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Update

Department gets new extension to draft Mutual Fire rehabilitation

PHILADELPHIA—Noting the advantages of rehabilitating rather than liquidating Mutual Fire, Marine Insurance Co., a state court is giving the Pennsylvania Insurance Department another 60 days to finalize a plan to rehabilitate the insurer.

The department will add provisions to the plan that address the availability of funds from state guaranty associations to pay policyholder claims and the possibility of paying claims as assets

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House committee prepares to pass product liability bill

By DEBORAH SHALOWITZ

WASHINGTON—A watered-down federal product liability reform bill is heading toward approval by a House committee.

In more than eight hours of markup last week by the House Energy and Commerce Committee, legislators agreed on several amendments to the bill, including one that subjects manufacturers to a stricter standard of liability than the original bill, two that provide more relief for manufacturers and one directing the Commerce Department to collect insurance information from state insurance departments.

However, committee members rejected numerous amendments, including one that would have allowed the Commerce Department to collect information directly from insurers.

The legislation, which the committee is expected to pass this week, establishes a uniform standard of liability for manufacturers and a number of defenses that manufacturers and product sellers could use in a product liability lawsuit.

However, the compromise bill is substantially weaker than the original version of H.R. 1115, which was introduced by Rep. Bill Richardson, D-N.M., last year (*BI*, March 2, 1987).

The bill now under consideration neither modifies nor eliminates joint and several liability and does not establish a cap on non-economic damages—two reforms that supporters of product liability legislation historically have said are important.

Furthermore, the committee on Thursday approved a broad amendment authored by Rep. Mike Synar, D-Okla., that would, among other things, subject manufacturers to a stricter standard of liability.

Rep. Thomas Tauke, R-Iowa, noted that "even those of us who are supporting this bill have some questions as to whether it will really do anything to affect the availability and affordability of insurance."

Rep. James Florio, D-N.J., who was instrumental in crafting the compromise product liability bill passed last December by the Commerce, Consumer Protection & Competitiveness Subcommittee (*BI*, Dec. 14, 1987), stated that the current bill "probably will have no impact on insurance rates."

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Competition takes toll on insurers' earnings

By JUDY GREENWALD

Commercial property/casualty insurers are unhappily—if not unexpectedly—watching their underwriting results and earnings slide downhill.

But, while most observers do not expect insurers' results to bounce back anytime this year, they don't expect them to decline dramatically either.

As premium volume flattens out or declines, the industry's combined ratio will increase this year, "but it is not going to jump up to 115%," barring a major catastrophe, said a spokesman for CIGNA Corp.

Uncertainty about various factors, including the impact of the the Tax Reform Act of 1986 on the insurance industry, "should keep this (competitive) situation fairly reasonable for a while," said George Yonker, assistant controller at SAFECO Corp. in Seattle.

First-quarter earnings were expected to decline simply because the market is in the down side of the cycle, said a spokesman for USF&G Corp., whose operating income fell 24.2% to $71.9 million in the first quarter.

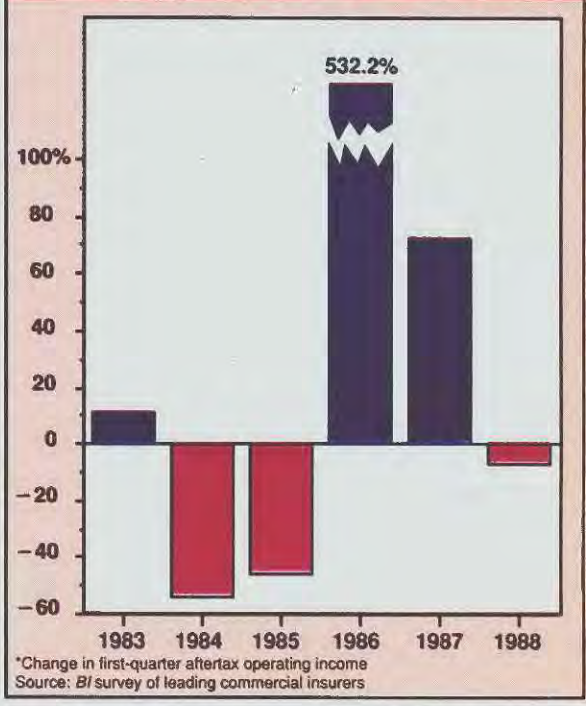
"More importantly, we still see an awful lot of discipline—at least in our markets—in terms of underwriting and pricing," he pointed out.

Price cutting will continue, commented Gordon D. Luce, assistant manager at securities broker Brown Bros. Harriman & Co. in New York. However, "I don't see anything out there to act as a catalyst to trigger the same kind of intense competition we saw in the last cycle."

"I think there's going to be less incentive for competition in the industry to reach" the level of competition that wounded the industry in the early 1980s, especially since tax reform has increased insurers' tax liabilities, said John H. Fitzpatrick, vp-finance for Kemper Corp. in Long Grove, Ill.

Observers also point out that while interest rates are rising, they are unlikely to reach the double digits, which would create an environment that fosters widespread cash-flow underwriting.

Insurer profits begin to erode*



*Change in first-quarter aftertax operating income
Source: *BI* survey of leading commercial insurers

While most industry pundits doubt that the industry downturn will reach cataclysmic proportions, insurers are feeling the pinch of competition.

Major commercial property/casualty insurers surveyed by *Business Insurance* reported that underwriting losses increased by 9.7% during the first quarter of 1988 to $1.2 billion from $1.1 billion in 1987. Last year, the same insurers reported a 34.9% increase

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Medicare-ordered refunds to be limited

By JERRY GEISEL

WASHINGTON—A provision in pending Medicare expansion legislation will force many employers with retiree health care plans to give each retiree $100 to $120 over the next two years, experts agree.

The Medicare legislation, cleared last week by the full House on a 328-72 vote and pending before the Senate, requires employers that eliminate the portions of their retiree health care plans that duplicate new benefits provided by the soon-to-be-expanded Medicare program to pass those savings on to retirees in two phases (*BI*, May 30).

In 1989, employers will have to pass on for one year the cost savings they achieve when they eliminate hospital benefits that duplicate Medicare Part A, which will be expanded that year.

In 1990, employers that cut back benefits that duplicate Medicare Part B will have to pass those cost savings on to retirees for one year.

The benefits that an employer with a "representative" retiree health care plan will be able to eliminate because of the Medicare expansion probably will have a value of $100 to $120 per retiree, estimates Richard Ostuw, a vp and senior group actuary in the Cleveland office of TPF&C, the benefit consulting division of Towers, Perrin, Forster & Crosby Inc.

Other consultants agreed that Mr. Ostuw's estimate is a good ballpark figure.

"We're not talking about a very significant sum," added Steven J. Ferruggia, a consulting actuary with Buck Consultants Inc. in Secaucus, N.J.

However, the savings to be returned to retirees under the so-called "maintenance of effort" provision could be higher for employers with ultra-rich retiree health care plans.

For example, Alan Reuther, associate general counsel in the Washington office of the United Auto Workers union, estimates that automakers will have to pay retired union employees between $200 and $250 in each of the two years because of the maintenance of effort provision.

While these payments are somewhat higher than some experts initially thought, benefit experts and lobbyists had feared—albeit briefly—last week that the impact of the maintenance of effort provision could have been much greater.

Some benefit experts were alarmed following the distribution of a 17-page news release last week from the Senate Finance Committee and House Ways and Means Committee explaining the maintenance of effort and other provisions in the Medicare legislation.

The news release said employers would have to give retirees the "present value" of the duplicative company-provided retiree health care benefits that would be eliminated when Medicare is expanded.

Some experts interpreted that to mean that employers would have to give retirees in 1989 and 1990 an amount equivalent to the savings that employers would accrue over retirees' expected lifetimes by cutting back duplicative benefits.

But congressional staffers said late last week that the news release was improperly worded and that the words "present value" will not appear in the official conference report on the Medicare legislation.

"The intent clearly was to limit" the provision to two years, said an aide to Sen. Donald Riegle Jr., D-Mich., the original

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Update

Mutual Fire plan ruling delayed

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become available from all sources.

Mutual Fire, insolvent by around $177 million, has not written business or paid claims since April 1986.

Judge James Crumlish of the Commonwealth Court of Pennsylvania in Philadelphia said in his order that "a modified plan of rehabilitation would be more beneficial than liquidation to the interests of Mutual Fire's policyholders and creditors."

Richard A. Brown, a Washington attorney representing the policyholders committee involved in the rehabilitation effort, called the judge's order "very positive." He said the committee had already drafted similar modifications to the rehabilitation plan.

In a related matter, the policyholder committee has filed a motion with the Commonwealth Court to bring an action against New York-based Alexander & Alexander Services Inc.; Evanston, Ill.-based Shand, Morahan & Co. Inc., A&A's former underwriting management unit; and surplus lines insurer Evanston Insurance Co. of Evanston, Ill., on charges that include violations of the Federal Racketeering Influenced and Corrupt Organizations Act in their alleged attempts to "acquire, or maintain interests in, or control" Mutual Fire.

The complaint says the defendants are liable to Mutual Fire for damages of at least $531 million.

AIDS panel asks COBRA cover

WASHINGTON—The president's commission on AIDS last week recommended that Congress expand the Consolidated Omnibus Budget Reconciliation Act of 1985 so former employees with AIDS could receive COBRA health care coverage until they become entitled to Medicare.

The recommendation, if accepted by Congress, would mean that employers potentially could have to extend COBRA coverage for years to people suffering from acquired immune deficiency syndrome. Currently, employers only have to extend COBRA coverage for a maximum of 18 months to former employees and 36 months to former employees' divorced, widowed or separated spouses.

Among the commission's other recommendations:

- The federal government, in conjunction with states, should set up experimental programs to subsidize the COBRA premium for AIDS patients unable to afford the full premium.
- Congress should amend the Employee Retirement Income Security Act of 1974 to make clear that self-funded employers can be required to contribute to the cost of state health care pools that provide coverage to high-risk individuals.
- A federal pool should be established that would reinsure or provide "stop-loss subsidies" for state health care pools.

Hancock winds down reinsurer

BOSTON—John Hancock Mutual Life Insurance Co. is withdrawing from the property/casualty reinsurance business to concentrate its resources on its John Hancock Property & Casualty Insurance Co. and Unigard Insurance Group units.

"The move to consolidate is a strategic management decision that will ultimately benefit our overall customer base," said Laurence P. O'Connor, president and chief executive officer of John Hancock Property & Casualty Holding Co.

John Hancock Reinsurance Co., formed in 1981, stopped accepting new business June 1 but will retain a staff to service all existing accounts. In 1987, John Hancock Reinsurance assumed $44.2 million in net premiums, down 25.8% from $59.6 million in 1986.

John Hancock's foreign reinsurance units in London and Bermuda will continue to write new business.

Cedant ranks low in insolvency

SPRINGFIELD, Ill.—Reinsurance claims filed by ceding insurers against an insolvent insurer are not entitled to the same priority as those filed by direct policyholders or state guaranty funds, according to the Illinois Supreme Court.

As a result, ceding insurers will continue to be categorized as general creditors in an insolvent insurer's liquidation and will stand fourth in line to receive the insolvent insurer's assets behind three other general creditors: the administrators of an insolvent insurer; secured claimants and employees of the insolvent insurer who are owed wages; and a class that includes direct policyholders or their beneficiaries and guaranty funds.

The court's ruling last month, which upheld a Cook County Circuit Court judge's decision, came in a lawsuit filed against Illinois Insurance Director John Washburn by nine companies that ceded business to Reserve Insurance Co. and Security Casualty Co. (*BI*, Sept. 14, 1987).

