during speeches, question and answer sessions and private discussions, conference participants debated whether limiting members' liability is a good idea.

Limiting members' liability for losses up to the amount they invest in Lloyd's syndicates would allow more syndicates to close their accounts on time, strengthen the security of the Lloyd's policy and increase investment at Lloyd's, say advocates of limited liability (*BI*, June 6).

"Unlimited liability is an anachronism," summed up Robert Hiscox, chairman of Lloyd's underwriting agency Roberts & Hiscox Ltd.

In a speech that sparked much of the discussion, Anthony G. Cooper, managing director of Wellington Underwriting Agencies Ltd., Lloyd's third-largest underwriting agency group, gave a detailed plan of how Lloyd's could limit members' liability by 1999 and still provide strong security for policyholders.

"I choose 1999 because I think it may well take up to 10 years to achieve the change to limited liability," Mr. Cooper explained to the group.

"Unless we move toward limited liability, Lloyd's will see more resignations than new members over the next five years," he said.

'Unless we move toward limited liability, Lloyd's will see more resignations than new members over the next five years,' predicts Anthony G. Cooper, managing director of Wellington Underwriting Agencies Ltd.

At the time limited liability is instituted, each Lloyd's "investor" would have to put up 25% of his allocated premium capacity in cash and provide a bank guarantee for the remaining 75% of his premium capacity, he proposed. Therefore, a new syndicate with a capacity of 10 million pounds would start with cash on hand of 2.5 million pounds.

"Having provided an initial investment of 25% and a bank guarantee of a further 75%, there would be no further liability for the investor," said Mr. Cooper.

Each syndicate's funds would be broken down into units of 10,000 pounds or 20,000 pounds for investment purposes. And Lloyd's investors would not invest directly in each syndicate as members do today, but would invest in investment plans called "unit trusts" controlled by members' agents, which would invest in a broad spread of syndicates, said Mr. Cooper.

The unit trust system could be implemented in the near future without changing the liability system, he added.

Mr. Cooper also pointed out that with the switch to limited liability, the Lloyd's Central Fund, which at year-end 1987 stood at 254 million pounds ($477.5 million at year-end 1987 exchange rates) would have to be far more substantial—at least 1.5 billion pounds ($2.7 billion at current exchange rates)—to pay claims if a syndicate's funds were exhausted.

If the fund were not tapped for 10 years, the fund would increase to more than 800 million pounds ($1.4 billion at current exchange rates), Mr. Cooper estimates. And, the fund could be increased to 1 billion pounds ($1.78 billion) if Lloyd's transferred part of its accumulated reserves to the fund, he said.

In order to close the unlimited liability syndicate accounts on Dec. 31, 1998, each syndicate would pay a premium to the Central Fund based on the syndicate's class of business.

The premiums paid to the Central Fund could total about 500 million pounds among all Lloyd's syndicates, bringing the Central Fund's total assets to about 1.5 billion pounds.

The fund would be tapped for syndicate losses only after the syndicate pays losses equal to 100% of the syndicate's 1999 capacity.

This method of closing pre-1999 accounts would solve Lloyd's Chairman Murray Lawrence's concern that all syndicates would have to run off old business before limited liability could be instituted, said Mr. Cooper.

Mr. Cooper's proposal was lauded by some participants at the conference.

For instance, Richard Youell, leading marine underwriter for a syndicate managed by Janson Green Management Ltd., said he was pleased "to see someone working so hard to limit liability. . .although I fear that 1999 may be too late."

However, others oppose limited liability in any shape or form.

Unlimited liability "is the product we sell," said Lloyd's non-marine underwriter Richard Hazell. "It is the product buyers come to us to buy. I believe that unlimited liability is a marketing asset and it would be a major problem to move to limited liability."

"I do believe that unlimited liability is important," added Alan Colls, chairman of Lloyd's broker Nicholson Chamberlain & Colls. "My fear is that limited liability will expose Lloyd's policy to question."

George E. Lloyd-Roberts, director of underwriting agency Lloyd-Roberts & Gilkes Ltd., added: "I am concerned about the level of debate" on abolishing unlimited liability.

"Lloyd's enjoys mythical powers because of unlimited liability and has an enormous advantage with (regulatory) authorities. We may want to hang on to it for the pluses that are hard to measure," Mr. Lloyd-Roberts said. ■

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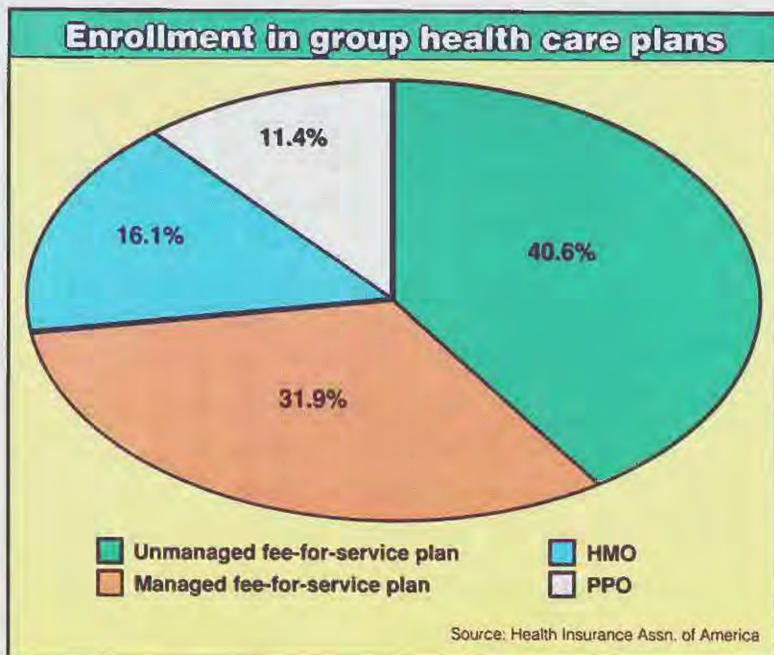
High health costs boost UR: Study

By ALISON KITTRELL



Approximately 60% of U.S. employees covered by employer-sponsored group health insurance plans are subject to at least some sort of utilization review, a new survey shows.

This finding suggests there is a managed care explosion in the United States, fueled by rising health care costs, according to the survey sponsor, the Washington, D.C.-based Health Insurance Assn. of America.

But, while utilization review in fee-for-service plans and so-called managed care plans that stress utilization review are gaining prominence, these approaches have yet to prove they can hold down health care costs, which surged again last year, the survey authors note.

In addition, health care cost inflation also is prompting more employers to self-insure, according to "The Changing World of Group Health Insurance," a spring 1987 survey of 771 employee benefit managers nationwide.

Some 16.1% of the 2.6 million U.S. employees represented by the survey were enrolled in health maintenance organizations in 1987, and an additional 11.4% were enrolled in preferred provider organizations, the survey says.

This enrollment "compares dramatically" with data from a 1981 Bureau of Labor Statistics survey of employers, which found that just 4% of employees were enrolled in either an HMO or a PPO.

In addition, 31.9% of employees were enrolled in fee-for-service plans that incorporate utilization review—ranging from second surgical opinions to pre-admission review. Adding these employees to HMO and PPO enrollment shows that approximately 60% of U.S. employees with group health insurance were enrolled in "managed care plans" in 1987, according to the HIAA survey.

While the term "managed care" generally has been reserved for HMOs and PPOs, the HIAA has coined the term "managed fee-for-service insurance," which it defines as a traditional indemnity plan with some form of utilization review. These managed fee-for-service plans are "the leading managed care product," the survey authors say. "No component of managed care grew more in absolute numbers during 1986-87 than managed fee-for-service."

Approximately 44% of enrollees in conventional indemnity plans were subject to pre-admission certification in 1987, compared with 20% in 1986 and 5% in 1984, the HIAA estimates.

In addition, more than half of the enrollees had a mandatory second surgical opinion program, the use of which also has increased dramatically in the last few years.

HMOs and PPOs, which both stress utilization review to control health care costs, also are being offered by more employers, according to the survey.

For example, 44% of the employers surveyed offered an HMO option to their employees in 1987, up from 38% in a 1984 study conducted by the Health Care Financing Administration.

"The major growth in the availability of HMO plans was among midsized and public employers," the survey authors point out. "About one of every seven small employers in our sample offered an HMO plan to their employees, whereas one of every three midsized firms and five of every eight large firms offers an HMO plan."

In addition, almost 17% of the employers surveyed offer a PPO.

While large employers and public employers are more likely to offer a PPO, the authors note, "Perhaps more significant is the surprising presence of PPO plans among small and midsized employers." PPOs are offered by 10% of small employers and 14% of midsized employers surveyed.

While the increasing number of employers offering HMOs and PPOs naturally has increased enrollment in these plans, HMO and PPO enrollment varies depending on the size of the employer offering the options, the survey found.

Among large employers, about 25% of eligible employees enroll in an HMO when it is offered. And, although small and midsized employers are less likely than large employers to offer an HMO, enrollment rates when a plan is offered are even higher: Some 46% of eligible employees at small companies and 41% of eligible employees at mid-sized firms choose the HMO option when it is available.

Furthermore, "HMOs and PPOs are most popular in the region of their birthplace, the West, where more than 22% of employees in employer-sponsored health care plans are enrolled in HMOs and 31% in PPOs," the survey says. "The Midwest is another region of substantial market share, with 20% of employees enrolled in HMOs and 8% in PPOs."

HMOs are weakest in the South, with only 8% enrollment, while PPOs are weakest in the East, where they have attracted less than 1% of employees. The survey authors attribute the lower PPO penetration in the East to Blue Cross/Blue Shield's domination of the market.

The survey authors remark that these figures are "a far cry from a decade ago when it was said, 'Everyone loves HMOs except doctors and patients.' "

Cutting costs is both the impetus for the growth in all types of managed care plans and the means for judging their success, the survey authors note.

"If the rising cost of health insurance has stimulated the managed care revolution, the future of managed care products rests on their ability to control costs, without sacrificing quality of care."

However, health care inflation, which had slowed somewhat in 1986, heated up again in 1987—the same year that managed care seemed to come into its own, the survey authors say.

The average monthly cost of family medical coverage was $210. Conventional plans tended to cost slightly less than PPO coverage, and PPO coverage was slightly less than HMO coverage.

Still, the authors say, "It is premature to pronounce managed care, and hence the competitive strategy, a failure in the fight against higher health care costs, until we understand how and why health care costs increased, and what type of plans were most successful in controlling costs."

Several factors contributed to the increase in health care costs in 1987, the survey says, including an increase in the overall inflation rate and a " 'catching up' for the previous three years, when insurers failed to increase premiums adequately."

A major contributor to the increase in health care costs, however, is "an increase in the quantity and intensity of ambulatory services that is driving inflation in the health care sector," the survey authors say.

Managed care programs say that keeping people out of the hospital is one of the keys to savings. But, the growing cost of outpatient care appears to be adding to the problem, the survey says, pointing out that while health insurance premiums rose an average of 20% between 1987-88, hospital charges, physician charges and hospital days either rose only slightly or declined. So, the authors say, outpatient care must be accounting for a large part of the increase.

"Thus, the principal challenge for private and public payers is to develop mechanisms to control the increasing number and complexity of services outside the inpatient setting," the authors say.