The decision means that it is unlikely that the approximately 175 insurers that ceded business to Reserve and Security Casualty will be able to recover anything from the insolvent insurers, because there is a limited amount of assets to be distributed to general creditors, attorneys said.

No ruling on punitive awards

WASHINGTON—The Supreme Court refuses to rule on the constitutionality of punitive damage awards.

The justices last week declined to consider seven cases involving the constitutionality of punitive damage awards, allowing awards ranging from $100,000 to $10 million to stand.

In declining to review the cases, the justices said that there was no "substantial federal question" at issue.

This refusal to tackle the punitive damage controversy comes on the heels of the justices' refusal last month to review a $1.6 million punitive damage award against Bankers Life & Casualty Co. in a bad-faith case (*BI*, May 23).

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ACIC wins some disputes, still faces high-stakes fight

By DOUGLAS McLEOD

NEW YORK—While American Centennial Insurance Co. has settled or won arbitrations with reinsurers over millions of dollars of losses on managing general agency business, it still faces arbitrations that could account for more than $80 million in recoverables.

About 20 reinsurers that participated on ACIC business produced by two managing general agents disclaimed liability for losses by early 1987. Most of the reinsurers claimed to be the victims of fraud on the MGA accounts (*BI*, Jan. 12, 1987).

Together, the reinsurers could ultimately have accounted for more than $124 million in reinsurance recoverable by ACIC, according to court papers and reinsurers.

Since then, however, 10 reinsurers have either agreed to settle ACIC's claims before arbitration hearings—by bringing past due balances current or by commuting their reinsurance agreements—or have lost their arbitrations, ACIC representatives say.

However, while ACIC has resolved some of its reinsurance problems, it still faces arbitration with seven reinsurers, including two high-stake disputes with Commonwealth Insurance Co. of Canada Ltd. of Vancouver, British Columbia, a Home Group Inc. unit that alone could account for a total of $60 million in recoverables on books of business produced by two MGAs.

ACIC, a former Beneficial Corp. subsidiary, was sold to a management group along with several other Beneficial Insurance Group units last year (*BI*, April 6, 1987).

Formerly a major property/casualty insurance and reinsurance market, ACIC was crippled by loss-plagued business and required reserve contributions totaling $365 million from Beneficial in 1986 and early 1987.

ACIC—now a Wilmington, Del.-based unit of First Delaware Holdings Inc.—currently is focusing its underwriting on credit property and personal lines insurance, though it eventually will move back into selected commercial lines, according to Vice Chairman Andrew M. Kerstein.

Most of the arbitration demands that were brought against ACIC involved business produced by one of its MGAs—The Underwriters Inc. of Parsippany, N.J.—and were triggered by ACIC's 1984 fraud lawsuit against the MGA and several others (*BI*, Oct. 29, 1984).

ACIC's lawsuit, filed in U.S. District Court in Newark, N.J., charged that The Underwriters, its owner, John A. Kraeutler, and several others conspired to defraud ACIC on reinsurance placements covering Associated Electric & Gas Insurance Services Ltd., a Bermuda-based utility industry captive.

ACIC mailed copies of its lawsuit to all of its retrocessionaires on the AEGIS risk, inviting them to participate in pursuing the complaint.

Instead, dozens of ACIC's treaty and facultative reinsurers disclaimed liability on business produced by The Underwriters, including the allegedly fraudulent reinsurance placements for AEGIS, according to Lawrence I. Brandes, a lawyer with the New York firm of Miller, Singer, Raives & Brandes, which represents ACIC.

Treaty reinsurers that disclaimed liability and subsequently demanded arbitration on The Underwriters

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E/S directory questionnaire deadline nears

Business Insurance will publish two directories in the Aug. 8 issue, which will contain a spotlight report on the excess and surplus lines insurance markets.

One directory will list underwriting managers, managing general agents and surplus lines brokers. The second directory will list surplus lines insurers and insurers that specialize in writing excess coverages.

To be listed, surplus lines insurers must write at least 50% of gross premiums on a direct, non-admitted basis; excess insurers must be U.S.-based and write at least 50% or $500,000 of gross premiums in excess liability insurance lines.

There is no charge to be included in either directory. However, companies that wish to be listed must fill out and return a questionnaire provided by *Business Insurance*.

Underwriting managers, managing general agents, surplus lines brokers, excess insurers and surplus lines insurers that have not yet received a questionnaire should request one by writing Marilou Jones, Directory Editor, *Business Insurance*, 740 N. Rush St., Chicago, Ill. 60611; or by calling 312-649-5279.

The deadline for returning completed questionnaires is June 27.

Florida department seizes benefit trust

By MICHAEL BRADFORD

TALLAHASSEE, Fla.—A self-insured health care trust sponsored by a Florida business association is in receivership until a state court decides whether the plan can be rehabilitated or should be liquidated.

And, the association is suing the fund's former third-party administrator, alleging that mismanagement triggered the fund's $4 million deficit.

The AIF Health Benefit Fund is being operated by the Florida Insurance Department under a Leon County Circuit Court receivership order issued last month at the request of the department and the trust. The 4-year-old fund provides health care benefits to around 10,000 employees and dependents of 750 companies that are members of Associated Industries of Florida, a broad-based business coalition headquartered in Tallahassee.

The trust has about $500,000 in assets and $4.5 million in liabilities, said an Insurance Department spokesman.

A plan to rehabilitate the trust is being developed by the Insurance Department and the association. The plan will be submitted to the court sometime this month, according to the spokesman.

"The court will decide if it is workable," he pointed out. "If it is, we will proceed to the next step. If it's not, we will have to liquidate."

However, both the department and the association are counting on rehabilitation, said the spokesman.

"We fully intend to revitalize the trust," said AIF President Jon L. Shebel.

Mr. Shebel said the trust continues to provide coverage and pay claims. If the trust is liquidated, the association will find alternate coverage for employees, he said.

"We have been talking to people for several months about going to a fully insured plan," Mr. Shebel explained. If the trust is liquidated, "we will have that available," he noted.

Two lawsuits have been filed against Hill, Richards & Cos. Inc., the former third-party administrator of the trust, Mr. Shebel

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Limit on Lloyd's names' liability urged

By STACY SHAPIRO

LONDON—Several leaders in the Lloyd's of London market are urging Lloyd's to change its historic membership requirement of unlimited liability for losses.

Several underwriting executives, brokers and members say that in light of the recent spate of large syndicate losses caused by U.S. asbestosis and pollution claims, the risk to members of being unlimitedly liable for losses outweighs the rewards.

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 the investment in Lloyd's, the executives contend.

However, some Lloyd's executives, including Lloyd's Chairman Murray Lawrence, say that Lloyd's could not change the market's unlimited liability system without creating other problems including having to run off all existing syndicates. The Lloyd's Council has rejected limited liability in previous examinations, but the council could review it again.

For the last 300 years, each Lloyd's member has been responsible down to his last penny to pay losses once syndicate reserves, deposits and members' special reserve funds have been exhausted. This unlimited liability has been the cornerstone of the security of each Lloyd's policy.

"Currently the whole basis of Lloyd's is out of date," said Lloyd's underwriter Robert Hiscox, who is a strong advocate of limited liability for members.

"I forecast lower membership in the next five years" because unlimited liability is too high a price for members to join.

"We are calling for limited liability," said Anthony Cooper, managing director of Wellington Underwriting Agencies Ltd., one of Lloyd's largest underwriting agencies. "A desirable consequence of that is that we could get rid of the three-year accounting system, close each year of account and not have any open accounts," Mr. Cooper explained.

"Unlimited liability has become an anachronism," he added.

"Unlimited liability is out of step with commercial practice," agreed David Springbett, chairman of Lloyd's broker PWS International Ltd. "It is absurd to talk about unlimited liability. Everything has a limit."

"A number of members when they write to me advocate limited liability," said a spokesman at the Assn. of Lloyd's Members. "There is an increasing number of people who are proponents of limited liability."

"Over the next three years, Lloyd's will think about a number of things to do with Lloyd's membership, and one of those is unlimited liability," said one Lloyd's executive. Lloyd's will have to look at its membership requirements because "resignations of Lloyd's members I'm sure will increase."

"I have little doubt that Lloyd's will look at limited liability in the future (because) the risk/reward ratio has gone totally wrong at Lloyd's. People perceive that the risks outweigh the rewards," the Lloyd's executive said.

However, several Lloyd's executives doubt that the market will change its requirement of unlimited liability for members.

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4 insurance initiatives filed in California reform battle

By GLENN HUNTLEY

LOS ANGELES—Four insurance reform initiatives and a fifth that would limit attorney contingency fees have been filed in California, killing any chance that the groups backing them will unite behind a single, comprehensive reform package.

Two initiative sponsors—The California Trial Lawyers Assn. and the Assn. of California Insurance Cos.—had been negotiating a compromise reform package to present to the state Legislature in the hope that a single bill could be introduced to eliminate the need for the ballot initiatives.

But that effort appeared doomed after talks broke down and the insurer group filed its petition last week.

"There's no turning back at this point," said a spokesman for the insurance industry association. More than 600 insurers are based in California or do business there.

"The tragedy is the insurance industry blew it" by failing to compromise and now facing the wrath of voters, said Will Glennon, legal analyst for the trial lawyers group.

"People are gullible, but I don't think people in California are gullible enough to vote for reform written by the insurance industry itself," he added.

The insurance reform campaigns were triggered by escalating auto insurance rates in the nation's largest private-passenger automobile insurance market (*BI*, Feb. 29). As much as $50 million may be spent promoting the initiatives by the time they appear on the November ballot.

In response to auto insurance rate hikes averaging 18% annually, consumer groups began circulating petitions earlier this year for five ballot initiatives that sought reductions of 20% to 50% in auto insurance rates, and one initiative that would roll back all property/casualty insurance rates in the state to 20% below 1987 levels.

The insurance industry, which attributed the rate

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Photo: Wide World

E&O policy covers sharp tongues

NEW YORK—The emcee Joel Grey portrays in the revival of "Cabaret" doesn't worry about legal repercussions from any of his biting remarks, but the producer of the nationally televised presentation of the Tony Awards is covered for that risk and others.

Don Mischer Production, which produced the 42nd annual Tony Awards presentation televised by CBS Sunday night from New York's Minkoff Theater, was covered for errors and omissions risks under a policy written by Fireman's Fund Insurance Cos. of Novato, Calif.

The E&O policy covered risks such as libel, slander, defamation, invasion of privacy rights, copyright infringement and unauthorized use of titles or characters during the broadcast, a Fireman's Fund spokesman said.

Albert G. Ruben & Co. of Los Angeles, exclusive broker for Fireman's Fund's entertainment division, placed the coverage for the Los Angeles brokerage firm of Gelfin, Newman & Wasserman, Mischer Production's broker.

The awards honor the top plays and performers during the past Broadway season.

Firemen's Fund also insured production of nine of the 18 plays or musicals nominated in the major Tony award categories, including "Cabaret," which was nominated as best revival of a play or musical.

Space launch companies push for federal indemnity

By LAURA MALT and STACY SHAPIRO

WASHINGTON—Commercial space launch companies are urging the Senate to pass a bill that would limit the amount of liability insurance the companies must buy and make the federal government liable for losses that exceed available commercial liability insurance capacity.

The bill, sponsored by Sen. Timothy Wirth, D-Colo., calls for amendments to the Commercial Space Launch Act of 1984 that would require space launch vehicle companies to buy insurance coverage of $500 million for third-party liability risks and $100 million for government property damage, or whatever is reasonably available in the insurance market.

The government would then indemnify the companies for any losses not covered by commercial insurance.

A House bill sponsored by Rep. Bill Nelson, D-Fla., that parallels the Senate bill, was passed by the full House in April (*BI*, May 2).

Commercial space launch companies say they need a promise of indemnification from the federal government to stay in business. Without it, underwriters may not be willing to insure the space launches or would charge such high premiums that the coverage would be unobtainable, they say.

However, the Department of Transportation, which currently has the authority to set liability insurance requirements for launches, strongly opposes the U.S. government offering indemnification to launch service providers for losses above available insurance limits, said Courtney Stadd, director of the DOT's Office of Commercial Space Transportation. "The indemnification is not necessary," Mr. Stadd.

Later this month, the DOT is expected to announce its conclusions on a "systematic hazard analysis,"

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Employers lambaste Section 89 rules

By JERRY GEISEL

WASHINGTON—Congress should consider simplifying the non-discrimination rules for welfare benefit plans, employers say.

Employers describe the rules as a nightmare that will cost them tens of thousands of dollars in added administrative costs with little or no value to employees, according to a survey conducted by the Assn. of Private Pension & Welfare Plans in April and released last month at the APPWP's annual conference.

Those rules, contained in Section 89 of the Internal Revenue Code, require employers to collect a mass of statistical information on the percentage of highly and non-highly compensated employees covered by welfare-type plans, like group health care plans.

This information then must be analyzed to determine if the welfare plans cover or are available to a sufficient percentage of non-highly compensated employees to enable the plans to pass a series of non-discrimination tests (*BI*, April 18).

While one employer said "words fail us" in trying to describe the impact of Section 89—slated to go into effect Jan. 1—other employers had plenty to say about the rules in their often emotion-filled comment letters filed with the APPWP.

"We have no problem with the general concept of non-discrimination requirements on welfare plans. Section 89, however, is an administrative abomination," said a letter from John Hancock Financial Services of Boston.

Section 89 is "a sledgehammer for a flea, and consultants will have a field day proposing $50,000 projects for $500 problems. . . .There just has to be more fruitful territory for the tax guys to mine," said the Providence Journal Co. in Providence, R.I.

"This is a totally needless exercise that is a waste of resources for our company," said Wm. Wrigley Jr. Co. in Chicago.

"Our plans are designed not to discriminate and do not discriminate," said the National Bank of Detroit. "It is senseless to have to invest the time and resources necessary for compliance with Section 89," the bank added.

"Section 89 requirements will result in a significant increase in the cost of doing business without any measurable corresponding increase in equity," said the County of San Diego.

Section 89 non-discrimination tests are a "wasted significant effort with no return value to anyone. All our employees have a free health care plan available for themselves and their dependents—no discrimination," said Eastman Kodak Co. in Rochester, N.Y.

"In addition, they can contribute toward costs of options—no discrimination. There should be some safe harbors for companies like us," Kodak added.

Other employers say it isn't fair to expect companies to comply with Section 89 because the U.S. Treasury Department has yet to issue regulations to assist in compliance.

For example, the Treasury Department has yet to explain how the rules will apply to employers operating different lines of business.

In addition, the Treasury has not published rules explaining how employers should value benefits when applying the non-discrimination tests.

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Congress OKs retiree benefit safeguards

By DEBORAH SHALOWITZ

Washington

WASHINGTON—A bill that would prohibit companies that file for bankruptcy from cutting off health and life insurance benefits to retirees is headed to President Reagan for signature.

Both the House and Senate approved the legislation late last month.

Under the bill, H.R. 2969, companies that have reorganized under bankruptcy laws would be required to continue paying life and health insurance benefits to retirees.

Those benefits could not be modified unless the company could prove to a court that modifications are necessary to prevent liquidation.

Also under the bill, companies emerging from reorganization must continue paying life and health insurance benefits to retirees.

"This bill will prevent companies from using bankruptcy as an excuse to renege on the promises they made to their retirees," said Sen. Howard Metzenbaum, D-Ohio, one of the sponsors of the legislation.

The push for the legislation began in 1986 when Dallas-based LTV Corp. temporarily cut off retirees' life and health insurance benefits. A court shortly thereafter authorized the company to temporarily restore the benefits. Then, Sen. Metzenbaum introduced and Congress approved a stop-gap emergency measure protecting these benefits in the event a company files for bankruptcy (*BI*, Aug. 4, 1986).

LTV retirees are still receiving their benefits.

PCB responsibility

The House Energy and Commerce Committee last month approved a bill that would require any firm storing or disposing of PCBs to show the same proof of financial responsibility as companies treating, storing or disposing of other kinds of hazardous waste.

Those rules require companies that treat or store hazardous waste to have sudden and accidental environmental impairment liability insurance covering all their facilities with limits of at least $1 million per occurrence and $2 million aggregate.

A company that also disposes of hazardous waste must additionally buy non-sudden EIL coverage with limits of at least $3 million per occurrence and $6 million aggregate.

Also, companies that treat, store or dispose of hazardous waste or polychlorinated biphenyls can show other proof of financial responsibility—such as by having a specific net worth or by purchasing bonds.

The bill, H.R. 3070, also would require transporters of PCBs to obtain permits from the U.S. Environmental Protection Agency for their activities.

Currently, owners of PCBs must maintain records on storage of the toxic chemical and disposers of PCBs must maintain records on disposal of the material. However, there is no federal regulation requiring tracking of PCBs from the owners through the PCBs' final disposal. Thus, when PCB material is abandoned or improperly handled, it is often difficult to identify the original owner.

Rep. Mike Synar, D-Okla., who introduced the legislation, pointed out that the bill "is an effort to correct major deficiencies in regulation of PCB disposal."

PCBs are synthetic chemicals that for almost 50 years were used primarily as insulating fluids in electrical transformers. Based on growing scientific evidence linking PCBs to cancer, tumors and reproductive system failures in laboratory animals, Congress in 1976 banned further manufacture of the chemical.

Federal regulations require that large volumes of electrical equipment containing PCBs, such as those used by utilities, be disposed of properly.

Civil servant liability

The House Judiciary Committee late last month approved a bill that would protect government employees from being held personally liable for things that happened while they were on the job.

The bill, H.R. 4612, would make the federal government the defendant in any tort lawsuits brought against a civil servant.

The legislation was introduced earlier this spring by Rep. Barney Frank, D-Mass., after the U.S. Supreme Court ruled on Jan. 13 that civil servants could be held liable for some actions taken during the performance of their official duties.

According to the Supreme Court in *Westfall v. Erwin*, civil employees are liable for duties their jobs require them to perform but not those that are "discretionary in nature." However, the ambiguity of that standard leaves the door open for future lawsuits against government employees.

Prior to the Supreme Court decision, the general rule was that civil servants would not be held liable for actions in the course of their official duties, according to a committee staffer.

Radar detector ban

Five national organizations last month petitioned the Federal Highway Administration to ban radar detectors in commercial vehicles.

Executives of the American Automobile Assn., the American Trucking Assn., the Insurance Institute for Highway Safety, the International Assn. of Chiefs of Police and the National Safety Council asked for the ban to improve truck and bus drivers' compliance with speed limit laws, according to a joint statement from the groups.

Radar detectors commonly are used by drivers of large trucks but they "serve no purpose other than to assist speeders to avoid detection by police," according to the petition.

Radar detectors "are not used, as their advocates claim, to help drivers monitor their speeds," the groups claim.

"A review of how radar detectors operate shows that they are singularly ill-equipped to do anything but act as a lookout to find police radar and warn drivers to reduce their speed before being apprehended," the petition says. ■

MOST CEO'S ARE SUFFERING FROM A SERIOUS HEALTH PROBLEM.

There's an epidemic sweeping the country that is causing considerable pain to upper management.

It's called Rising Employee Health Benefits Costs.

This year alone, many commercial health insurers are slated to hike their premiums. This, after the many record increases of last year.

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School district triples health plan options

By GLENN HUNTLEY

Benefit beat

The nation's 12th-largest school district will merge its numerous health insurance options under a triple-option plan to be offered to employees this fall.

Humana Medical Plan Inc. will become the sole underwriter of indemnity, health maintenance organization and preferred provider plans offered to 12,000 employees and 3,000 retirees of the Hillsborough County School District in Tampa, Fla., beginning Oct. 1.

Also starting in October, Wittner Employee Benefits Group, the St. Petersburg, Fla., consultant that represented Humana in negotiations with the district, will provide administration services for the school district's compliance with the continued health care coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985.

The school district had voted early this year to consolidate its medical plans with a single insurer.

But that decision was accelerated when its indemnity plan insurer, Aetna Life Insurance Co. of Florida, gave notice that it was losing money on the plan and would cancel coverage for about 7,000 employees unless the school district paid the deficit.

The district, which also contracts with four area health maintenance organizations, chose to cancel the Aetna plan and switch its indemnity plan members seven months early to the Humana plan.

Employees enrolled in the HMOs will continue to be covered under those plans until Oct. 1. The HMOs include: CIGNA Healthplan of Florida Inc.; HMO Florida/Healthwin, a division of Lincoln National Corp.; Equicor Health Plan of Florida Inc.; and Physicians Health Plan of Florida Inc.

Humana was able to gear up in time to serve the school district's indemnity plan participants, said John W. Fraser, vp of Wittner.

On short notice, Humana established a special telephone service to answer employees' questions, issued new identification cards and prepared customized benefit materials prior to the April takeover.

In addition, Humana began soliciting physicians to join its preferred provider network and hopes to add at least one additional hospital before Oct. 1, Mr. Fraser said. Currently, the Humana network includes 14 hospitals.

When the triple option plan is fully effective this fall, Hillsborough County School District employees at more than 200 work sites will choose from three options:

- An indemnity plan that requires an annual deductible of $200 per individual or $400 per family.

The plan pays 90% of PPO hospital services, 80% of non-PPO hospital services and 80% of all physician services, up to a maximum out-of-pocket expense of $1,000 per covered person. The lifetime maximum benefit under the plan is $1 million per person.

- An HMO that provides 100% coverage at participating hospitals with no copayments or deductibles.

Physician services are paid in full after a $5 per-visit copayment. The HMO also covers prescription drugs, vision care, home health care and ambulance services with varying copayments.

- A PPO that pays 100% of services at Humana hospitals and 90% of services at other participating hospitals, with no deductibles. Non-participating hospitals' services are paid at 70% after an annual deductible of $100 per individual and $200 per family.

Annual maximum out-of-pocket expenses are $500 per person for expenses charged by participating providers and $1,500 per person for charges by non-participating providers.

The options are intended to encourage school district employees to select the managed care plans over the indemnity plan, which has covered most of its employees in the past, Mr. Fraser said.

Early response indicates that 65% of the district's employees are opting for the PPO with the balance split between the HMO and indemnity options.

Under the triple-option plan, the district will pay a $98.82 monthly premium for each single employee, while subsidizing premiums for employees with dependent coverage.

The district's 12-month employees with one dependent will pay $98.82 per month, while those with two or more dependents will pay $138.36 per month.

Enrollment in the triple-option plan is open until September when most of the district's employees return to work.

Employer coalition

The Chicago-based Midwest Business Group on Health will grow as a result of its merger with Nebraska's Omaha Cost Containment Coalition.

The Omaha group, which includes 17 employers and 10 health care providers, was established in 1980 to provide education for its members, according to its director, James Mortimer.

However, the local group has found it can more efficiently provide services through the larger regional coalition, he said.

"I think we can efficiently staff a local group from here (Chicago), compared to the costs of hiring a director and doing it all locally," Mr. Mortimer said.

The Midwest Business Group on Health will provide staff support for local meetings and projects in Omaha as well as provide access to health program managers outside their area.

The merger was effective April 1, but employers will have the option of joining the Midwest group as their current memberships with the Omaha group expire, he said.