In addition to increasing utilization review in fee-for-service plans and enrollment in HMOs and PPOs, health care cost inflation has brought changes in financing traditional health care plans, according to the survey.

There has been a significant increase in self-insured health care plans: Some 52% of the employers surveyed in 1987 were fully self-insured, compared with 46% of the same employers surveyed in 1984.

The survey estimates that more than 60% of the 117 million Americans with conventional employer-provided coverage are enrolled in a plan with some aspect of self-insurance, compared with 5% in 1975.

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The survey information is published in the Summer 1987 issue of the magazine "Health Affairs."

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Largest U.S. reinsurers' first-quarter 1988 results

(All amounts in thousands of dollars) (Ranked by net reinsurance premium written)

Reinsurers	Policyholders' surplus (reinsurers only)	Net reinsurance premiums written 1988	Net reinsurance premiums written 1987	Net reinsurance premiums earned	Losses & loss adjustment expenses	Loss ratio	Underwriting expenses	Expense ratio	Combined ratio 1988	Combined ratio 1987
General Re	$2,064,975	$511,546	$598,781	$525,852	$375,676	71.4%	$141,324	27.6%	99.0%	100.9%
Employers Re	905,033	340,921	342,464	321,271	250,016	77.8	77,780	22.8	100.6	98.3
American Re	533,734	247,338	252,568	217,392	163,629	75.3	64,394	26.0	101.3	97.5
North American/Swiss Re	545,406	178,150	174,099	158,881	116,315	73.2	52,564	29.5	102.7	103.7
Munich Re	456,737	160,777	174,589	172,959	116,104	67.1	52,055	32.4	99.5	99.1
Prudential Re	421,020	143,600	164,789	139,159	100,228	72.0	46,415	32.3	104.3	98.4
USF&G	N/A	138,096	103,752	145,609	101,208	69.5	37,655	27.3	96.8	95.9
Continental Casualty	N/A	96,945	71,024	67,921	53,687	79.0	20,530	21.2	100.2	108.4
Transatlantic Re	159,090	73,767	75,064	75,462	61,459	81.4	17,517	23.7	105.1	105.4
CIGNA Re	168,702	70,294	71,575	57,521	43,647	75.9	16,906	24.0	99.9	100.4
National Re	171,669	67,798	87,365	69,441	57,363	82.6	12,501	18.4	101.0	102.2
Continental Re	120,849	63,455	74,863	60,177	51,050	84.8	16,121	25.4	110.2	104.4
Constitution Re	147,415	60,499	58,189	61,262	45,529	74.3	16,080	26.6	100.9	99.4
Transamerica Re	142,998	59,363	N/A	42,809	29,753	69.5	17,620	29.7	99.2	N/A
Kemper Re	295,318	58,024	94,810	61,338	50,150	81.8	10,963	18.9	100.7	100.6
St. Paul Re	N/A	56,641	53,525	54,233	39,590	73.0	15,434	27.2	100.2	100.2
Skandia America Group	291,650	51,701	49,774	58,306	42,091	72.2	16,503	31.9	104.1	107.2
PMA Re	56,691	49,182	60,343	25,958	22,111	85.2	8,410	17.1	102.3	102.1
Constitution State Mgt.	N/A	46,314	59,321	50,945	40,946	80.4	11,760	25.4	105.8	101.9
U.S. International Re	105,465	44,447	50,403	47,084	34,802	73.9	13,307	29.9	103.8	102.9
Totals for top 20	**6,586,752**	**2,518,858**	**2,617,298**	**2,413,580**	**1,795,354**	**74.4**	**665,839**	**26.4**	**100.8**	**100.6**
Total for all companies	**9,144,000**	**3,173,697**	**3,327,753**	**3,072,873**	**2,288,967**	**74.5**	**847,813**	**26.7**	**101.2**	**100.8**

Source: Reinsurance Assn. of America

Reinsurer results

Continued from page 3

merica Corp. acquired Commercial Risk Underwriters Insurance Co. in October and, thus, did not report first-quarter 1987 results (*BI*, Oct. 26, 1987).

The overall U.S. reinsurance industry posted a 101.2% combined ratio for the first quarter, a slight deterioration from the 100.8% ratio posted the comparable period in 1987. The industry reported a 102.3% combined ratio for all of 1987.

The Top 20 reinsurers—again excluding Transamerica Re—reported a 100.9% combined ratio for 1988's first quarter, compared with a 100.6% ratio for the comparable 1987 period. The Top 20 also reported a 102.3% combined ratio for all of 1987.

The U.S. reinsurance industry's policyholder surplus increased 13% to $9.1 billion as of March 31 from $8.1 billion at March 31, 1987. In addition, surplus as the end of the first quarter was 5.4% higher than the $8.7 billion posted at year-end 1987.

Barring any major catastrophes, reinsurers generally do not expect any significant deterioration in their combined ratios this year.

"I don't expect them to get worse. I don't expect them to get any better, either," said Paul Ingrey, president of F&G Re in Morristown, N.J., a USF&G Corp. subsidiary. USF&G's reinsurance operations reported a combined ratio of 96.8% at the end of this year's first quarter, up from 95.9% in 1987.

"If we don't have natural catastrophes, we should be fairly close to where we are," said Mr. Bunaes of Constitution Re, which posted a 100.9% combined ratio in the first quarter of 1988, compared with a 99.4% combined ratio for 1987's first quarter.

"I would hope that we're going to remain fairly consistent with what showed in the first quarter," said Skandia America's Mr. Bensinger. Skandia America posted a 104.1% combined ratio for the first quarter, compared with a 107.2% ratio for the comparable period a year ago.

Don Smith, president and chief operating officer of Kemper Reinsurance Co., said that "assuming no major catastrophes, we would probably be just about where we were at the end of last year as far as combined ratio goes." Kemper Re's combined ratio rose slightly to 100.7% in this year's first quarter from 100.6% in the first quarter of 1987 and was down from 101.9% at year-end 1987.

This year's underwriting results should be "fairly close" to 1987's, agreed Michael Fitt, chairman and chief executive officer of Employers Reinsurance Corp. in Kansas City, Mo., adding, " '88 is not a tremendous concern for me." Employers Re posted a 100.6% combined ratio in the first quarter, up from 98.3% in the first quarter of 1987 and 99.8% at year-end 1987.

However, "I think '89 is going to be a very difficult year because of the softening market," Mr. Fitt said.

"We might uptick a fraction," said William D. Warren, chairman and president of National Reinsurance Corp. in Stamford, Conn., which posted a 101.0% combined ratio for the first quarter compared with a 102.2% ratio in 1987's first quarter.

Most reinsurers expect premium volume, at best, to remain even and more likely to decline during the remainder of 1988.

Prudential Reinsurance Corp. forecasts that premium volume will be down about 20% for the year, said President James M. Dwane. Pru Re is giving up some accounts because of deteriorating pricing, while business that it retains will generate lower, although still adequate, premium, he noted.

For the quarter, Pru Re's net written premiums shrank 12.9% to $143.6 million from $164.8 million, partly because some business that ordinarily would have been written in the first quarter was written in the second quarter instead, said Mr. Dwane.

Kemper Re, whose premium volume declined 38.8% to $58 million in the first quarter, anticipates about a 25%-30% decline in premium volume for the year, Mr. Smith said. "That's the closest we can get at this point" in terms of an estimate, he said.

"We expect the full year to be down by 5%," said Constitution Re's Mr. Bunaes. Constitution Re's premium volume increased 4% for the first quarter to $60.5 million from $58.2 million, which he attributed to "special circumstances."

Skandia America's Mr. Bensinger said he hopes that 1988 premium volume will remain even with 1987's, but he "wouldn't be surprised if it's fairly reduced" because of the softening market.

For the first quarter, Skandia America reported a 3.9% increase in premium volume to $51.7 million from $48.8 million.

While National Re's premium volume dropped 22.4% in the first quarter to $67.8 million from $87.4 million, "by year-end it's going to smooth out a little better," Mr. Warren said. He estimates that National Re will write between $300 million and $316 million in premiums this year, compared with $316.1 million in 1987.

"We anticipate from a premiums written point of view a flat year," Mr. Fitt said. Employers Re's premium volume was virtually flat for the first quarter, decreasing 0.5% to $340.9 million from $342.5 million in the first quarter of 1987.

"We're still projecting for the balance of the year a modest increase overall," commented Mark Mosca, vp and manager of the treaty department at NAC Re Corp. in Greenwich, Conn. NAC Re reported the premiums increased 2.4% in the first quarter to $39.6 million from $38.6 million. ■

Health Policy Coalition

Continued from page 3

remains one of our top priorities," Mr. Smith said.

"We are trying to change the direction of health care policies," Mr. Weller said.

This month, Mr. Weller and Mr. Smith testified before the House Subcommittee on Labor-Management Relations. "Wherever we have addressed our ideas we have received enthusiastic reception," said Mr. Weller.

Their testimony, titled "Health Policy At The Crossroads," examines current health policies and offers alternatives.

During its testimony, the coalition said the government "focuses on new financing gimmicks and ignores the opportunity to purchase health care with positive incentives for value."

Mr. Weller

According to the coalition, the United States spends more on health care than any other country, and yet 37 million people remain uninsured.

To increase the availability of insurance coverage, the group says legislators should remove restrictions that prevent small businesses from combining their buying power to negotiate favorable rates with insurers.

The coalition is asking Sen. George Mitchell, D-Maine, to sponsor its legislation, the Small Employers Health Insurance Availability/Affordability Act, which would encourage the formation of groups of employers to buy health care coverage for their employees. The operation of such groups now is under tight restrictions in some states.

The bill is based on a successful program of the Great Cleveland Growth Assn.'s Council of Smaller Enterprises, which combines the purchasing efforts of 5,200 small employers to obtain health care coverage for 100,000 employees and their dependents at affordable rates. Blue Cross/Blue Shield of Ohio provides most of the coverage for the small employers council.

If affordable health care is available to all workers, "there will be no reason for Section 89," said Mr. Weller.

Section 89 of the Internal Revenue Code requires employers that provide health care benefits to offer them in equitable proportions to all employees (*BI*, April 18).

"It's good in theory, but the complexity in complying with the rules is too onerous," Mr. Weller said.

The coalition also testified that an estimated $100 billion is being spent annually on ineffective or marginally effective health care services.

For example, "in some communities, 20% of women at age 70 have had hysterectomies. In other communities 70% have undergone the same treatment that may not have been necessary," Mr. Weller said. "About 85% of medical procedures are done without the doctors knowing if that particular procedure will have the best outcome for the patient."

The coalition proposed that the Senate Appropriations Committee allocate the $7.5 million needed to fund a program that could "provide patients, doctors and hospitals with information on the efficacy of medical procedures."

The brainchild of Dr. John Wennberg, a professor of community and family medicine at Dartmouth Medical School, the Patient Outcome Assessment Research Program would be directed by the U.S. Department of Health and Human Services to help physicians choose treatments that have proved most successful, Mr. Woods said.

"That's the problem, getting good medical value," he added.

On behalf of the economically disadvantaged, the coalition has proposed that Congress provide incentives for the nationwide expansion of the California Hospital Competitive Bidding Program, which requires hospitals in that state to bid on Medicaid business.

The coalition also opposes lifting the wage cap on workers' contributions to the Medicare program to raise funds for a new long-term care benefit, as was proposed in the home health care bill sponsored by Rep. Claude Pepper, D-Fla. (*BI*, June 13). Currently, only the first $45,000 of wages is subject to the Social Security tax.