However, health care providers will not be able to join the regional group.

The Midwest Business Group on Health currently has 145 employer members in nine states.

●

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Opinions

Changing times

TRADITIONS, CUSTOMS and standards should be subject to constant challenges to determine whether they are still valid or should be changed.

"We've always done it that way" is a lousy excuse for continuing any practice or mode of operation. Challenges to the status quo are not threatening because if the tradition, custom or standard is valid, it will stand up to the challenge.

That is why the talk in London about changing from unlimited liability for Lloyd's of London names to limited liability is appropriate (see story, page 3). Just because Lloyd's has operated for 300 years under a system of unlimited liability is no reason not to now examine whether that system should be maintained into the 21st century.

It is clear why the issue is being raised: Huge losses at several syndicates may cost the syndicate members a great deal of money.

The concept of unlimited liability is fine when profits roll in. But when names are called on to pay losses beyond the money they have initially invested, it is no wonder people are questioning whether unlimited liability is such a good idea.

There are a whole host of logistical problems that would have to be solved for Lloyd's to change from an unlimited liability system and a slew of new rules would have to be written. No doubt, it could be accomplished.

But, there is another issue to consider: Adopting a limited liability system at Lloyd's could result in less cautious underwriting, ultimately reducing the profits to be made at Lloyd's and creating exactly the opposite effect from what those advocating limited liability say they want.

Those advocating limited liability say it will be necessary to attract investors at Lloyd's.

Lloyd's underwriters historically have charged more for the insurance they provide partly because they are committing their names to unlimited liability. And policyholders have been willing to pay the higher price for the absolute security that all their losses will be paid no matter how many losses Lloyd's names suffer.

This has proved for 300 years to work. Many people have made a lot of money as names at Lloyd's, and the marketplace has grown dramatically. And, the continued growth has allowed Lloyd's underwriters to offer the world's business enterprises capacity for risks that otherwise would go uninsured.

Under a limited liability system, Lloyd's underwriters would no longer have a good reason for charging a higher premium for their capacity because the absolute security would be lost. Therefore, profits would be reduced.

In addition, just knowing that putting one's stamp on a policy no longer risks the personal wealth of every name behind that stamp will certainly change an underwriter's attitude in accepting a risk. Lloyd's underwriters already are known for a big risk appetite. How much larger would their risk appetite grow if they knew their names' liability would be limited to their investment?

Lloyd's underwriters have responded to the changing legal climate and have sought to limit their names' liability by restricting the terms of the coverage they underwrite. This may work.

Nonetheless, whether Lloyd's should retain its system of unlimited liability surely is an issue worth seriously exploring.

Letters

Prudential decision won't set precedent

To the editor: The May 23 Perspective article discussing *Central National Insurance Co. of Omaha vs. Prudential Reinsurance Co.* focused on the decision from the California Court of Appeal regarding, among other issues, a reinsurer's liability for bad-faith and for late-reported claims.

The decision, although noteworthy, is probably more of academic interest since the California Supreme Court on May 5 ordered the decision de-published. As such, it lacks precedential value.

Jonathan F. Bank
Buchalter, Nemer Fields & Younger
Los Angeles

Don't misinterpret San Francisco study

To the editor: As one of the participants in a recent London conference sponsored by the Insurance & Reinsurance Research Group Ltd., I commend *Business Insurance* on the excellent coverage given to the various presentations (*BI*, May 9).

However, I would like to correct any misimpressions your readers may have gotten from the summary of my comments about the current study by EQE Engineering on the possible vulnerability of San Francisco fire houses to a major earthquake.

Based on our quick walk-through at the start of the project, EQE believes that the floor loading capacity of some of the older fire stations will need evaluating as part of the structural analysis being conducted.

However, we will not know the extent of any retrofitting required until our study is completed.

The San Francisco fire house project is representative of the many projects EQE is involved in that are aimed at helping major corporations and real estate investors manage their earthquake risks. As I indicated in my comments, the extensive preparedness measures taking place in the public and private sectors should help avoid a major financial disaster in the insurance industry when a great earthquake strikes.

I urged the reinsurers at the conference to gain a better understanding of the risk and reflect that understanding in reduced rates for the companies that are taking steps to minimize their losses from an earthquake.

Earl J. Aurelius
Vp
EQE Engineering
San Francisco

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Clarifying HMO rules on community rating

To the editor: Two individuals quoted in the article "Benefit Managers Scrutinize HMOs" (*BI*, April 25)—Neil Austin, staff manager-health care cost containment of Pacific Telesis Group, and David W. Brown, a consultant with A. Foster Higgins HealthGroup—both state that an employer is only required to pay a community rate to a federally qualified health maintenance organization when it has been "mandated" by the HMO (i.e, the HMO has officially requested inclusion in the employer's health benefits plan in accordance with federal regulations).

Mr. Brown's statement that "In a nonmandated situation, the federal regulations permit an employer to negotiate whatever rate is mutually acceptable" is simply wrong.

Federally qualified HMOs are currently required by statute and regulation to charge a community rate to all group purchasers for its benefit packages. The whole purpose of the legislation introduced by Rep. Henry Waxman, D-Calif. —H.R. 3235, which is also discussed in the article—is to give federally qualified HMOs some flexibility from the community rating requirement and allow a modified form of experience rating for their products. Until such time as that bill passes, federally qualified HMOs must continue to community rate their products.

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

■ *Editor's note: The federal HMO Act of 1973 does not prohibit employers and federally qualified HMOs from negotiating a mutually acceptable rate other than a community-based rate, regardless of whether the employer has been mandated to offer the HMO, according to a spokesman at the U.S. Department of Health and Human Services' Office of Prepaid Health Care, which oversees federally qualified HMOs.*

Furthermore, employers that offer federally qualified HMOs—but have not been mandated to offer the HMO—are not required by the federal HMO Act to contribute toward the HMO premium an amount equal to what they contribute toward indemnity plan premiums, the spokesman said.

H.R. 3235, the amendment to the HMO Act proposed by Rep. Henry Waxman, would clearly enable employers and federally qualified HMOs to negotiate premiums based on the health care cost experience of the employer's group.

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Retiree health care costs staggering: Panel

By STACY ADLER

CHICAGO—Mounting unfunded retiree health care obligations represent a ticking time bomb for employers, experts say.

"It is estimated that employers have $85 billion" in unfunded health care liabilities for current retirees, said Thomas P. Flanagan, a managing partner in Touche Ross & Co. in Chicago.

Mr. Flanagan made the remarks at the fourth annual Harold H. Hines Jr. Memorial Symposium last month. The symposium, "Unrecognized Liabilities and the Corporate Financial Statement: The Ticking Time Bomb," was cosponsored by the Chicago Chapter of the Risk & Insurance Management Society and The Insurance School of Chicago.

"Increased retiree benefits and early retirees spell tremendous liabilities and ones that were never thought of," Mr. Flanagan warned.

It is estimated that by 1996, employers will be providing health care benefits for one retiree for every two workers on their payroll, he noted.

In a move to require employers to bring unrecorded retiree health care benefits to the corporate balance sheet, the Financial Accounting Standards Board later this year is expected to propose new rules for how employers should account for these obligations in their balance sheets.

Specifically, the proposed FASB rules could require that the costs of retiree health care liabilities be accrued as an annual expense against corporate earnings over the working lives of covered employees (*BI,* Nov. 23, 1987).

"The financial impact of this is staggering," said Mr. Flanagan. "In the case of our older, more mature companies, the focus on the balance sheet is probably going to result in a very large negative net worth impact."

In fact, Mr. Flanagan said it is possible that the proposed accounting rules could effectively wipe out the net worth of a company—for accounting purposes—"even a company with billions of dollars in positive net worth."

However, recognizing these liabilities on the corporate balance sheet can help employers better run their businesses, according to Maureen M. Culhane, vp-pension and insurance in the Chicago office of Goldman Sachs & Co.

For example, Ms. Culhane pointed out that LTV Corp., which filed for reorganization under Chapter 11 of the U.S. Bankruptcy Code in 1986, reported it had devoted 7% of the sales of its steel segment to retiree health care costs and pension liabilities.

Although this was "very high," the accrued liability actually was much higher, Ms. Culhane said.

If LTV had included retiree health care costs and pension liabilities in the total cost of their steel products, the company may have sought to reduce retiree benefits before being forced into bankruptcy, she said.

Many businesses do not include retiree medical costs and pension liabilities when determining the cost of their product or when making other business decisions, Ms. Culhane said.

However, "it is very important to understand and accrue the costs of your retiree obligations into your current product price," she stressed.

Robert A. Pritzker, president and chief executive officer of The Marmon Group Inc. in Chicago, agreed. An avid fan of the defined contribution approach to employee benefits, Mr. Pritzker said "it is crazy to promise now to pay some unknown amount in the future."

He said all but two of the company's pension plans are defined contribution plans and that those two defined benefit plans soon would be changed.

In general, however, Mr. Pritzker criticized FASB rules because they attempt to make all companies report their finances in the same manner.

"It is hard to imagine an auditing firm and a foundry can have the same financial statement," he said.

In addition to retiree health care benefits, employers face several other "ticking time bombs," the speakers said.

Potential product and environmental impairment liabilities represent huge unrecognized costs for companies, they said.

'It is crazy to promise now to pay some unknown amount in the future,' says Mr. Pritzker.

The problem plaguing companies is "How does a corporation include (on its balance sheet) costs it cannot foresee?" explained Mr. Flanagan of Touche Ross.

He noted that a $100 million cleanup order from the Environmental Protection Agency can "bankrupt many small companies."

Similarly, Mr. Pritzker said product liability-related costs consume 30% of the expenses for one of his company's products. He declined to specify the product line.

Tobacco companies also are being hurt by the numerous product liability lawsuits working their way through the courts, even if the companies win in court.

For example, Philip Morris Cos. Inc. stock historically traded at a price-to-earnings ratio of between 87% and 115% of the market average, said Ms. Culhane of Goldman Sachs. But, as of May 23, Philip Morris' price-to-earnings ratio was 8-to-1, which was about 70% of the market average on that day, she said.

Ms. Culhane said this drop is due, in part, to the market's reaction to product liability suits pending against the company.

The merger market also looks at a company's non-balance sheet liabilities, Ms. Culhane said, explaining that a potential acquisition could be thwarted due to large unrecorded liabilities.

"There is a clear trend toward greater disclosure of these liabilities," she said.

Edwin S. Overman, president emeritus of the Insurance Institute of America and the American Institute for Property & Liability Underwriters in Malvern, Pa., moderated the discussion.

The Harold H. Hines Jr. Memorial Symposium is presented annually in memory of Mr. Hines, who was considered a scholar of the insurance industry and risk management. He was president and chief executive officer of broker Rollins Burdick Hunter Co. when he died in June 1984. ■

Jackson commends physician mutuals

By DONNA DiBLASE

SAN DIEGO—Physician-owned insurers should not rest on their laurels despite their success in making medical malpractice coverage available and affordable for medical professionals, says a leading London reinsurance underwriter.

"I see a tendency among some physician-owned insurance companies to think they have solved these problems. However, you must remember that we do operate in an industry that is subject to cycles and trends that are beyond our control," said Robin A.G. Jackson, a director of Merrett Holdings P.L.C. and underwriter for syndicate 799, Lloyd's of London's largest non-marine syndicate.

"Don't forget how you came into existence," he told insurers attending the annual meeting of the Physician Insurers Assn. of America May 26-28 in San Diego.

'I see a tendency among some physician-owned insurance companies to think they have solved these problems,' says Robin A.G. Jackson of Merrett Holdings P.L.C. 'Don't forget how you came into existence.'

Mr. Jackson was referring to the tight insurance markets in the 1970s and 1980s, when rates for professional liability insurance for medical professionals skyrocketed, while capacity all but disappeared. These problems forced the development of a new wave of physician-owned insurers that write malpractice coverage for health care professionals.

"Doctors were facing rapidly increasing premiums and physician insurers were able to provide doctors with consistently priced insurance products. I felt from the very beginning that if anyone was in a position to do this, that the chances were best for a company run by and for physicians," Mr. Jackson continued.

"You were in a better position to relate to your policyholders. These policyholders were much more likely to listen to your advice as physicians when it came to areas like risk management to avoid malpractice," he observed.

As a result, significant improvements were made by the medical community to limit actual malpractice, he said.

Along with urging physicians and hospitals to follow risk management principals, physician-owned insurers have helped to stabilize the medical malpractice insurance market through adequate pricing, he said.

"Another important accomplishment is the relative stability of your premiums during 1985 to 1987, when the premiums in the rest of the industry weren't very stable. On the whole, we in the London reinsurance community had a lot to do with that stability as well," he added.

As a major underwriter of reinsurance for medical malpractice insurers, Mr. Jackson said he has worked closely with PIAA members for more than 10 years.

In fact, some 90% of medical malpractice reinsurance is placed in the London market, according to PIAA President Douglass M. Phillips, who also is chief executive officer of Medical Mutual Insurance Co. of North Carolina. "The London market has always been there for us and has always had the capacity," he said.

"U.S. reinsurers don't write medical malpractice reinsurance because, of all of their lines of business, medical malpractice is the most unpredictable for them," Mr. Phillips added.

The London market will continue to be a major market for medical professional liability reinsurance, Mr. Jackson said.

"Three years ago, people in London were wondering if we had too much medical malpractice. There is not the same level of concern today because there is more predictability" since the doctor-owned medical malpractice insurers now have several years of claims experience, Mr. Jackson explained.

And, it is not likely that the competition in many lines of insurance and reinsurance will spread to medical malpractice, Mr. Jackson predicted.

"We have to look at the potential softening today and compare it to the last soft market in 1979. At that time, there was a very significant increase in capital in the industry and interest rates were much higher than today. Then, insurers were earning significant investment income," he said.

"This cycle could be very different in that we haven't had that significant increase in capital in the industry and because interest rates are lower," he added.

However, physician-owned insurers must take care not to sharply increase rates in the future, Mr. Jackson said.

"I am concerned that malpractice premiums are now increasing at a greater rate than general inflation," he said, adding that "we will again arrive at an affordability rather than an availability problem."

The insurers also would be wise to avoid expanding their operations too quickly, he said.

"I believe you have reason to be cautious when expanding operations or lines of coverage. The most successful companies in the industry are those that specialize and not those that generalize. That's why you were created in the first place: to respond to the failures of the general insurance companies," he explained.

Physician-owned insurers also would be most successful in providing stable coverage to medical professionals by limiting the number of states in which they write coverage, Mr. Jackson said. Direct communication between the insurer and the local medical community is necessary for successful underwriting.

"A lot of you are going to face some very tough decisions in the coming years, so it would be naive to believe there are no challenges in the future," he told the insurers.

For example, along with tort reform, physicians and their insurers will have to face such issues as malpractice claims related to treatment for acquired immune deficiency syndrome, Mr. Jackson said. ■

ARM architect, scholar Robert Mehr dead at 70

By BRIGITTE MAXEY

CHAMPAIGN, Ill.—Robert I. Mehr, a professor emeritus of finance and one of the founders of the Associate in Risk Management designation, died last month at the age of 70.

While serving as a professor at the University of Illinois in Urbana-Champaign, Mr. Mehr's well-known text, "Principles of Insurance," first was published in 1952.

He received many awards for his books, monographs, articles and papers in economics, finance, risk management and insurance. Among his honors were two Elizur Wright awards—named for one of the first state insurance commissioners—which recognize outstanding and original contributions to insurance literature. The Wright awards recognized Mr. Mehr's co-authored text, "Modern Life Insurance," in 1956, and his co-authored text, "Risk Management in the Modern Business Enterprise," in 1964.

In 1966, Mr. Mehr helped create the educational program for risk managers that offered credentials similar to the Chartered Life Underwriter and the Chartered Property Casualty Underwriter designations. The ARM designation "provides a professional designation to risk managers," said Edwin S. Overman, president emeritus of the Insurance Institute of America.

Mr. Overman credited Mr. Mehr with promoting the idea that "risk management was a science unto itself." This was reflected in Mr. Mehr's "Risk Management in the Modern Business Enterprise," considered the first book of risk management instruction, Mr. Overman said.

Robert I. Mehr taught at the University of Illinois from 1947-1977.

Mr. Mehr was described as a "seminal thinker," by T. Emerson Cammack, associate dean for undergraduate affairs at the University of Illinois.

"An example of his great ideas would be his founding the Pacific Insurance Conference," Mr. Cammack said.

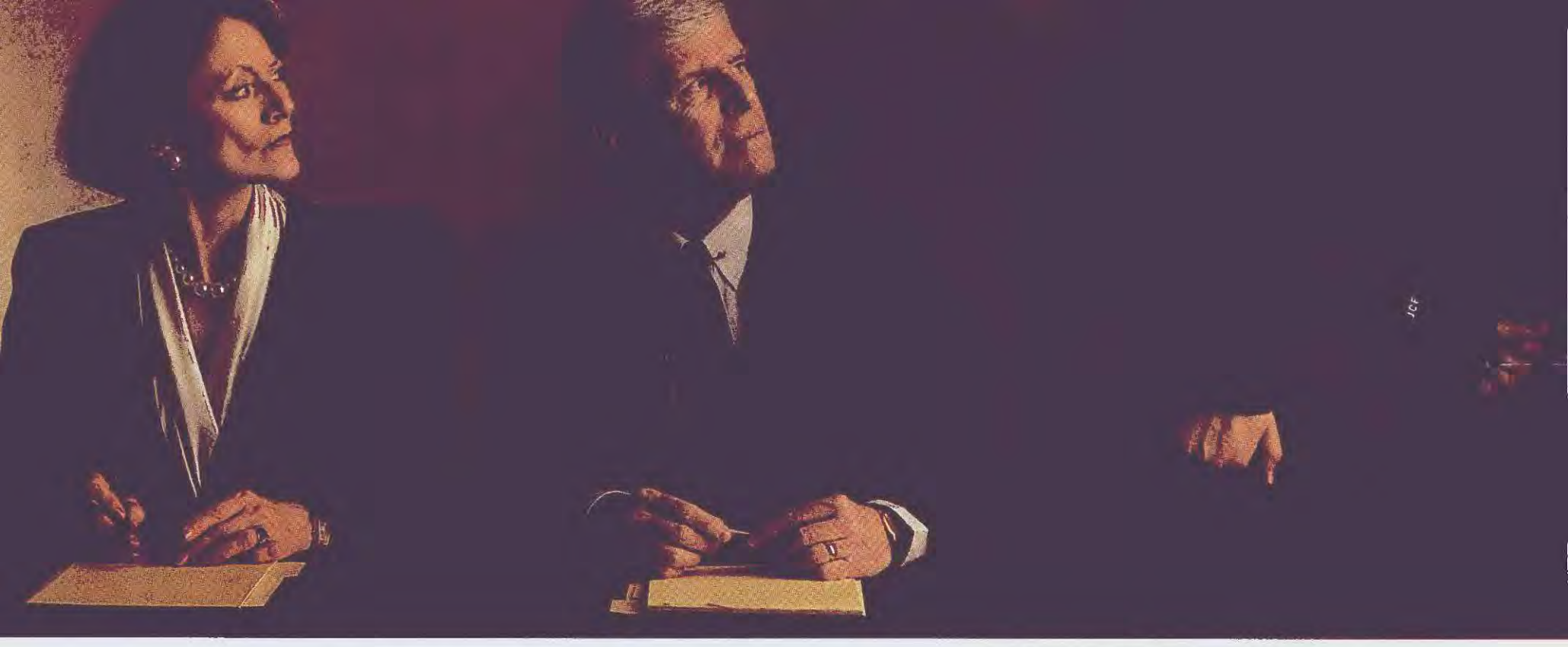
Insurance professionals representing countries surrounding the Pacific Ocean have met annually since 1963—at worldwide locations—to exchange ideas about the insurance industry.

In 1970, Indiana University commissioned Mr. Mehr to conduct a long-range study of the implications of inflation and growth on the future of the insurance industry in the United States.

Mr. Mehr, who taught at the University of Illinois from 1947 to 1977, also was a visiting professor at institutions including Nankai University in China; Bernard M. Baruch College in New York City; the University of Connecticut at Storrs; and at the Graduate School of Caracas in Caracas, Venezuela.

Mr. Mehr was an expert witness in insurance litigation and a consultant.

Mr. Mehr also served as president of the American Risk & Insurance Assn., formerly the American Assn. of University Teachers of Insurance, in 1968; his presidency of the American Society for Insurance Research in 1956; and, his editorship of the Journal of Risk and Insurance from 1974 to 1980. ■



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Bahamas captive conference

Buyers shape insurance products: Lichota

By MICHAEL BRADFORD

NASSAU, Bahamas—The commercial insurance industry may be heading into a "user-driven" cycle as buyers increasingly demand development of insurance products that truly meet their needs and create their own risk-financing facilities, a bank risk manager asserts.

Policyholders are changing the way commercial insurance is bought and sold because they are becoming more particular about the insurance products they purchase, says Edith F. Lichota, senior vp in charge of risk management at Irving Trust Co. in New York.

"I think we've gotten to the point where users demand a product which is, in fact, a product designed for their use," Ms. Lichota told about 40 attendees at last month's captive insurance conference sponsored by the Bahamas Assn. for International Insurance.

Such demand is evidenced by the development of specialty coverage facilities to insure particular risks such as environmental liability, trucking, railroad and other risks, she said.

And, insurance buyers "are now saying: 'We want stability and predictability and we can't get it from the commercial market so we're going out to try and create it for ourselves.' "

However, a "user-driven" marketplace does not mean one in which insurance buyers are taking over the industry, Ms. Lichota explained.

"By user-driven, I don't mean that users won't call on management companies or brokers for assistance," she said. "Most of us who are risk managers, no matter how good we think we are, also have to admit in our weaker moments that we are not in the market often enough or regularly enough to be really plugged into what is going on in the commercial marketplace."

"We will always need support and services of various kinds," Ms. Lichota said.

The severity of past insurance cycles made insurance buyers more demanding, she said.

Risk managers can't live "with the extreme swings that a severely cyclical market keeps visiting on us," she said. "There are risk managers who lost their jobs when the last hard market hit."

When the market changed, the credibility of some risk managers was undermined because they were unable to warn management of the drastic price increases on the horizon, she said.

"One of the other things that came out of that last hard cycle was an extreme distrust on the part of buyers of the commercial marketplace in general," Ms. Lichota added.

As insurance buyers develop specialty and alternative markets, they should work on relationships with commercial markets, Ms. Lichota advised.

"It's my opinion that one of the new attitudes that we should be developing—and I see it in some places actually developing—is the attitude that there has to be a partnership relationship between the mechanisms developed by the users and the commercial market," she said.

In fact, alternative and specialty insurance facilities could become a valuable source of information to traditional commercial insurers, Ms. Lichota noted, leading to development of insurance products that better fit the buyers' needs and help stabilize the marketplace.

"I do believe as the new vehicles develop and they start to develop a good interface with the commercial market, that they can provide a source of information. . .that the commercial market has never had," she said.