The coalition strongly opposes the mandated health care bill sponsored by Sen. Edward Kennedy, D-Mass., which would require employers to provide a minimum level of benefits to their employees (*BI*, Feb. 22).

Mr. Woods

"What the bill is really saying is provide benefits no matter what the cost or the value of the benefits," Mr. Woods said.

This is the type of legislation that Mr. Weller said "will only exacerbate the problems" of providing employee benefits.

Mr. Woods concurred that the benefit bills that have been proposed so far will not solve the nation's health care problems, calling them "perverse in nature" and "overpriced."

It would be unfeasible for small businessmen to try to pay for 80% of health care coverage per employee, which the Kennedy bill would mandate, Mr. Woods asserted.

During its testimony before the House Subcommittee on Labor-Management Relations, the coalition said that employees "are under the illusion" that employee benefits are free. But, "in reality, employee health insurance costs largely represent lost wages."

●

Information about joining the Health Policy Coalition can be obtained by writing Charles D. Weller of Jones, Day, Reavis & Pogue, 901 Lakeside Ave., Cleveland, Ohio 44114; 216-586-3939.

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Agenda

Keynote Address ***Monday, August 1***
Benefits Communicators — The New Dimension
Wesley Poriotis, Chairman and Chief Executive Officer of Wesley, Brown & Bartle, a management consulting and executive search firm in the benefits and communications field, sets the tone for the 1988 EBC Conference with a look at the benefits communicator as business person, creative artist, benefits practitioner, or all three. Who are they, where are they coming from and what does the future hold?

Employee Assistance Programs
If you don't use it, you loose it. To achieve high participation and maximum value for your company's EAP investment, you've got to do more than just communicate. You've got to market the product to your employees. Hear the strategy applied by one company.

Long Term Care
Problems & Solutions. This session presents a case study from one of the first corporations to introduce long term care as an employee benefit. See this company's success story.

EBC Awards Luncheon
Recognizing outstanding communications programs, Alfred Malecki, Publisher, Business Insurance, presents the 16th Annual EBC Awards. Also shown will be the first place a-v winner.

Concurrent Sessions
These three workshops all on state-of-the-art interactive communication programs are presented as concurrents, giving you the opportunity to attend all sessions. These case studies will be presented by both company and consultant firm. Time will be provided after Monday's sessions for additional demonstrations and informal questions/answers.

#1 Flexible Benefits
Abbott Lab's Flex Benefits System, developed by Alexander & Alexander Consulting Group, gives employees a unique tool for making complex benefit decisions. This direct access, interactive system allows employees to model 'what if' scenarios for health care, flexible spending accounts and their 401(k) plan.

#2 Pension/Profit-Sharing & Retirement Planning
Projecting financial scenarios for employee retirement — Allstate's "Search For Security" program, developed by their consultant, Mercer-Meidinger-Hansen, offers new visions. And because it's educational and fun to use, information is better retained.

#3 Benefits Communication & Management
Becton Dickinson is using technology, developed by their consultant, The Wyatt Company, to communicate and administer it's long term savings plan. Employees can sign-up, check account balances, calculate loans and more, in a private, secure, user friendly environment.

401(k) Under Tax Reform ***Tuesday, August 2***
Communicating 401(k) plans and changes to employees within this new tax reform environment can be complicated, even for a seasoned communicator. Here's what has worked — and what hasn't — for one company.

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Luncheon
Jerry Geisel, BI's Washington Editor, gives you a *View From The Capitol.*

Wellness Programs
Michael Scofield, PhD, leads this panel on effectively communicating the health promotion message to employees. Panelists representing large, medium and small size companies discuss the communication channels needed for a very different benefit area — promoting good health and positive lifestyles. They'll look at what works and what has backfired for their own companies.

Adjournment
Until next year ...

Speakers

Craig Bryars
Consultant
THE WYATT COMPANY
WORKSHOP #3:
Interactive Communication

Catherine A. Corse
Asst. VP/Mgr.,Employee Benefits
BARNETT BANKS INC.
Employee Assistance Programs

Pattie Duca
Mgr. Employee Benefit Planning
BECTON DICKINSON & COMPANY
WORKSHOP #3:
Interactive Communication

Jerry Geisel
Washington Editor
BUSINESS INSURANCE
LUNCHEON SPEAKER:
From the Capitol

Beth Leaman
Vice President
BENEFACTS, INC.
ALEXANDER & ALEXANDER CONSULTING GROUP
WORKSHOP #1:
Interactive Communication

Alfred Malecki
Publisher
BUSINESS INSURANCE
LUNCHEON SPEAKER:
EBC AWARDS

Karen Manning
VP, Employee Benefits
AMERICAN EXPRESS
TRAVEL RELATED SVCS, CO.,INC
Long Term Care

Daniel McCarthy
Asst. VP, Comp & Benefits Planning
ALLSTATE INSURANCE COMPANY
WORKSHOP #2:
Interactive Communication

Kathryn J. McIntyre, A.R.M.
Editor
BUSINESS INSURANCE
OPENING REMARKS

Laurel Nicholson
Principal
MERCER-MEIDINGER-HANSEN
WORKSHOP #2:
Interactive Communication

Wesley Poriotis
Chairman & CEO
WESLEY, BROWN & BARTLE
KEYNOTE SPEAKER

Robert Schumacher
Director, Corporate Benefits
ABBOTT LABORATORIES
WORKSHOP #1:
Interative Communication

Michael Scofield
Mgr. Employee Health Promotion
AT&T
Wellness Programs

Russel Wert
Director of Benefit Services
AETNA LIFE & CASUALTY
401(k) Under Tax Reform

Herb Zeltner
President
HERBERT ZELTNER CONSULTING INC.
You Be The Judge

Registration

The BI Conference opens Sunday, July 31, with registration check-in and a cocktail reception from 5-7pm. Sessions begin Monday, August 1 at 8:30am. The conference adjourns Tuesday, August 2 at 3:30pm.

The cost is **$650**. A 10% discount is offered to additional registrants from the same company. The fee includes sessions, workbook, educational materials, and scheduled functions.

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Cancellations must be received in writing. A refund will be made on cancellations received before July 1.
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Business Insurance Circulation Breakdown*

Commercial Consumers

Administrative:	
CEO's Presidents and Owners	2,779
Vice-Presidents, General Managers and Other Administrative Personnel	3,155
Financial:	
Chief Financial Officers and Vice-presidents of Finance	2,732
Secretaries, Treasurers, controllers and other Financial Personnel	5,585
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	10,021
Sub-total	**24,272**
Associations	481
Government, Unions and Educational Institutions	972
Commercial Consumers Sub-total	**25,725**
Insurance Agents and Brokers	10,697
Insurance Companies	7,344
Actuaries, Attorneys, Adjusters, Appraisers and Consultants	4,311
Others Allied to the Field	1,982
TOTAL	**50,059**

* Source Business/Occupational breakdown of qualified circulation, Nov. 30, 1987 issue, as submitted to BPA for Dec. 1987 BPA Publisher's Statement.

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NOTICES

NOTICE INVITING PROPOSALS

Sealed proposals are invited by the City of Los Angeles, California for a Comprehensive Risk Management Program in accordance with Request no. F 9073, available from the Office of the Purchasing Agent, Room 850, City Hall East, 200 N. Main St., Los Angeles, CA 90012-1826. Proposals, which may be mailed or hand delivered to the above address, will be opened at 11:00 a.m., Thursday, August 11, 1988. A Proposer's Conference discussing the work anticipated and answering any questions that may arise will be held at 10:00 a.m. on July 12, 1988 in the City Administrative Office, Suite 300, City Hall East, 200 N. Main St., Los Angeles, CA 90012-4190. Written questions and conference reservations should be submitted in advance to the City Risk Manager at that address.

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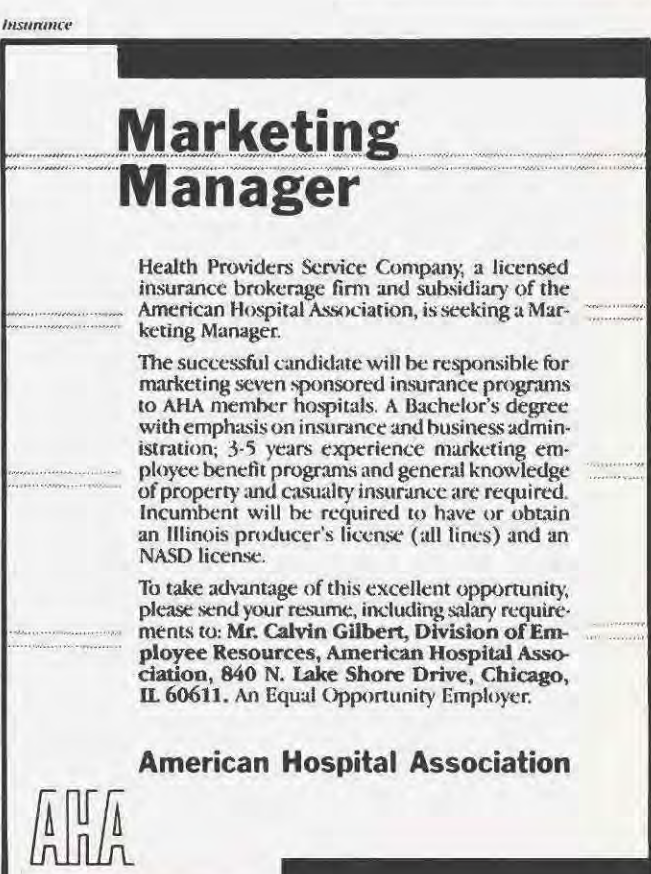

English legal system reform urged

By CAROLYN ALDRED

LONDON—A judicial advisory committee that reviewed the English civil justice system recommends major changes that would make it easier and cheaper for plaintiffs to sue for damages.

In a consultative document published this month, the committee—chaired by Sir Maurice Hodgson, former chairman of Imperial Chemical Industries P.L.C.—recommends a host of procedural changes to simplify and improve the efficiency of the English judicial system, which is used in England and Wales. Scotland and Northern Ireland, which also are part of the United Kingdom, have separate legal systems.

The 181-page document also calls for a re-examination of class-action lawsuits and contingency fee payments to lawyers. Both currently are prohibited under English law.

The recommendations follow increasing public and media pressure for radical changes in England's legal system to allow more people to claim compensation for injuries and damages from manufacturers, retailers and service providers.

In particular, Citizen Campaign—a group supported by lawyers, consumer activists and several members of Parliament—launched a campaign on May 19 to "seek reform to enable citizens harmed by the actions or products of others to obtain fair and prompt compensation at reasonable cost."

Government ministers are studying the committee's proposals, which were submitted three years after the Civil Justice Review was set up by Lord Hailsham, Britain's former Lord Chancellor, to "improve the machinery of civil justice in England and Wales by means of reform in jurisdiction, procedure and court administration and, in particular, to reduce delay, cost and complexity."

The Lord Chancellor is head of Britain's judiciary.

The independent advisory committee appointed to conduct the review included Sir Kenneth Bond, vice chairman of the General Electric Co. P.L.C.; Robert Kerr, assistant general manager of British insurance company Guardian Royal Exchange P.L.C.; representatives of consumer associations; and leading lawyers.

Although the committee was limited mainly to examining English court procedures, its report suggests that the Lord Chancellor's department, the government department responsible for administering all higher courts in England and Wales, conduct further reviews into other major aspects of the legal system.

For example, the report recommends that the present Lord Chancellor, Lord Mackay of Clashfern, institute "a separate study by one of the law reform agencies of the case for extending the availability of representative or class actions, or establishing other procedures, to be available in cases where there are large numbers of litigants whose claims or defenses have a common basis. The study should extend to the funding of such cases."

The English legal system currently allows "representative" actions by or against members of a group. Under the system, when many claimants plan to file similar suits against a defendant, an attorney chooses one or a few lead cases.

Since there is no contingency fee system under English law, a court usually orders the losing party to pay all court costs. Therefore, if the defendant prevails in the lead case, all claimants would pay the court costs, thereby reducing the financial risk per claimant of taking a claim to trial.

But, only some claimants in multiparty actions are eligible for financial aid from the government, making it financially prohibitive for some claimants to join multiparty litigation.

A proposal that would provide government-provided financial aid to many more plaintiffs in multiparty litigation currently is before Parliament as an amendment to the Legal Aid Bill.

'The prohibition on contingency fees and other forms of incentive schemes should be open to re-examination,' the report recommends.

The report also recommends that "the prohibition on contingency fees and other forms of incentive schemes should be open to re-examination."

And, although "reform of the substantive law of negligence was not within the scope" of the review, "it was clear from responses to consultation that there existed a body of opinion in favor of some form of no-fault scheme; that is to say, a scheme in which compensation for injury is obtainable without proving fault and is provided outside the tort system," the report states.

The report recommends that the Lord Chancellor "should consider, in consultation with the insurance industry, the feasibility of a no-fault scheme, restricted to less serious road accidents and financed by private insurance."

According to the Civil Justice Review committee, deficiencies in the English legal system include:

- The cost of litigation, which "is often quite disproportionate to the amount involved in the claim. Thus, the legal costs of both parties to a personal injury case which goes to trial often equal or exceed the damages recovered," the report states.

"Fear of costs is one of the greatest deterrents to using the courts," the report adds.

Of 850 personal injury awards in England's High Courts in 1986, 220 totaled less than 5,000 pounds ($8,900 at current exchange rates) and only 110 totaled more than 50,000 pounds ($89,000).

- The complexity of litigation. "Too many cases are dealt with at an unnecessarily high level," the report says.

Many of the personal injury cases dealt with in England's High Courts could be handled by one of England's 257 County Courts, the report says.

- Delays in bringing cases to trial. "Studies on personal injury cases and the Commercial Court highlighted unacceptable delays," the report says.

The study recommends reducing the permitted time between issuing and serving a lawsuit to four months from 12 months.

Currently under English legislation, personal injury proceedings must be issued within three years of the incident or knowledge of the cause of an injury. The claimant then has a year to serve the lawsuit to the defendant.

The report also recommends amending the 1980 Limitation Act so that a defendant must file a counter lawsuit by the time a claimant's lawsuit is served. Currently, a counter lawsuit must be filed by the time a claimant's suit is issued.

The committee also recommends:

- Expanding the system of pre-trial hearings in the High Court on an experimental basis.
- Reducing the processing time for claimants applying for government-sponsored financial aid for claimants who cannot afford to pay legal costs.

Calls for changes in England's legal system have increased during the last 12 months from both public campaigns and from the legal profession itself.

In particular, the efforts by up to 1,500 alleged victims of the anti-arthritis drug Opren to seek compensation through the English courts have attracted substantial media coverage in the United Kingdom and prompted Citizen Action to set up a Compensation Campaign, known as CITCOM, for legal reform.

Although many of the claimants recently accepted an out-of-court settlement from Opren manufacturer Eli Lilly & Co. of Indianapolis, English Court of Appeals Judge Sir John Donaldson expressed dissatisfaction during the court proceedings with both the inability of the English legal system to cope with class actions and the inadequacies of legal aid funding.

CITCOM's officers and advisors include Lord Scarman, a recently retired senior appellate judge; Ralph Nader, the U.S. consumer activist; David Tench, legal officer for the British Consumers' Assn.; Guy Dehn, legal officer for the National Consumer Council; several leading lawyers; and at least seven members of Parliament.

Among Citcom's proposals are:

- The establishment of a Compensation Advisory Board to review guidelines and formulas for determining court awards. "The guidelines should place higher value than at present on factors such as pain and suffering and loss of quality of life," the group states.
- Increasing the availability of government-sponsored financial aid for litigants.
- Providing publicly funded judicial inquiries into cases involving many claimants.
- Allowing class-action suits.
- Abolishing or amending the development risk, or state-of-the-art, defense included in the British Consumer Act, which introduced strict liability in Britain this year.

"We also wish to continue other possible initiatives, notably in the field of no-fault compensation and extensions of the concept of strict liability," said CITCOM Chairman Des Wilson at a press conference held to launch the campaign.

Major U.K. product liability litigation, "notably Opren," has established that the English system of justice does not satisfactorily adapt itself to mass tort cases, leading to a "clamoring for changes" in the English legal system, said David McIntosh, senior partner with the London-based law firm of Davies Arnold & Cooper, who represented Eli Lilly in the U.K. litigation.

Although Mr. McIntosh conceded that "access to civil justice needs improving," he warned that the "campaign for change is so vociferous it may go too quickly."

However, even if all the proposed changes are adopted, English manufacturers and their insurers still will have less to fear than their U.S. colleagues, he noted.

"I don't think we'll get the same problems in Europe (as in the United States) because of the general reliability of the judicial process," Mr. McIntosh said.

He noted, for instance, that most civil cases in Europe are tried before a judge rather than a jury and most European judges are "willing to hand out socially unpopular judgments" if that's what the law requires.

Other reasons why awards in the United Kingdom are unlikely to equal those in the United States include the fact that the British state welfare system provides compensation to injured people and U.K. courts cannot award punitive damages, lawyers say. ■

U.S. courts influence British reforms: Scholar

By STACY SHAPIRO

LONDON—Changes to the English legal system currently under consideration may be derived from decisions made in California courts 25 years ago, according to a British professor of law.

"Ideas (in legal systems) nowadays move from the West to the East," said Basil Markesinis, Denning professor of comparative law at the University of London's Queen Mary College.

"It takes 15 years for ideas to get from California to New York and 10 years for them to come here from New York," Mr. Markesinis said.

However, he stressed that the English judicial system should adopt only some aspects of the American legal system.

Mr. Markesinis was among the 40 people, including several American and British lawyers, to attend a London seminar sponsored by the Chicago law firm of Mayer, Brown & Platt earlier this month.

The seminar, which turned into a debate over the advantages and disadvantages of the U.S. civil justice system and its influence on the British legal system, was held the same night that a consultative document reviewing the civil justice system in England and Wales was issued by a committee headed by Sir Maurice Hodgson.

The 181-page Civil Justice Review proposal recommends major changes in the English legal system, which is used in England and Wales. The changes would make it easier and cheaper for claimants to sue (see related story).

The proposed changes include adopting a contingency fee system. Contingency fees currently are not allowed in English and Welsh courts.

If the changes are implemented, "we will go toward" the U.S. judicial system, said Robin A.G. Jackson, director of Lloyd's of London underwriting agency group Merrett Holdings P.L.C.

However, Mayer, Brown & Platt partner Leo Herzel said he does not think the contingency fee system will be introduced in England and Wales.

Overall, the U.S. judicial system was largely criticized by seminar attendees.

Mr. Markesinis, the University of London law professor who has spent several years examining and teaching the U.S. legal system, told the Americans: "I am intrigued, surprised and sometimes shocked at your legal system."

Mr. Markesinis said he finds the U.S. civil justice system "immensely costly." He pointed out, for example, that for every dollar recovered in an asbestosis lawsuit, $1.59 is spent on legal fees.

And, awarding punitive damages, which is not allowed in British courts, is "tricky and dangerous," he said. "Why should extra money going to punish a defendant go to enriching a plaintiff?" The U.S. judicial system should follow West Germany's lead and donate punitive damage awards to charities, Mr. Markesinis said.

Mr. Jackson, who called himself "a consumer of the American judicial system," said that in theory the U.S. legal system sounds very good because the poor man is just as entitled to his day in court as the rich man.

However, he pointed out, America's founding fathers "didn't realize how rapacious American lawyers would become."

Mr. Jackson said that as a Lloyd's non-marine underwriter he has "been in the trenches" as a defendant, plaintiff and expert witness in U.S. cases, so his "perspective is as somebody who has to pay for the (American) judicial system."

For example, he said that, in theory, there is nothing wrong with depositions. But for those who give depositions, the procedure is "time-consuming" and "nerve-racking," he said, pointing out that thousands of hours can be consumed "to produce nothing."

Mr. Jackson noted one unidentified case in which millions of pages of depositions were produced. "It sounds wonderful in theory, but it is damned expensive."

Class actions are also nice in theory, he said, but in fact the American public is suffering the "real cost" of these suits by keeping lawyers constantly at work.

Mr. Jackson is one of the defendants in antitrust litigation filed against the insurance industry by 18 state attorneys general in U.S. District Court in San Francisco and by the Texas attorney general in Texas state court. Mr. Jackson would not comment on the litigation at the seminar (see story, page 1).

Mr. Herzel of Mayer, Brown & Platt largely agreed with Mr. Jackson about the advantages and disadvantages of the U.S. legal system. However, he said, "I have serious doubts that you can say one legal system is more efficient than the other."

One U.S. lawyer suggested that one way that British underwriters and businessmen can circumvent the American judicial system is through arbitration clauses in insurance and reinsurance contracts. The clauses should state that all disputes must be settled through arbitration in Britain.

However, Mr. Jackson said that in disputes between ceding insurers and reinsurers, many times both parties try to get around arbitration clauses in order to litigate. And many arbitration proceedings, including two or three in the United Kingdom, are becoming mini-trials, he said. ■

Lloyd's Council appraises operations

By CAROLYN ALDRED

London

LONDON—The Council of Lloyd's will discuss fundamental changes in Lloyd's of London's business methods and membership requirements this year, Chairman Murray Lawrence says in the Corporation of Lloyd's annual report.

Issues the council is likely to confront in 1988 include:

- The impact of an electronic network being set up by Lloyd's in partnership with Lloyd's Insurance Brokers Committee, the Institute of London Underwriters and the Policy Signing and Accounting Center.

The electronic network is designed to cut down on paperwork and reduce the time it takes to place policies and pay claims.

"There can be no doubt that the facility has the potential to alter fundamentally our trading methods," Mr. Lawrence says.

- The creation of a single European insurance market by 1992, when cross-border insurance placement among European Community member nations will be allowed (*BI*, May 16).

"A free community market for insurance will act as a potent impetus for our marketplace," Mr. Lawrence said.

"In addition, there may well be a need for change in the traditional methods used for the transaction of some classes of business: The council will consider these carefully on their merits," Mr. Lawrence stated.

- A review of the market's capital base.

"The council believes that (members') deposits and means requirements should be strengthened and, later this year, it will give careful consideration to recommendations arising from a review of this topic and related issues," said Mr. Lawrence.