"The more the commercial carriers interface with the user-developed facilities, the more the user facilities themselves will become

Continued on next page

Island nation wants to attract more captives

By MICHAEL BRADFORD

NASSAU, Bahamas—The Bahamian government has its eyes set on a more diversified economy, and that goal includes attracting more captive insurance companies to the islands, says an official of the Caribbean nation.

Besides tourism, "banking and financial services contribute significantly to the Bahamian economy," said Clement T. Maynard, deputy prime minister of the Bahamas, who spoke at a conference sponsored last month by The Bahamas Assn. for International Insurance.

While "tourism is the nation's No. 1 industry," the Bahamas would rather not be so heavily dependent on one industry, he said. The Bahamas would like to attract more captive insurers, as well as increase foreign and local investment in agriculture, fisheries, banking and financial services, manufacturing, shipping and other areas, he said.

The deputy prime minister pointed out that the External Insurance Act of 1983 was enacted to provide broad benefits for captive insurers. Those benefits, which are currently used by about 30 captives, include:

- Exemption from a 1% premium tax levied against local companies.
- No restrictions on investment of premiums.
- Complete confidentiality regarding insurance activities in the Bahamas.
- Exemption from corporate, income, sales and profit taxes.

The Bahamas has proven itself as a choice domicile for captives because other offshore businesses like banking and ship registration have flourished, he said.

The Bahamas offers "efficient support services" to captives, including banking, management, accounting and auditing firms, Mr. Maynard said. "We have a trained work force for captive insurance companies," he added.

And the Caribbean nation's "track record shows that our political philosophy is in harmony with that of the modern Western democracies," he said. ■

Continued from previous page
the research base for the commercial market," Ms. Lichota said. "And the two will both be much stronger for the exchange."

Ms. Lichota said the development of alternative facilities can spur the commercial market to jump back into a coverage area it had abandoned.

As an example, she cited Bankers Insurance Co. Ltd., the Bermuda-based captive that she helped develop to write bankers blanket bond and directors and officers liability insurance for large commercial banks (*BI*, March 30, 1987).

"We put it there because there was no capacity," Ms. Lichota said of the Bermuda captive. "I had $25 million in D&O coverage. At the renewal date, one carrier had withdrawn from the market," and another was asking for a $10 million letter of credit for the amount of coverage the bank would retain, she said.

"That is the entire market. Six months later, we put BICL up. And within 10 days, there was a market back for commercial D&O for big banks."

Ms. Lichota said that while other factors may have prompted insurers to jump back into the D&O market, it was clear BICL provided some impetus.

"It was less than two weeks that there were commercial underwriters back in the market because they looked at this facility and said, 'My God, if the banks put enough money in there to take care of themselves, they're going to realize they don't need us and we have to make sure that doesn't happen.' "

Ms. Lichota said, "I do not suggest that that kind of ultimate threat is in anybody's best interest, but I think everybody should realize that there is a balance of interests in this whole area of responding to coverage needs and that the opportunities are endless in order to answer them." ■

Reinsurer may factor in domicile choice

By MICHAEL BRADFORD

NASSAU, Bahamas—A company forming a captive insurer should weigh the interests its potential reinsurers have in various captive domiciles, advises a vp of a major reinsurer.

"Reinsurers really prefer a controlled regulatory environment with a very stable political and banking climate" for the captives they reinsure, said Hank Anderson, vp at National Reinsurance Corp. of Stamford, Conn.

However, captive owners may prefer an environment "with not as much oversight. There's a balance there that has to be struck," said Mr. Anderson at a conference sponsored by the Bahamas Assn. for International Insurance last month in Nassau.

"It's imperative that you bring the confidence level of the reinsurer up to a certain point. You don't get that in certain domiciles," he said.

Mr. Anderson called the Bahamas "a marvelous domicile. Reinsurers love the Bahamas."

Because conditions in the commercial insurance industry led to the development of more alternative insurance facilities, reinsurers are increasingly dependent on alternative mechanisms like captives for increased profitability, Mr. Anderson said.

Reinsurers' written premiums are shrinking. "Most of all, it's the loss of that business to the non-traditional markets," he said.

Reinsurers' written premiums also are suffering because ceding companies are keeping larger retentions, and "obviously market cycles have something to do with it," he said.

Captives, self-insurance and other alternative risk financing mechanisms will grow 51%, from $47 billion in premiums in 1987 to around $72 billion in 1990, according to statistics from Conning & Co., he said.

Meanwhile, commercial lines insurance premiums will reach $215 billion by 1990, up about 34% from about $160 billion in 1987.

Reinsurers "have to look—we must look—to alternative risk mechanisms to continue" to grow, Mr. Anderson said.

There is currently around $50 million to $60 million in reinsurance capacity available to captives from around a dozen reinsurers, according to figures Mr. Anderson quoted from the Reinsurance Assn. of America.

"Each market, however, has its own niche by lines of coverage and attachment points that reduce this amount to probably about $25 million," he said. Still, that amount is "usually more than enough capacity for most captives," he said.

He also warned that there still are coverage availability problems for captives looking to cede tougher risks, such as errors and omissions liability, directors and officers liability, medical malpractice and lawyers professional liability.

"Professional lines have tended to be written by very few markets, and the underwriting and claims talent that goes with that is spread very thin," Mr. Anderson said.

And, reinsurance company managements do not like the idea of putting aside capital to write such risky business, he said.

Also, not many reinsurers are interested in writing stop-loss covers, Mr. Anderson said. "Very, very few markets are willing to entertain this line any more because of the incredibly poor underwriting results over the past few years," he said. ■

Conferees bullish on captive climate

NASSAU, Bahamas—Speakers at a two-day captive conference and workshop sponsored last month by the Bahamas Assn. for International Insurance were bullish on the captive industry.

Conference moderator Bernard Brown, a principal with Risk Strategies Inc. in Darien, Conn., said offshore captives continue to flourish despite tax law changes and expansion of the Risk Retention Act.

"The offshore market has continued to show quite a bit of strength," said Mr. Brown. "I think that's a testimony to the favorable attitudes that most offshore domiciles have toward captive insurers and their development and the ease with which alternative risk financing mechanisms can be formed offshore as opposed to some of the onshore domiciles."

The Bahamas is trying to recapture some of the prestige it once held as a center for captive activity. The Bahamas was home to about 200 captives until the 1970s, when confusing legislation drove those companies to other locations.

In a luncheon speech, Bahamas Deputy Prime Minister Clement T. Maynard said he hoped the meeting would allow officials and regulators to learn how to improve the domicile and attract captives.

About 40 attendees gathered for the half-day workshop on May 11 and the day-and-a-half of sessions that started May 12, held at the Royal Bahamian Hotel in Nassau.

Information on Bahamas captives is available from the Insurance Department, Ministry of Finance, Rawson Square, Nassau, N.P., Bahamas, 809-322-1060.

U.S. domiciles make changes to spur growth

By MICHAEL BRADFORD

NASSAU, Bahamas—Captive insurance companies will grow both in the United States and offshore, predicts a captive expert.

"In the United States, business is booming," said Alan Page, senior vp at broker Johnson & Higgins in New York.

"But I would say business is booming as part of a worldwide trend" of increased captive activity in all domiciles, Mr. Page continued at a captive conference held by the Bahamas Assn. for International Insurance in Nassau last month.

Vermont is on a roll as a captive domicile and is keeping a lot of companies from leaving U.S. shores, he said.

Regulatory officials in Vermont are pro-captive, and capitalization requirements are liberal, he pointed out. Earlier this year, Vermont had 124 captives, compared with about 30 captives in the Bahamas (*BI*, April 18).

Other states also are positioned for captive growth, according to Mr. Page.

"Colorado seems to be poised for a comeback," he noted. But, he added that Colorado is having trouble regaining some of the momentum it lost in the late 1970s and early 1980s when captives found the state's regulatory environment too harsh.

Mr. Page

In 1987, amendments to the Colorado Captive Insurance Company Act of 1972 eliminated some restrictions on captives and liberalized capitalization requirements for single-parent insurers. Colorado currently boasts 26 captives.

Delaware also has amended its captive law, which was adopted in 1984. Previously it required owners of captives to have their principal place of business in the state. "That hurt the law," Mr. Page said.

Legislation signed into law April 8 deleted that provision and allows captives incorporated in other jurisdictions, including offshore, to operate in Delaware as Delaware-chartered captives (*BI*, May 16; April 18).

However, Mr. Page said the Delaware group is not as enthusiastic, from the governor on down, about supporting captives as in "a go-go state like Vermont."

The United States also offers its own island domicile that could entice captives to head west instead of east to established domiciles, said Mr. Page.

"Hawaii is a place that I think is going to succeed very nicely," he said. "Hawaii is close to California, and Californians have been complaining bitterly about flying to Bermuda for years now," he pointed out. "We're seeing a lot of activity out there."

Hawaii has so far licensed two captives: Surety Pacific Insurance Co. Inc., which writes workers compensation, general liability, automobile liability and physical damage insurance for its parent, O'Brien Corp. of San Francisco; and Royal Hawaiian Insurance Co., owned by Duty Free Shoppers Limited Partnership of Honolulu and San Francisco, which writes surety bonds to cover its parent's obligations with the state for a concession at Honolulu International Airport.

Although Illinois is seen as a "tough regulation state," there is potential there for growth as a captive domicile, Mr. Page pointed out.

"Their captive law, I think, is really designed for big folks," he added, noting that captive insurers are required to form with $2 million in capital and surplus.

Illinois has licensed only one captive so far, but "there seems to be quite a few in the pipeline," Mr. Page said.

Tennessee and Virginia do not appear to be big threats to take captive business from offshore domiciles, according to Mr. Page. Tennessee has licensed 11 captives but is not aggressively seeking the companies, and Virginia has not licensed any captives, he said.

It takes total support from the government and regulators to make a domicile successful, Mr. Page pointed out. ■

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Aftershock

Varying earthquake indemnity rates vexing for multinationals

By Jerome Karter

International issues

UNLIKE SOME HIGH-RISK flyers, international insurers do not like to feel the earth tremble beneath their feet. But, while their cautiousness is essential, their earthquake shock sublimits are vexing U.S. multinationals with subsidiaries in Japan.

It is no secret that international insurers indemnify only 60% of the earthquake shock and fire following exposure for all property situated in the prefectures of Tokyo, Chiba-Ken and Kanagawa-Ken (Zone 5, as established by the Foreign Non-Life Insurance Assn.).

In addition, international insurers usually sublimit the earthquake shock peril outside of Zone 5 in combination with locally issued and non-admitted policies.

The reasoning behind these underwriting restrictions is well-grounded:

- First, Japan is located in the Circum-Pacific seismic zone, the belt in which 80% of the world's earthquakes occur. In contrast, the Alpide seismic zone, which extends from Java through the Himilayas and the Mediterranean, accounts for only 17% of the world's seismic activity.
- Second, since it is surrounded by water, Japan also is exposed to aftershock loss from the perils of soil liquification and tsunamis, perils similar to those occurring in other low-lying coastal areas of the world.

Direct damage resulting from soil liquification can be extensive. For example, the vibrations from the June 1964 earthquake centered near Niigata compacted the city's soil, causing the groundwater to flow upward and to reduce the soil to quicksand. Large sections of the city were destroyed in the process.

Tsunamis—giant waves that are caused by seismic disturbances on the sea floor—can travel at speeds of up to 500 m.p.h. Although the height of the wave crest is low at sea level, the immense energy of tsunamis converts into waves as high as 50 feet when they lose speed in shallow coastal waters. As the tsunami approaches the shore, the sea withdraws, then rushes back in a series of gigantic waves that often travel far inland, destroying property in their wake.