Meanwhile, the Lloyd's Council has commissioned London consultant and accounting firm Peat Marwick McLintock & Co. to study the costs incurred by underwriting agencies complying with regulations introduced under the Lloyd's Act of 1982.

The regulations, among other things, greatly increased the amount of information underwriting agencies must distribute to their members.

The annual report notes that the Corporation of Lloyd's operating revenues for the year ending Dec. 31, 1987, increased 15.1% to 140.7 million pounds ($264.5 million) in 1987 from 122.2 million pounds ($180.9 million) in 1986, while pretax operating surplus increased 32.3% to 20.5 million pounds ($38.5 million) from 15.5 million pounds ($22.9 million).

Lloyd's Central Fund, which would pay policyholders' claims if members' funds proved inadequate, fell 8.9% to 254.4 million pounds ($478.3 million) in 1987 from 279.2 million pounds ($413.2 million) in 1986.

The fall was partly due to payments of 50.5 million pounds ($94.9 million) related to the settlement among Lloyd's, outside companies and members of loss-riddled syndicates formerly managed by PCW (Underwriting Agencies) Ltd.

In addition, the report points out that an additional 22.2 million pounds ($39.5 million at current exchange rate) of the Central Fund's assets has been earmarked for members' underwriting deficiencies in regard to PCW syndicates, while 1.8 million pounds ($3.2 million) has been earmarked for deficits from other syndicates, including those formally managed by Oakeley Vaughan (Underwriting) Ltd.

The October stock market crash caused the Central Fund's investment income to decline by 83.9% last year to 6.2 million pounds ($11.7 million) from 38.6 million pounds ($57.1 million) in 1986.

Insurer stocks climb

Stock prices of many British insurance companies rose earlier this month following the publication of a stock analyst's report that British companies are potential acquisition targets by European insurers.

"The U.K. is the only major European market where unfriendly takeovers are readily achievable," according to the report published by County Natwest Securities Ltd.

The dismantling of insurance trade barriers between European Community member nations, scheduled for 1992, is already causing substantial corporate activity in Europe with many insurance companies looking to establish footholds in other EC nations (*BI*, May 16).

"Historically, most European insurance companies have tended to concentrate on their domestic markets. Now, the opportunity to participate in a much larger market is pushing group's such as Italy's Generali, West Germany's Allianz and the leading French and Swiss companies, toward the creation of pan-European groups," analysts Chris Pountain and Simon Willis state in the report.

PWS profits drop

The strong British pound and the softening commercial property/casualty insurance market have cut profits at Lloyd's of London broker PWS Holdings P.L.C. for the six months ending March 31.

Pretax profit fell 51.1% to 2.2 million pounds ($4.2 million at March 31 exchange rate), compared with 4.5 million pounds ($7.3 million at appropriate exchange rate) for the same period last year. Meanwhile, revenues also fell slightly to 9.1 million pounds ($17.3 million) from 9.8 million pounds ($15.8 million).

"The sharp decline (in profits) is due principally to the combined effect of the strength of the pound against other currencies, especially the U.S. dollar, which has reduced our profits by approximately 1.4 million pounds ($2.6 million), and very competitive conditions in the insurance market," said PWS Chairman Ron Peet.

Comings and goings

Merrett Underwriting Agency Management Ltd. has appointed former CIGNA Corp. underwriter **Gerry Olijslager** as property underwriter of its new Lloyd's syndicate 1068.

Sedgwick Group P.L.C. has appointed **Bryan Cooper** as director and chief executive of its Isle of Man captive management subsidiary, Sedgwick Group Management Services Ltd. Mr. Cooper replaces **Michael Linck**, who is retiring but will remain a non-executive director. Mr. Cooper will be supported by **David Vick** as manager of the company.

Lloyd's broker Gibbs Hartley Cooper Ltd. has appointed three senior brokers in its newly formed reinsurance division: **Mike Bishop** named joint managing director of the division, while **Keith Walker** and **Morley Speed** have been named directors. Messrs. Bishop, Walker and Speed formerly were Golding Stewart Wrightson executives, prior to its acquisition by London broker Willis Faber P.L.C.

Robin Etheridge has been appointed a director of English & American Underwriting Agency Ltd.

Robin Snook will retire as deputy manager of the Mercantile & General Reinsurance Co. at year-end, after 41 years with the company.

Mr. Snook will be replaced by **John Austin**, who is currently assistant general manager.

Mark Boucher has been appointed managing director of the captive insurance division of Alexander Howden Group Ltd. ■

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Business Insurance

ntitrust suits

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ould beef up the conspiracy arges."

Attorneys general from 18 states ive filed suit in U.S. District ourt in San Francisco against operty/casualty insurers, reinrers, trade organizations, brors and individuals, alleging that e defendants conspired to mapulate the U.S. commercial liality insurance market.

A similar suit filed by the Texas torney general also is pending in state court in Austin.

The attorneys general's suits inide allegations of "boycott, coeron and intimidation"—acts specifically barred by the :Carran-Ferguson Act, the 1945 w that gives insurers limited imunity from federal antitrust ws.

The suits, which are largely entical, charge that defendants nspired to eliminate the occurice-based commercial general liility insurance policy drafted by : Insurance Services Office Inc. d to exclude all pollution cover: from both the occurrence and ims-made CGL forms.

Among the pretrial orders made Judge Schwarzer at Thursday's nference:

• All pretrial motions must be ed by Dec. 16, giving both sides : next six months to conduct disvery.

'I would instruct defendants to outline your specific summary judgment concerns and develop very specific questions. Then, direct your discovery at those questions only so that we avoid piecemeal motions," the judge said.

> 'It's in your interest to consolidate your presentations because the more pages you file, the less attention paid per page,' Judge William W. Schwarzer told defense attorneys during a pretrial conference.

• Responses to the motions will be due on April 28, 1989. During the time between the filing of motions and responses, both sides would be able conduct further discovery.

• Replies to these responses will be due on June 16, with pretrial hearings beginning on July 7.

• Briefs will be limited to 25 pages each.

To minimize the number of briefs, Judge Schwarzer also ordered the defendants to break down into groups with similar considerations, such as insurance company defendants, reinsurer defendants and trade association defendants.

The judge then told each group to file one brief on issues relating to the McCarran-Ferguson Act, one brief on the issues of state antitrust laws and one brief on whether British-based defendants can be included in U.S. antitrust litigation.

"It's in your interest to consolidate your presentations because the more pages you file, the less attention paid per page," Judge Schwarzer quipped. "However, a 25-page limit does not mean that ceiling will become the floor for all briefs," he said, adding that he would welcome briefs that were shorter than 25 pages.

The judge also ordered that disputes over discovery will be handled via telephone conference calls. This will limit the amount of time spent in court as a result of discovery disputes, he said.

By limiting discovery to whether the defendants' alleged actions were exempt from antitrust laws, Judge Schwarzer limited the defendants' quest to obtain additional documents from the attorneys general.

One defense attorney estimated that the attorneys general have an additional 55,000 pages of discovery documents that they have not yet turned over to the defendants.

Continued on next page

Ruling in LTV pension dispute outs burden of proof on PBGC

By STACY ADLER

NEW YORK—The Pension Benefit Guaranty Corp. force LTV Corp. to restore three massively underided pension plans if it proves that the financially ubled steel producer can afford to re-assume the ins' liabilities, a federal district court ruled last ek.

However, Judge Robert W. Sweet of the U.S. District urt for the Southern District of New York in Man:tan denied the PBGC's motion for a summary judgnt ordering the steelmaker to restore the plans, say; the PBGC acted in an "arbitrary and capricious" nner in returning the plans to LTV last fall.

Judge Sweet said the fact that LTV has created new nsion plans is not by itself proof that LTV, which : filed for reorganization under Chapter 11 of the i. Bankruptcy Act, can afford to maintain the old ns.

In the meantime, administration of the terminated ns will shift back to the PBGC, the federal agency t insures pension plans. The PBGC ordered LTV to ume administering the plans in September.

PBGC Executive Director Kathleen P. Utgoff said agency "is considering other legal steps to re- e the issues of this case and relieve the uncertainty ed by retirees" of LTV. The PBGC has the option of urning to the court after conducting additional :-finding, appealing the ruling to a higher court or h.

In September 1987, the PBGC ordered LTV to rele administering the pension plans after the comy, as part of a collective bargaining agreement with United Steel Workers Union, established new pen- plans that restore to union members certain non- 3C-guaranteed benefits that were lost when the old plans were terminated.

The PBGC charged the new plans were an illegal continuation of the old plans (*BI*, Sept. 28, 1987).

The terminated plans, which cover about 100,000 retirees, were underfunded by approximately $2 billion when LTV filed for bankruptcy in 1986.

Judge Sweet's ruling offered mixed blessings for LTV and the PBGC.

The PBGC was pleased that the judge upheld the federal agency's ability to restore terminated pension plans—even to companies that have filed for bankruptcy.

In LTV's favor, Judge Sweet said the PBGC did not show a "factual or legal" basis for restoring the terminated pension plans.

"The PBGC failed to set forth adequately a basis for its conclusion that LTV Steel's financial condition had improved in ways that were not foreseeable at the time of termination and that could reasonably be attributed to long-term factors," said Judge Sweet in his decision.

Raymond A. Hay, chairman and chief executive officer of LTV, said he hopes the decision would cause the PBGC to "abandon its litigation and begin serious negotiations of its claims in bankruptcy."

Last month LTV proposed a reorganization plan in which the steelmaker would make a "substantial" payment to the PBGC to partially satisfy the pension plans' $2 billion of unfunded liabilities.

The proposed payment is larger than the PBGC's historic recovery of 7 cents per $1 of liability in underfunded plans that agency has taken over, LTV says.

In return for this payment, the three plans would remain terminated (*BI*, May 9).

The PBGC, though, already has rejected the proposed reorganization plan. ■

BIS vendor omitted from *BI* directory

The following company was itted from the directory of emyee benefit information systems t appeared in the May 30 issue *Business Insurance*:

X Corp.

523 McDaniel Drive, West :hester, Pa. 19380; 215-696-6600

ear founded: 1985.

oftware products:

FLX spending Series Two: ,000-$20,000; unbundled hardre and software; personal comter; first installation, 1985; 25 al installations; 12 employee ben- department installations; funcis include administration of flexibenefit plans, flexible spending ounts and 401(k) allocation; can be used to communicate benefit programs to employees.

• The Enroller: $1,395; unbundled hardware and software; personal computer; first installation, 1986; 19 total installations; 12 employee benefit department installations; functions include management of plan enrollment, providing benefit selections to employees, generating status reports, enrollment forms and tax illustrations; can be used to communicate benefit programs to employees.

• COBRA Administrator: $1,395; unbundled hardware and software; personal computer; first installation, 1987; 21 total installations; 11 employee benefit department installations; functions include providing COBRA compliance and claims administration.

• FLX Discriminator; $3,750; unbundled hardware and software; first installation, 1988; two total installations; functions include Section 89 testing and administration.

Staff: Five total staff members, three professional staff members.

Clients: 25 total clients. 12 employee benefit department clients, 85% with less than $200 million in gross revenues, 10% $200 million-$500 million, 5% $1 billion-$3.5 billion.

User support: User groups and meetings, telephone assistance available 8½ hours per day.

1987 gross revenues: Not reported.