Underwriters refer to the direct damage that results from these perils—as well as to losses resulting from the collapse of houses, factories, river banks, destruction of roads, cracks in the ground and landslides—as a "primary disaster."

A "secondary disaster" refers to any resulting indirect damage, such as fire or water damage. Commonly, the spread of fire accelerates the calamity of an earthquake.

A third category, "tertiary disaster," refers to panic; that is, the confusion caused by terror-stricken people or by the spread of false rumors. Tertiary disasters are generally aided by reports of the magnitude and intensity of earthquakes.

Magnitude—the amount of energy released by an earthquake—is measured in whole numbers and decimals between 1 and 9 on the logarithmic Richter scale. Each whole number represents a magnitude of energy approximately 31.5 times greater than the next lower number.

Intensity, on the other hand, measures the effects of shaking of the earth's surface at a given point. Although the Modified Mercalli scale is most commonly used in the United States, Japan relies on the Japan Meteorological Agency's scale to express seismic intensity. While the Mercalli scale is denoted with Roman numerals from I to XII, the Japan Meteorological Agency's scale uses a range of 0 to VII.

The Tokyo Metropolitan Government annually spends 200 billion yen ($1.6 billion) on measures designed to protect people and property from earthquake disaster. In a similar vein, U.S. multinationals should have an effective disaster plan for protection against earthquake loss in Japan. A twofold plan should include insurance to protect property and a safety plan to protect employees.

Let's look first at insurance.

The concept of insuring assets in Japan against earthquake shock and fire following the shock did not gain prominence until the end of World War II. Even today, U.S. multinationals and foreign participants in joint ventures are more apt to buy earthquake insurance than are Japanese firms. The difference in buying habits corresponds directly to a difference in underwriting approaches.

To begin, Japanese property insurers, unlike their U.S. and British counterparts, underwrite as one peril the exposure of both direct and indirect damages that are caused by primary and secondary disasters.

More important, Japanese underwriters had trouble obtaining sufficient earthquake reinsurance capacity to insure large multinational investments in Japan. The solution was found in a gentlemen's agreement: Japanese insurers agreed to insure indigenous risks for 30% earthquake indemnity within Zone 5 and 60% elsewhere in Japan, while foreign insurers agreed to insure U.S. multinational business—as well as their joint venture clients—for 100% earthquake indemnity throughout Japan.

But, as values at risk grew during the booming mid-70s, Japanese insurers cut in half their former indemnity levels: to 15% from 30% for insurance within Zone 5 and to 30% from 60% for insurance elsewhere in Japan. At the same time, foreign insurers collectively agreed to limit earthquake indemnity to 60% for U.S. multinationals operating in Zone 5, although they continued to insure at 100% levels elsewhere in Japan.

Today, international insurers still write 100% earthquake indemnity insurance on the personal belongings of foreign residents in Zone 5. However, as reinsurers have become less willing to use up their worldwide earthquake capacity in Japan, foreign insurers have been careful to stipulate, in clear policy language, the exact amount and type of coverage afforded by both local and non-admitted property policies.

Oftentimes, complexities arise when Japanese underwriters insure the local parts of a foreign joint venture. In these cases, the Japanese underwriter will provide its authorized 15% to 30% earthquake capacity, while the foreign underwriter provides its permitted 60% to 100%. The combined underwriting usually results in odd indemnity ratios, depending on one or more of the following: the percentage of foreign and Japanese capitalization; the use of foreign or Japanese coinsurance or reinsurance; and the scope and nature of the overall joint venture insurance program.

Earthquake rates in Japan vary by zone, by construction and by the percentage of indemnity purchased. For example, an international insurer will charge a tariff rate of 0.333% for a class "B" building—which is a steel, non-combustible structure—in Zone 5. The insurer develops the rate by applying the 60% indemnity ratio to the 100% tariff rate of 0.555%.

In contrast, the same foreign insurer will charge a rate of 0.16% for the same class of risk in the prefecture of Yamanashi, which is in Zone 6, the country's second-highest earthquake zone. In Zone 4—which is the third-highest earthquake zone and includes the prefectures of Ibaraki, Tochigi and Gumma—the rate also would be 0.16%.

Despite its cost, most U.S. multinationals buy insurance to protect assets because the physical effects of an earthquake are highly predictable. Yet, some of these U.S. multinationals do not mandate a safety plan to protect employees against the effects of an earthquake.

The Tokyo Metropolitan Government provides the following safety rules in an earthquake:

- Ensure your safety first. Stay away from furniture and other objects that may easily fall down and crouch under a solid desk, table, etc.
- Turn off sources of fire quickly.
- Don't rush outside. If you panic and rush outdoors, you may be hit and injured by falling concrete, signboards, glass, etc.
- In case of a fire, extinguish it immediately. If a fire should break out, extinguish it immediately after the first big jolt ends.
- Open the door for escape. In high-rise buildings, the doors may get stuck. When you feel a jolt, open the doors immediately to secure an exit.
- Behave calmly and obtain accurate information. In the event of an earthquake, information on the quake and damage will be broadcast over the radio and public address systems. Keep a portable radio on hand. Don't be misled by rumors.
- Don't use the elevator. A power failure may halt elevators in operation.
- Stay away from narrow alleys, cliffs and river banks. An earthquake may cause parts of buildings and walls to collapse or trigger landslides. If you happen to be outdoors, stay away from these dangerous places, evacuate to a nearby open space or to a solid building and check on the situation around you.
- Cooperate in fighting fires and in giving first aid.
- Evacuate on foot and minimize the goods you carry. In case of danger of fire or landslide, it will become necessary to evacuate to a safe place. During an evacuation follow the instructions of police or other persons in charge.

One last word of caution: Jishin kiotsukete kudasai! (Beware the earthquake!)

Jerome Karter is senior vp and manager of the New York International Department of Johnson & Higgins. His column appears the first Monday of every month.

ASK A BENEFIT ACTUARY

Retiree benefit costs accounting rule near

Q **What is the status of the Financial Accounting Standards Board's retiree welfare benefit project?**

A The Financial Accounting Standards Board has apparently reached several tentative conclusions regarding the accounting for post-employment welfare benefits. Not surprisingly, many of FASB's tentative conclusions have strong parallels in FASB No. 87, "Employers Accounting for Pensions." While these tentative conclusions could still be changed before FASB releases its exposure draft, it appears that the board has made substantial progress toward developing an accounting standard.

Some of FASB's tentative conclusions regarding how the charge against earnings—the net periodic cost—for post-employment welfare benefits follow:

- For benefits related to service—such as a retiree life insurance plan providing a death benefit equal to a percentage of final year's pay multiplied by years of service—the board appears to have settled on attributing the cost of the plan from date of hire to the expected retirement date. As with pensions, cost would be attributed for an employee to a particular year of service under the "projected unit credit" actuarial cost method.
- For benefits unrelated to service—such as a retiree medical plan that provides retirees the same coverage irrespective of their service with the employer—the board appears to have concluded on attributing cost from date of hire to date of first eligibility for benefits, again using the projected unit credit actuarial method.
- The board appears to have concluded that there should be an off-balance-sheet transitional obligation when a plan sponsor must comply with the new accounting standard. This obligation would be equal to the unfunded "expected benefit obligation"—the unfunded actuarial accrued liability under the projected unit credit cost method—and would be amortized as a part of the net periodic cost.
- The board has tentatively concluded that the prior service obligation resulting from a plan initiation or amendment should also have delayed recognition and should be amortized as a part of the net periodic cost.

The board has also reached some tentative conclusions regarding a minimum liability for the balance sheet. The minimum liability would be the unfunded present value of future benefits for current retirees and employees currently eligible to separate from service and receive benefits. This minimum liability would be offset by an intangible asset. If FASB 87 parallels are followed, this intangible asset would have a cap equal to the sum of the unamortized prior service obligation and the unamortized transitional obligation. If the minimum exceeded the intangible asset, a negative adjustment to shareholders' equity would result.

The tentative conclusion regarding the net periodic cost and minimum balance sheet liability will have profound ramifications for many companies, especially those with mature workforces that have not prefunded any retiree medical benefits. A net periodic cost for retiree welfare benefits of similar magnitude as the net periodic pension cost might result. In addition, significant liabilities would be placed on the balance sheet and a negative shareholders' equity adjustment could result.

The tentative schedule for the project appears to be as follows:

- Exposure draft: summer 1988.
- Public hearings in exposure draft: first quarter 1989.
- Final standard issued: late 1989. The final standard will make net periodic cost rules effective for years starting after Dec. 15, 1991, and minimum liability rules effective for years starting after Dec. 15, 1993.

Downside to ignoring IRC Section 89 tests

Q **What is the downside to not performing Internal Revenue Code Section 89 non-discrimination tests?**

A This question comes from a welfare benefit plan sponsor with relatively simple medical plans. The plan sponsor offers a medical indemnity plan and a health maintenance organization option. A medical reimbursement account is also offered to employees for medical charges not covered by a medical plan and for the nominal employee contributions required for dependent coverage. The plan sponsor is concerned about the resources it will need to expend in order to gather the data and perform the Internal Revenue Code Section 89 non-discrimination tests.

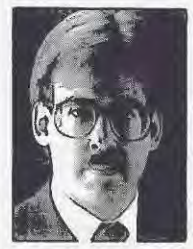
The downside risk to not performing the IRC Section 89 non-discrimination tests is that the Internal Revenue Service might upon audit take a position that the value of *all* welfare benefits provided to highly compensated employees constitute "discriminatory excess" benefits; that is, benefits provided to highly compensated employees in excess of those permitted by IRC Section 89. If the IRS were to prevail in such a position, the employer would not have properly reported earnings on Form W-2 for the year in question and the highly compensated employee would have underreported his taxable income. Additional penalties and taxes would result.

While it may sound somewhat far-fetched for the IRS to take a position that all benefits provided to highly compensated employees are "discriminatory excess" benefits, the Joint Committee on Taxation Staff's Description of the Technical Corrections Bill seems to indicate that this is the direction the IRS would move. The pamphlet says, "Of course, as is generally the case, the taxpayer has the burden of proof with respect to establishing the 'discriminatory excess.' Thus, the 'discriminatory excess' includes all employer-provided benefits for highly compensated employees, except to the extent that the taxpayer maintains sufficient records to demonstrate to the Internal Revenue Service that such benefits do not constitute 'discriminatory excess.' "

This statement, if followed by the IRS, has onerous implications for the concerned plan sponsor asking the question. While it is highly unlikely that the plan sponsor in question will have problems passing the IRC Section 89 non-discrimination tests, it could occur that unusual patterns of choice between the indemnity medical plan and the HMO could result in discrimination. The usual pattern of salary reductions (i.e., greater reductions by highly compensated employees) could also result in the reimbursement account being discriminatory. Without at least gathering the data necessary to perform the non-discrimination tests, it appears that the plan sponsor would not have maintained the records needed to demonstrate to the IRS that its welfare benefits are not discriminatory.

Would you like advice from an experienced colleague on a risk management, benefits management or actuarial problem? Four features in the Perspective section of Business Insurance can give you some answers.

Ask A Casualty Actuary, Ask A Benefit Actuary, Ask A Benefit Manager and Ask A Risk Manager answer written questions from readers on risk and benefits management issues and actuarial problems.



Mr. Miner

This month's column on actuarial issues in the benefits field is written by William J. Miner, an actuary with The Wyatt Co. in Chicago. Richard E. Sherman, a principal with Coopers & Lybrand in San Francisco, answers actuarial questions in the casualty field. Susan M. Werner, director of risk management at Hardee's Food Systems Inc. in Rocky Mount, N.C., answers risk management questions. And, Joseph W. Duva, director of employee benefits at Allied-Signal Inc. in Morristown, N.J., answers benefits management questions.