Principal officers: Ed Hughes, president; Karen Fitting, director-marketing. ■

Update

Howden judge disqualified

Continued from page 2

1977, according to a spokeswoman for the Serious Fraud Squad.

The pretrial hearing, which started in early June and was scheduled to end Thursday, will decide whether prosecutors have a strong enough case against former Howden Chairman Kenneth V. Grob; former Lloyd's underwriters Ian R. Posgate and Colin Hart; and former Howden Director Jack H. Carpenter. The defendants are charged with various criminal offenses including theft, conspiracy and dishonesty in dealing with Howden and Lloyd's syndicates (*BI*, June 13).

The defendants were first accused in 1982 by Howden and parent Alexander & Alexander Services Inc. of misappropriating $56 million of Howden and Lloyd's underwriting funds.

Criminal charges against former Howden Finance Director Allan Page, which Magistrate Mallinson dropped during the pretrial hearing, will not be reinstated when the hearing is repeated this week, said the fraud squad spokeswoman.

B.A.T. sues over blocked bid

LOS ANGELES—B.A.T. Industries P.L.C. and its U.S. subsidiary, Batus Inc., are suing the California Insurance Department over its ruling last week blocking the British conglomerate's proposed acquisition of Los Angeles-based Farmers Group Inc.

The suit, filed Wednesday in Los Angeles Superior Court, alleges the department's action, based on an interpretation of a state law, is unconstitutional because it inhibits interstate trade without demonstrating a legitimate local need.

Insurance Commissioner Roxani Gillespie, citing state law, ruled that B.A.T. was more than 10% owned by government entities and thus not eligible to own or operate an insurer in California.

However, Batus contends that no single government agency or pension fund owns more than 2% of its parent company.

B.A.T. has offered to buy Farmers for $4.5 billion, or $63 per share. Farmers' stock was trading at $56.88 late last week.

Blast caused $100 million loss

NEW YORK—The explosion at a Henderson, Nev., rocket fuel plant last month is estimated to have caused $100 million in insured property damage to surrounding structures.

The Property Claim Services division of American Insurance Services Group Inc. reported that insured property damage to businesses and homes in Henderson totaled $40 million; damage to buildings and vehicles in Clark County totaled $10 million; and major damage to schools, factories and commercial structures amounted to $50 million. The incident was assigned Catastrophe No. 56 by PCS.

Estimates of the damage to the plant and a nearby marshmallow factory destroyed in the explosion are unavailable (*BI*, May 9).

American International Group Inc. wrote both property and liability insurance for Pacific Engineering & Production Co., which owned the plant.

Orion, Guaranty near merger

NEW YORK—Orion Capital Corp. and Guaranty National Corp. have agreed to merge subject to Guaranty National stockholders' acceptance of Orion's $8.75 a share offer.

The merger agreement replaces an Orion offer to buy all outstanding stock for $8.25 a share. That offer prompted three class-action suits by Guaranty National shareholders, who held that the tender offer was too low. Plaintiffs' attorneys have agreed to drop the suits in light of the new offer.

Orion already owns 49.8% of Guaranty National. Non-Orion stockholders of Guaranty National are expected to vote on the proposal in late September. If shareholders approve the merger, Guaranty National would remain a separate entity with its own management, said Alan R. Gruber, Orion's chairman.

New York-based Orion Capital's insurance subsidiary, Orion Group, writes specialty property and casualty business. Guaranty National is an Englewood, Colo.-based insurance holding company.

Briefly noted

San Mateo County Superior Court Judge John J. Bible has denied a request by **Aerojet-General Corp.** to reconsider his May 25 decision that government-mandated hazardous waste cleanup costs are not covered by comprehensive general liability policies (*BI*, June 13). Aerojet is now seeking appellate court review of the decision. . . .The MacArthur Co. and Western MacArthur Co. of Minneapolis are seeking U.S. Supreme Court review of the **Manville Corp. reorganization plan,** challenging bankruptcy court approval of more than $700 million in asbestos bodily injury claim settlements negotiated between Manville and 29 insurers. . . .The European Community Council has ratified the EC's directive on freedom of insurance services allowing **cross-border placement of commercial insurance** (*BI*, May 16). . . .The Environmental Protection Agency has proposed adding 229 hazardous waste sites —including 14 sites owned by the federal government—to its **Superfund list**, bringing the total number of sites to 1,177. The EPA also dropped 30 sites from the list. . . .An attorney for the government of India says any settlement that **Union Carbide Corp.** reaches with victims of the December 1984 Bhopal poison gas disaster without the government's approval would be unacceptable and invalid. . . .A Vietnam veteran has filed a new **Agent Orange class-action suit** in Texas state court on behalf of those veterans who did not know they had been injured by the chemical defoliant at the time of a May 1984 settlement between 60,000 veterans and seven Agent Orange manufacturers (*BI*, May 14, 1984). The suit seeks $15 million in compensatory damages and $50 million in punitive damages.

Antitrust suit

Continued from page 33

Another defense attorney told the court that the defendants have sufficient documentation if the case is limited to whether the insurers' alleged actions are not subject to antitrust statutes.

"I believe the defendants' position is that if the complaint of violation of antitrust is all we have to defend, then we think we can demonstrate that the conduct alleged in the suit falls within various provisions of antitrust laws," said Stephen M. Axinn of the New York law offices of Skadden, Arps, Slate, Meagher & Flom.

Mr. Axinn is representing General Reinsurance Corp., which is named in the suits.

"However, if things will be brought up in addition" to the antitrust exemption, "we would like to be able to discover information now because we don't want to waste the court's time because we might need additional proceedings" to examine evidence supporting those allegations, he said.

"If it turns out that the turnover of additional material does not produce new evidence, then we will be comfortable that no additional charges will come up in trial," he continued, trying to convince the court to order the delivery of the information.

However, Judge Schwarzer reiterated that discovery would be limited to topics related to the antitrust exemption, not the attorneys general's coercion or boycott charges.

"What's the point of getting more information about a conspiracy unless we establish that a conspiracy would violate the McCarran Act?" the judge asked.

In addition, the judge refused to order that all evidence in the case be kept confidential. Instead, he directed the parties to draw up a list of documents they believe include trade secrets and said he would then rule whether these documents could be released.

The defendants maintain that the documents they are seeking from the attorneys general primarily contain "third-party" information—information that was obtained by subpoena or through interviews conducted by the plaintiffs in their investigation.

The attorneys general pointed out in their status conference statement that they were making every effort to produce the information.

The attorneys general's statement also charges that while the defendants are awaiting discovery information from the plaintiffs, the insurers have not yet provided any documents to the plaintiffs.

In addition to clashing over the production of documents, the insurers and attorneys general also disagree over the facts in the case.

While both sides agree that the focus of the suit is on the activities related to the development, filing and state regulatory review of ISO's commercial general liability policy forms, they disagree on whether defendant insurers and reinsurers illegally made anti-consumer revisions to the forms and conspired to boycott writing CGL coverage.

"Anti-consumer revisions were made in the ISO CGL for[ms] as the result of illegal conduct of the defendants," says t[he] plaintiffs' status conference statement.

"A conspiracy between ISO and other defendants to sta[n]dardize both 'umbrella' and excess insurance forms also [was] alleged."

However, the defendants' conference statement points [out] that "what defendants will dispute—and vigorously—are [the] inaccurate characterizations placed upon their activities [by] the plaintiffs and the legal conclusions the plaintiffs atten[pt] to draw."

The defendants' statement concedes that communicati[ons] among the defendants concerning the CGL forms did ta[ke] place and that "sometimes strongly stated views were [ex]pressed by interested parties regarding various aspects of [the] forms under consideration." However, the statement co[n]tinues that this "dialogue was public, intense and encoura[ged] or even demanded by the state insurance regulators."

In addition, the insurers' statement requests that [the] plaintiffs "provide more specific factual submissions o[n a] defendant-by-defendant basis and identify the proof, [ob]tained during the two-year pre-complaint investigatio[n] upon which they base their generalized allegations of" b[oy]cott, coercion and intimidation.

However, the plaintiffs argue in their statement that [the] insurers' arguments "beclouds plaintiffs' case, which is p[led] with great factual specificity."

Judge in antitrust litigation moves quickly

By DONNA DiBLASE

SAN FRANCISCO—U.S. District Court Judge William W. Schwarzer promises to expedite the massive antitrust litigation filed by state attorneys general against the property/casualty insurance industry.

Presiding over a pretrial status conference in the litigation, he quipped to the more than 50 lawyers representing both sides that "I'm not going to ask everyone here to state their names because then we'll be here all morning."

And, in reaction to arguments by both sides over the delivery of plaintiffs' documents to the defendants, he directed limited pretrial discovery. "The ticking of meters in this room is overwhelming," he observed.

About 100 people—mostly lawyers and a few reporters—attended the June 23 hearing, held in the "ceremonial courtroom" in U.S. District Court in San Francisco.

Following the two-hour conference, the cavernous room was filled with loud chatter about the smoothness of the proceedings. Overall, attorneys for both sides expressed satisfaction with the judge assigned to their case.

For example, "this judge is one of the most renowned in the country in terms of managing discovery. The pretrial schedule is an effort to narrow the issues in the case and it will give the insurance industry an opportunity" to prove its case, observed Thomas Greene, a deputy attorney general for the state of California and the administrative liaison counsel for 18 attorneys general who have filed antitrust actions in the federal court.

Mr. Greene led the discussion for the plaintiffs during the conference.

One defense attorney added that "we're very pleased with the judge. The direction is very efficient and will ensure that we don't spend too much time in discovery on the case."

Before the proceedings started, attorneys milled about the room, meeting and greeting colleagues.

One attorney observed that the busy room reminded her of the huge asbestos coverage litigation proceedings of recent years.

At the front of the courtroom, on both the defendants' and plaintiffs' sides of the room, five rows of three chairs each were neatly arranged. Between each block of chairs were four huge polished wood tables surrounded by high-backed leather chairs—two tables for the defendants and two for the plaintiffs.

In addition to these seats, attorneys for each side also filled in seats in two jury boxes on each side of the room. Other attendees were instructed to fill the pews close to the front of the court room.

The busy scene quickly cam[e to] order as Judge Schwarzer ente[red] the courtroom. After asking [for] brief introductions from princi[pal] lawyers for each side, he noted t[hat] he had searched all of his affi[lia]tions with either side represen[ted] in the case to document that [no] bias would result from his pres[id]ing over the case.

"The only connection I co[uld] find was a homeowner's poli[cy] written by Allstate Insurance [Co.] of Northbrook, Ill., one of the [in]surers named in the lawsuits, [he] said.

And, throughout the proce[ed]ings, Judge Schwarzer mad[e it] clear that all of his orders w[ere] made in the spirit of efficiency.

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McCarran-Ferguson proposal

Continued from page 1

past losses and other economic and social factors in order to project future losses and establish rates.

"I'm totally convinced" that the result of eliminating insurers' antitrust exemption would "be a lessening of competition," said Dennis Hoffmann, president of John Deere Insurance Group Inc. in Moline, Ill.

It would "be a burden to our company," he added. John Deere Insurance Co., the property/casualty division of Deere & Co., reported $160 million in net written premium volume in 1987.

Risk managers, too, criticized the proposal.

The bill is an "overly simplistic approach to a complex problem," said Richard Heydinger, director of risk management for Hallmark Cards Inc. in Kansas City, Mo., and president of the Risk & Insurance Management Society Inc.

The proposal, which was approved June 15 by the House Monopolies and Commercial Law Subcommittee, would make subject to antitrust law:

- Insurance price fixing or the development and publication of recommended rates and the sharing of data regarding expenses and profits.

However, the bill would still allow insurers to share information on paid losses and incurred-but-not-reported losses.

- Tying the sale of insurance to any unrelated insurance product.
- Allocating specific markets or customers among competing insurers.
- Activities that would force competitors out of specific markets.

The bill also would:

- Allow companies with more than $20 million in annual premiums to engage in joint loss trending activities for three years after the proposal's enactment. Insurers with less than $20 million in premium could engage in loss trending for five years after enactment.
- Give the Federal Trade Commission and the Justice Department authority to investigate possible insurer antitrust violations.

The bill had not been scheduled for consideration by the full House Judiciary Committee as of late last week, but there's a possibility that the bill could be taken up by the Judiciary Committee as early as this week.

Under a rule established by House Speaker [Jim] Wright, D-Texas, any bill cannot be considered by [the] full House of Representatives this year unless it is [re]ported out of at least one committee by July 1.

However, there could be exceptions to this rule, [con]gressional observers point out.

The legislation was approved by the subcomm[ittee] largely along party lines just several days aft[er it] was crafted by Rep. Jack Brooks, D-Texas, who is [ex]pected to become chairman of the House Judic[iary] Committee next year after current Committee Ch[air]man Peter Rodino, D-N.J., retires (*BI*, June 20).

The bill would amend the McCarran-Ferguson [Act,] the 1945 federal law giving insurers limited immu[nity] from federal antitrust law and granting states pri[mary] regulation of the industry.

According to Rep. Rodino, the McCarran-Ferg[uson] exemption "has placed the insurance industry in [a fa]vored catego[ry] other majo[r in]dustry enj[oys]. Anti-compet[itive] practices cl[early] prohibite[d in] other majo[r in]dustries—in[clud]ing price fi[xing] and market [allo]cations—are [un]touched by [fed]eral antitrust enforcement."

'Tampering with McCarran-Ferguson is not going to address the volatility of the affordability/availability cycles, if that's what Congress is trying to do,' says Jon Harkavy, director of governmental affairs for RIMS.

And, because "the industry does not perform co[mpe]titively, it is the consumer who suffers," he said[. In] recent years, sharply escalating rates have price[d in]surance out of the reach of thousands of American[s.]

However, risk managers, insurers, brokers and industry observers say that amending McCarran[-Fer]guson is not the right way to address the volatil[ity of] the insurance cycle.

"Tampering with McCarran-Ferguson is not goi[ng to] address the volatility of the affordability/availa[bility] cycles, if that's what Congress is trying to do," sai[d Jon] Harkavy, director of governmental affairs for RI[MS in] New York.

Although RIMS does not have a specific positi[on on] the legislation yet, Mr. Harkavy noted that "th[e pri]mary focus of (the bill) seems to be rates," alth[ough] advisory rates "have not been particularly ab[used] by the industry."

Mr. Heydinger said that even if McCarran-Ferg[uson] had been repealed before the 1980s, "there wo[uld]

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.ife/health insurers

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nrelated insurance product could hurt the fe/health insurance industry.

"This is of concern to us because group ealth and life insurance often are sold to- ether. If you buy group health, you buy roup life from one insurer," explained a pokeswoman for the American Council of ife Insurance and the Health Insurance ssn. of America in Washington.

And, life/health insurers fear that any ange in insurers' antitrust immunity ould inevitably lead to antitrust law- its, including litigation like that filed gainst the property/casualty industry by 19 ate attorneys general (*BI*, June 20; March).

Life/health insurers concede that their action to proposals to amend McCarran- erguson have been muted compared with e cries from the property/casualty indus- y.

"There is concern in the (life/health) in- try, but it has not been voiced very dly," observed William F. Mullin, government and industry relations for w York-based Metropolitan Life Insur- e Co.

Certainly our concerns are not as strong the property/casualty industry's since the pact of the proposed changes clearly ould impact that segment of the indus- more heavily," Mr. Mullin explained.

'What is the most unsettling is that we ve yet to perceive any reason why the law s to be changed," he added.

One life/health insurer executive added: 'e are kind of frustrated because the move reform McCarran-Ferguson is sort of ng driven by problems in the property/ sualty industry and we're just being thrown in with the wash."

"Until a lot more antitrust lawsuits are brought to court, like the current ones by state attorneys general, we won't know" the effects of McCarran-Ferguson amendments on life/health industry, said Roy Woodall, executive vp of the National Assn. of Life Companies, a Washington-based trade organization.

The life/health insurance officials noted they are not greatly concerned about restrictions on the sharing of loss and profit data and the development of recommended rates because life/health insurance premiums are calculated far differently from property/casualty insurance rates.

Instead of using an industrywide rating bureau to set recommended rates, life insurers use mortality tables or other historical information compiled by various industry organizations, like the Society of Actuaries, to develop their rates.

This data probably would not be subject to antitrust laws under the proposal passed by the House subcommittee.

In addition, health insurers determine group rates based on the prior year's claims experience of a particular group, plus administrative costs. Individual health policies are priced based on health care cost inflation and other actuarial factors such as the age and health condition of each policyholder.

"Most life/health insurers develop rates internally based on experience under a particular type of business, plus the cost of expenses to do business. However, they do make some use" of shared data like mortality tables, explained Laurence McCarty, vp for governmental affairs at Prudential Insurance Co. of America in Washington.

Amending the McCarran-Ferguson Act would not significantly affect life/health insurers' ratemaking process because "rates are set based on a group's claims experience and the insurers' expenses to administer the plan," added Joseph Chrostowski, group practice leader with The Wyatt Co. in New York.

"While the changes currently being discussed don't constitute a repeal of McCarran-Ferguson, the laundry list of changes throws into question a lot of activities that now are strictly being regulated by the states, such as guaranty funds and risk pools for the uninsured," added Stephen Schneider, director of government affairs for Evanston, Ill.-based Washington National Life Insurance Co.

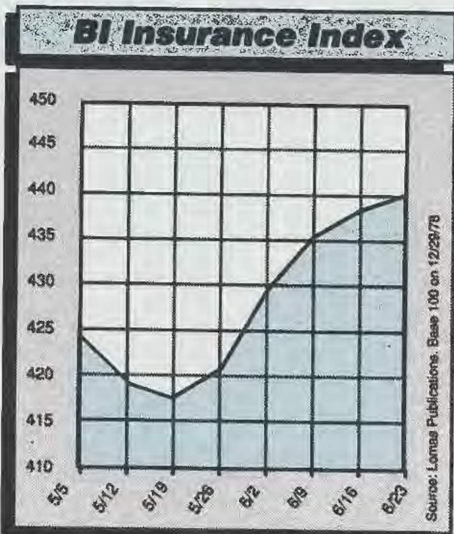
"These changes will make no progress toward problems being faced by the industry, such as the tort crisis and rising health care costs," Mr. Schneider said.

Many in the life/health industry stress that changes to McCarran-Ferguson will inevitably lead to antitrust litigation against life/health companies as well as property/casualty insurers.

"Our biggest fear is that repealing McCarran-Ferguson will open the industry to a barrage of lawsuits," said the ACLI/HIAA spokeswoman.

"Our greatest concern in the life/health industry" is that litigation, like claims disputes, that life/health insurers have already defended would be refiled "to make sure we didn't violate antitrust laws," said James S. Matthews, second vp and assistant general counsel for the group insurance operations of Northwestern National Life Insurance Co. in Minneapolis.

Consequently, the time, money and other resources expended by insurers to defend antitrust litigation would mean higher costs and reduced service for policyholders, he said. ■



Insurance industry stocks climbed for the fifth consecutive week, as the *Business Insurance Index* jumped 1.7 points to 440.9 on June 23, from 439.2 on June 16. Advancing issues were led by NAC Re Corp., up 8.7%; Fireman's Fund Corp., up 7.6%; Baldwin & Lyons Inc., up 6.7%; ITT Corp. (Hartford Insurance Group), up 4.7%; Sears, Roebuck & Co. (Allstate Insurance Co.), up 4.2%; and AVEMCO Corp., up 4%. Declining issues were led by Aneco Reinsurance Co. Ltd., down 12.1%; Farmers Group Inc., down 7.3%; The St. Paul Cos. Inc., down 5.8%; Re Capital Corp., down 4.8%; Tokio Marine & Fire Insurance Co. Ltd., down 4.2%; and USF&G Corp., down 3.8%. Issues showing the most activity during the period were: Farmers Group Inc., 4.2 million shares traded; USF&G Corp., 3.8 million shares traded; and Sears, Roebuck & Co. 2.8 million shares traded. The *Business Insurance* index gained a slight 0.4% for the period, lagging behind the leading market indicators: The Dow Jones 30 Industrials gained 2.6%; the Standard & Poor's 500 gained 1.9%; and the New York Stock Exchange Composite rose 1.7%.

IcCarran-Ferguson proposal

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ve been an iota of difference in the hard market."

'I just don't think that what they're doing will make a material ference" in insurance rates, agreed Norman Chanzis, director of k management for American Standard Inc. in New York.

n addition, insurers and brokers say Rep. Brooks' proposal would ually reduce competition in the property/casualty industry and ssibly could increase the number of insurer insolvencies.

'The most troublesome part of the bill" is the prohibition against s trending activities, said Charles L. Ruoff, senior vp of stra- ic planning for Fred S. James & Co. Inc. in New York.

Mr. Ruoff explained that if insurers cannot engage in trending ivities, they may not enter new lines of business, thereby reducing npetition. Or, if insurers do enter new lines of business without ng able to collectively trend, they then may price policies inade- ately, potentially leading to future insolvencies.

While larger insurers would be able to hire actuaries to analyze s trends, smaller insurers probably could not afford to, noted the IS' Mr. Baiocchi.

maller insurers—those with between $5 million and $200 million annual net written premiums—"are the companies that need the ources of an organization like AAIS," he said.

t is "likely" that some small insurers would not be able to stay in iness if they trend losses themselves, agreed the ISO spokeswoman.

Mr. Ruoff also pointed out that although the bill allows the FTC and the Justice Department to investigate antitrust violations, it does not say how the federal government will gather the information for its investigations, possibly opening the door to federal reporting requirements for insurers.

And, if insurers had to approach the FTC or the Justice Department for safe harbor rulings about every potential antitrust violation, it would throw a significant delay into an insurer's ability to react to the marketplace, RIMS' Mr. Harkavy commented.

He also pointed out that "state insurance commissioners are going to jealously guard their turf."

If state insurance commissioners perceived that their power to regulate the insurance industry was eroding, Mr. Harkavy said they could respond by returning to the state rating board concept that was used in the 1950s and early 1960s, under which all insurance rates were set much like electric utility rates.

That "scares the hell out of me," Mr. Harkavy declared.

In effect, having a state rating board would "substitute a regulator's judgment of what a rate should be for the marketplace," he explained.

"RIMS members would not do well if we went back to the old rating concept," he predicted. "What a mess that would be on a 50-state basis." ■

British Issues

June 23 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence pence
Comml Union	400	15.2	21.9	5.3	407—400
Genl Accident	908	10.5	47.9	5.1	908—895
Gdn Royal Exch	973	14.5	55.2	5.6	973—927
Royal	420	11.1	26.4	6.1	420—417
Sun Alliance	995	16.2	43.1	4.2	995—985
Brokers					
Bradstock	214	12.0	5.0	3.1	214—214
CE Heath	439	16.8	34.5	7.8	439—424
Hogg Robinson	178	14.2	9.6	5.2	179—153
Lloyd Thompson	165	14.3	6.8	4.0	167—163
PWS Holdings	198	8.3	14.4	7.1	198—198
Sedgwick Grp	240	14.9	16.4	6.7	240—225
Steel Brrl Jones	197	12.2	13.7	6.8	197—197
Willis Faber	268	14.0	15.4	5.7	270—264

Source: Philip Olsen/Alan Clifton, Insurance Industry Specialists Kitcat & Aitken Stockbrokers, London

BI Industry Stock Report

JUNE 23, 1988 **6/17/88 THRU 6/23/88**

Company	Exchange	Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
BROKERS												
lexander & Alexander Svcs.	NYSE	23.13	0.0	30.3	24.50	17.75	279	1.00	4.3	14.6	3.40	6.80
aldwin & Lyons Inc.	OTC	16.00	6.7	33.3	15.50	12.00	1	0.20	1.3	6.2	18.31	0.87
orroon & Black Corp.	NYSE	31.50	-1.6	11.5	34.75	28.00	181	1.08	3.4	4.8	12.42	2.54
allagher Arthur J. & Co.	NYSE	18.00	2.9	12.5	18.00	13.88	17	0.48	2.7	11.9	5.16	3.49
all Frank B. & Co.	NYSE	4.50	0.0	56.3	5.50	2.88	79	0.00	0.0	11.9	0.00	N/A
ilb, Rogal & Hamilton	OTC	11.25	2.3	15.4	12.75	9.75	27	0.00	0.0	11.9	0.00	N/A
arsh & McLennan Cos. Inc.	NYSE	54.25	0.0	9.6	56.00	45.25	494	2.40	4.4	13.3	6.74	8.05
e & Assoc. Inc.	OTC	9.00	0.0	28.6	9.25	6.75	0	0.40	4.4	8.7	0.57	15.79
BROKERS	AVERAGE		1.3	24.7					2.6	9.9		
CONGLOMERATES & HOLDING COMPANIES												
rkley W.R. Corp.	OTC	25.75	2.0	7.3	29.00	23.50	108	0.36	1.4	6.3	17.63	1.46
rkshire Hathaway Inc.	OTC	4025.00	0.6	36.4	4050.00	2755.00	87	0.00	0.0	19.6	69.38	10.90
T (Hartford Group)	NYSE	52.88	4.7	17.5	53.13	43.25	1960	1.25	2.4	7.1	52.23	1.01
ars Roebuck & Co. (Allstate)	NYSE	37.00	4.2	10.0	39.88	32.25	2834	2.00	5.4	9.1	34.74	1.07
CONGLOMERATES	AVERAGE		2.9	17.8					2.3	10.5		
INSURERS & REINSURERS												
tna Life & Cas Co.	NYSE	45.63	1.1	0.8	49.88	39.50	987	2.76	6.0	6.5	53.56	0.85
merican General Corp.	NYSE	30.88	0.4	-2.7	36.38	27.50	1134	1.40	4.5	8.4	27.99	1.10
ner Heritage Life Invt	NYSE	25.25	2.0	4.1	26.00	24.00	2	1.08	4.3	11.4	20.98	1.20
ner Indty Fin'l Corp.	OTC	10.00	0.0	11.1	11.75	8.25	5	0.56	5.6	15.4	15.26	0.66
merican Int'l Group	NYSE	58.00	-0.2	-3.3	65.38	49.00	1425	0.40	0.7	9.5	33.56	1.73
eco Reins Ltd.	OTC	2.75	-12.1	-18.6	4.00	2.88	6	0.00	0.0	4.7	2.51	1.10
n Corp.	NYSE	25.75	2.5	12.5	27.00	21.88	114	1.28	5.0	9.0	15.13	1.70
gonaut Group	OTC	44.00	-1.1	47.9	49.00	29.50	126	0.00	0.0	7.2	29.19	1.51
VEMCO Corp.	NYSE	26.00	4.0	32.5	25.25	17.88	24	0.34	1.3	12.6	7.74	3.36
elvedere Corp.	AMEX	5.25	0.0	19.9	6.00	4.38	1	0.04	0.8	7.6	7.87	0.67
usiness Mens Assurn Co.	OTC	35.00	1.8	30.8	36.75	25.50	31	1.20	3.4	63.6	27.39	1.28
hubb Corp.	NYSE	56.88	0.2	1.8	63.38	51.25	423	2.16	3.8	6.5	46.13	1.23
GNA Corp.	NYSE	47.00	1.1	7.1	51.88	42.75	761	2.96	6.3	6.4	49.19	0.96
A Fin'l Corp.	NYSE	56.88	-2.8	2.2	64.25	51.00	119	0.00	0.0	8.2	46.40	1.23
ntinental Corp.	NYSE	38.88	2.6	0.3	41.63	34.75	629	2.60	6.7	7.4	42.10	0.92
ham Corp.	OTC	27.00	2.9	25.6	28.00	21.50	32	0.92	3.4	27.8	26.00	1.04
rmers Group Inc.	OTC	56.88	-7.3	41.3	65.75	40.50	4233	1.44	2.5	13.9	22.02	2.58
Fireman's Fund Corp.	NYSE	31.75	7.6	22.1	31.00	25.75	443	0.50	1.6	529.2	26.17	1.21
Fremont Gen Corp.	OTC	10.25	-2.4	6.4	13.50	8.75	37	0.60	5.9	529.2	16.75	0.61
General Re Corp.	NYSE	54.88	2.1	-1.8	56.38	45.50	802	1.20	2.2	10.9	26.21	2.09
Home Group Inc.	NYSE	13.00	-1.0	9.4	14.38	11.50	156	0.20	1.5	2.8	17.65	0.74
Hanover Ins Co.	OTC	23.63	-0.5	1.6	26.25	20.50	171	0.36	1.5	5.3	25.10	0.94
Harleysville Group Inc.	OTC	15.13	-0.8	15.3	16.38	13.38	5	0.40	2.6	6.7	16.65	0.91
Hartford Steam Boiler Insp	OTC	28.50	2.7	23.9	29.25	22.50	110	1.20	4.2	10.6	10.65	2.68
Kans City Life Ins	OTC	30.75	0.4	17.1	30.75	25.25	0	0.00	0.0	10.6	0.00	N/A
Kemper Corp.	OTC	23.88	0.5	16.5	25.25	20.75	306	0.72	3.0	7.5	26.50	0.90
Lawrence Ins. Group	AMEX	16.50	3.1	144.4	16.75	6.88	9	0.32	1.9	17.0	4.35	3.79
Liberty Corp. S.C.	NYSE	40.00	0.0	12.7	47.25	34.50	6	0.80	2.0	14.8	17.40	2.30
Lincoln Nat'l Corp.	NYSE	47.63	-0.3	18.7	48.75	40.25	214	2.36	5.0	9.2	36.62	1.30
NAC Re Corp.	OTC	26.63	8.7	50.0	27.00	18.50	254	0.00	0.0	15.5	19.92	1.34
Nobel Ins Ltd.	OTC	5.25	2.3	-40.0	9.50	4.50	23	0.44	8.4	25.0	9.37	0.56
Northwestern Nat'l Life	OTC	28.38	1.4	24.0	29.25	22.63	28	1.12	3.9	7.3	35.05	0.81
Ohio Cas Corp.	OTC	33.50	0.0	-7.6	38.25	32.25	61	1.88	5.6	7.9	27.86	1.20
Old Rep Int'l Corp.	OTC	23.88	-2.1	19.4	24.75	19.13	85	0.74	3.1	5.5	27.82	0.86
Orion Cap Corp.	NYSE	17.50	0.7	29.6	17.63	13.13	12	0.76	4.3	5.9	9.34	1.87
Phoenix Re Corp.	OTC	9.00	0.0	38.5	9.50	6.75	38	0.00	0.0	6.5	11.08	0.81
Protective Life Corp.	OTC	13.38	1.0	9.2	15.13	12.25	39	0.70	5.2	12.7	17.25	0.78
Re Capital Corp.	AMEX	10.00	-4.8	-4.8	11.75	9.13	2	0.00	0.0	62.5	11.49	0.87
Provident Life & Acc Ins Co.	OTC	20.00	0.0	28.0	21.88	15.63	307	0.84	4.2	153.8	27.45	0.73
St. Paul Cos. Inc.	OTC	42.63	-5.8	-7.3	51.00	38.25	708	2.00	4.7	6.1	35.83	1.19
SAFECO Corp.	OTC	25.75	3.5	-7.2	30.00	22.75	1372	1.08	4.2	8.2	21.39	1.20
SCOR US Corp.	OTC	9.00	0.0	-2.7	9.50	7.25	0	0.00	0.0	6.5	9.20	0.98
Seibels Bruce Group Inc.	OTC	13.25	1.9	17.8	14.25	11.00	54	0.80	6.0	8.6	12.51	1.06
Selective Ins Group Inc.	OTC	24.50	2.1	28.9	24.50	19.25	58	1.24	5.1	5.6	19.52	1.26
Statesman Group Inc.	OTC	3.81	3.3	-18.8	5.56	3.56	23	0.05	1.3	5.6	3.48	1.09
Tokio Marine & Fire Ins	OTC	74.25	-4.2	12.7	85.88	63.25	36	0.19	0.3	66.3	0.00	N/A
Torchmark Corp.	NYSE	32.88	3.6	34.2	33.13	24.50	179	1.00	3.0	10.5	12.24	2.69
Transamerica Corp.	NYSE	34.88	0.4	17.2	36.75	29.75	382	1.84	5.3	7.0	24.94	1.40
Travelers Corp.	NYSE	36.63	-0.7	4.3	40.00	33.00	636	2.40	6.6	9.4	45.28	0.81
Trenwick Group Inc.	OTC	12.50	-2.0	22.0	13.00	9.75	13	0.16	1.3	10.8	15.41	0.81
United Fire & Cas Co.	OTC	27.00	0.0	3.8	27.00	24.00	1	1.08	4.0	5.1	22.56	1.20
United States Fid & Gty	NYSE	31.75	-3.8	11.4	34.38	28.88	3757	2.64	8.3	7.1	19.53	1.63
UNUM Corp.	NYSE	23.75	-0.5	28.4	24.38	17.88	350	0.48	2.0	11.8	28.53	0.83
USLIFE Corp.	NYSE	36.38	0.0	27.6	39.00	28.00	323	1.28	3.5	9.4	46.77	0.78
Washington Nat'l Corp.	NYSE	27.75	1.8	16.2	28.63	24.00	16	1.08	3.9	21.9	32.33	0.86
Zenith Nat'l Ins Corp.	NYSE	22.88	-0.5	52.5	23.88	15.00	54	0.88	3.8	10.2	12.26	1.87
INSURERS/REINSURERS	AVERAGE		0.2	15.8					3.3	25.4		
ALL COMPANIES	AVERAGE		0.5	17.0					3.1	23.0		

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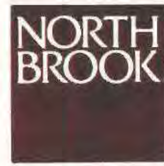

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