Mr. Miner's and Mr. Sherman's columns appear alternately on the first Monday of each month. Mr. Duva's and Ms. Werner's columns appear alternately on the second Monday of each month. Mr. Miner's next column will appear in August.

Address your questions to ASK, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611-2590. Please give us your name, title and employer; however, Business Insurance will consider unsigned letters.

Policy doesn't require a sole cause of loss

A general liability and fire insurance policy that covered losses caused by a windstorm did not require that wind be the sole or unaided cause of the collapse of a warehouse roof, according to the Supreme Court of Arizona.

Fred Koory Jr. purchased general liability, fire and named peril insurance coverage for his warehouse from Western Casualty & Surety Co. The warehouse roof collapsed during a March 1983 storm. It was agreed that the policy covered losses caused by windstorm and that the wind contributed, in some measure, to the roof's collapse. Various other factors, including the weight of pooling water and the roof's age and condition, also contributed to the collapse. Western denied Mr. Koory's claim under the windstorm provision of the policy. Mr. Koory sued. The trial court ruled for the insurer and the court of appeals affirmed the trial court.

The state Supreme Court reversed, stating that although the force of the wind and the condition of the insured property were relevant to a proper definition of windstorm, they do not limit coverage. The court emphasized that the plain language of the policy here did not require that the wind be the sole cause of loss.

Absent limiting language in the policy, the court said that Mr. Koory was entitled to recover if a windstorm was the proximate cause of his loss, even though there may have been other contributing causes.

Koory vs. Western Casualty & Surety Co., Supreme Court of Arizona, May 26, 1987 (*BI*/01/F.—$10).

Legal briefs

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

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Inland marine conference

Pricing discipline is key to managing cycle: Vairo

By MICHAEL BRADFORD

HERSHEY, Pa.—If insurers are ever going to manage the volatile cycles that mark their business, they have to be willing to let some business get away, the head of a major insurance company says.

"I firmly believe that if we're ever to manage the insurance cycle, we must—as you do for inland marine—measure the risk carefully and then price it adequately," said Robert J. Vairo, president and chief operating officer of Morristown, N.J.-based Crum & Forster Inc.

"If we cannot get that price, we must be willing to say, 'Below this price we simply won't write the risk,' and walk away from the account," Mr. Vairo told members of the Inland Marine Underwriters Assn. at their annual meeting last month in Hershey, Pa.

That is a tough mandate, and it takes "determination and discipline," Mr. Vairo acknowledged. "But, in my view, this is the only way we're going to regain the confidence of policyholders, politicians and shareholders, and maintain the kind of financial results we need to grow and prosper as an industry."

Mr. Vairo, who has worked as an inland marine underwriter, said that inland marine insurers' disciplined approach to underwriting is needed throughout the property/casualty insurance business.

"Discipline, particularly in pricing, has never been more important than it is today" so that the mistakes of the last round of rate-cutting, which was followed by huge price increases and coverage availability problems, will not be repeated, he said.

Still, Mr. Vairo pointed out, some insurers currently appear to be caught up in a round of price-cutting.

"Our field intelligence tells us that a lot of companies are chasing business and cutting prices. Fundamentally, there's no justification for that kind of activity."

In fact, with the increased tax liabilities that commercial insurers are facing as a result of the Tax Reform Act of 1986, along with inadequate loss reserves that many insurers show, insurance companies "should be going the other way" with pricing, Mr. Vairo said.

Despite the current market softening, Mr. Vairo said he does not see "an orgy of price slashing."

"This doesn't mean it won't be competitive. It will. After all, that's a major characteristic of the insurance business. We are just a very competitive industry, and that's as it should be.

"However, within each company there ought to be a high level of discipline set for our products and our markets that will not allow irresponsible underwriting and pricing," he said.

The cause of the current competitive cycle can be traced to insurance company management, according to Mr. Vairo.

"Management sends conflicting signals to the field—they tell (field offices) to grow by 20% to 30%, and, by the way, make sure you get the right price for the risk. And don't lose any good renewals.

"If I'm an underwriter, this kind of message tells me I've got to cut the price to compete on business. What's needed is a clear signal from the CEO right on down that says, 'Look, this is our price, and below this we just can't afford to write this risk.' "

Although Mr. Vairo acknowledged that "a company like Crum & Forster can't exert enough influence on the market to stabilize it," he said the insurer is attempting to "contribute to that goal, and so are other responsible companies."

Crum & Forster has devised a way to measure each risk and determine a minimum price that can be charged to insure it. The system includes loss experience information on the particular risk and data on expenses associated with writing the line of business in the state where it is located.

"What we do is analyze each product line in each state and measure the level of rate adequacy," Mr. Vairo noted. "Obviously, where we have an inadequately filed rate to start with, we can't discount that rate as much as if we had a full rate."

Crum & Forster uses this method on individual risks, not to price entire classes of business, he said. "We're saying that this very good risk, with its loss experience, premium and expenses, can be discounted this much—which becomes the floor price—the absolute bottom" below which point the insurer knows it is going to lose money. "That's our walk-away price," he explained.

That pricing discipline is in place throughout Crum & Forster's operations, Mr. Vairo said. "And I truly believe it is the reason why we are in a stronger, more secure financial condition than at any time in our recent past.

"I don't have to tell you that when we take a risk today and promise to pay losses over the next five, 10 and even 30 years, we'd better be right about our price to fund those losses. We have an obligation not only to our shareholders but to the public to be around when they have a claim," Mr. Vairo said. ■

AMIM designation in demand

MALVERN, Pa.—The Insurance Institute of America's newest program, the Associate in Marine Insurance Management, is drawing a crowd of professionals seeking the new designation.

About 430 registrants in May took the first of six exams that make up the program, which is aimed at educating entrants in the ocean and inland marine insurance industry and broadening the knowledge of those already working in those areas.

The American Institute of Marine Underwriters and the Inland Marine Underwriters Assn. worked closely with the IIA to develop the program.

The program leading to the AMIM designation typically will take three years to complete, said Arthur L. Flitner, assistant director of curriculum of the IIA. However, participants holding a Chartered Property Casualty Underwriter designation can complete the program sooner because they can skip four of the courses that are also in the CPCU curriculum.

Mr. Flitner stresses that the AMIM program was not developed solely for marine specialists.

"If it were, it would not include four CPCU courses. In fact, a major consideration in its development was that it provide a broad-based program that would allow those involved in marine insurance to look beyond the boundaries of ocean and inland marine coverages and gain knowledge of insurance and risk management principles, insurance company operations, law and management."

Risk managers, agents and brokers, adjusters and others seeking a greater understanding of ocean and inland marine coverages would benefit from earning the designation, according to Mr. Flitner.

More information is available on the AMIM program from the Insurance Institute of America, Field Services Department, 720 Providence Road, Malvern, Pa. 19355-0770; 215-644-2100.

—By Michael Bradford

Agent/Broker Topics

A monthly editorial section sent exclusively to agents and brokers

Agents map financial plan for success

By LAURA MAZZUCA

Adding financial planning to an agency's or brokerage's cadre of services is touted as yet another way to survive in a competitive marketplace.

Experts agree that clients are increasingly interested in "one-stop shopping," or dealing with firms with broad product and service portfolios. Such diversification gives a property/casualty insurance agency a competitive edge in client retention, consultants say.

"Independent agents have a tremendous, untapped resource in their current customers," said Bruce W. Saenger, president of The Saenger Organization, a financial services industry consultant in Medway, Mass. "By adding financial planning, agents can increase commissions and, more importantly, provide a valuable service that's crucial for retaining clients and attracting new ones."

"If you have a client buying insurance and insurance-related matters, why let him spend his money in another area?" asked David A. Bakst, an attorney at Morrison, Mahoney & Miller in Boston, who specializes in working with agencies and brokerages to establish financial planning divisions.

But those promoting diversification into financial planning have different ideas of what the service should entail.

Some promote financial services as selling insurance and financial products and advice to individuals, which was the thrust of financial planning services movement in the early 1980s. Others suggest that financial planning services also include selling employee benefit products to clients' firms.

Mr. Bakst believes "true financial planning provides advice to individuals on how to manage their available funds for the buildup of capital for when their working income ceases." The term has more application for individuals than for commercial entities since "the business hopes it will be earning money forever," while the individual cannot.

The function of a commercial financial planner is "more of a salesman trying to install a product with a client," such as 401(k) or Keogh plans, Mr. Bakst says.

Edwin P. Morrow, chairman of Confidential Planning Services Inc. in Middletown, Ohio, says financial planners can serve the employee benefit plan needs of small companies. "Very few are qualified to do financial planning for major companies."

And Carol A. Hammes, a consultant with The Middleton Group in Lisle, Ill., calls financial planning "anything you do to help protect the assets of a corporation or an individual."

Financial products offered to individuals can include retirement planning, life and disability insurance, annuities, estate planning. and investments.

Employee benefit products and services sold to client firms include reviewing an entire benefits program and selling benefit products such as group life and health insurance and 401(k) plans.

But, selling financial planning is not quite as simple as sitting back and giving advice, said Mr. Morrow.

And, even though Mr. Bakst believes that agents can benefit greatly from diversifying into financial planning, it's not necessarily for everybody.

"People in the insurance business have been thinking along these lines for a long time," he said, "but that doesn't mean that somebody who sells a lot of boiler and machinery insurance should do financial planning."

Continued on next page

Financial planning services

Although there has been a "significant increase" in agencies adding financial planning services over the last five years, "very few firms have had the level of success" hoped for, said Andrew Tasker, president of Tasker Financial Marketing Inc., a consultant in Cleveland.

"While there are a lot of similarities between products (insurance and financial planning), it really is a different business," Mr. Tasker said. "It's like creating a business from the ground up."

"Financial planning was real trendy a couple of years ago," said Ms. Hammes. "But a lot of guys tried it and it wasn't anywhere as easy as it seemed to be."

One of the problems is a lack of patience; agency principals frequently don't give the concept enough time to get off the ground, said Ms. Hammes.

She estimates that 10% of the agencies and brokerages that try financial planning give it up within two years because the service isn't turning a profit.

"You have to give it at least three years before you make any money on it," she added.

And, financial planning, since it calls for an impartial opinion on the part of the planner, is "totally alien to the insurance agency environment," which is sales-driven, she added.

Clients value impartiality, Mr. Morrow agreed, and agents may have problems being impartial when dispensing advice.

Ms. Hammes

But while acknowledging that agents are by nature salespeople, Mr. Morrow said "agents realize that if you hard-sell a policy, it's likely to lapse."

And although an agency's existing property/casualty insurance clients should be the base of an expansion into financial planning services, existing clients also can be leery of doing business with a property/casualty insurance agency just entering this new field.

"If they've perceived of you in the past as strictly an insurance agency, there is some skepticism to be overcome," said Mr. Morrow.

If launching financial planning services is not undertaken with caution, "it's going to be expensive, frustrating and probably a failure," Mr. Morrow warned.

Depending on how it is set up, a financial planning program can cost from $40,000 to more than $150,000 for the first year, with most of this outlay for the financial planner's salary, consultants say.

Mr. Morrow reported that the salary could be as low as $40,000 a year to start, plus a percentage of the profit from selling financial planning services and products, including fees and commissions.

Mr. Saenger estimates it could cost between $40,000 and $60,000 to hire a financial planner, depending on geographic area and the financial planner's experience. Additional clerical support and computer software will add another $5,000 to $6,000 to this initial outlay.

Ms. Hammes put the figure at closer to $70,000 per year, an expense that she points out will not be recouped for several years.

Mr. Bakst is more optimistic about costs and how soon a profit can be made from selling financial planning services. "The only cost of this division is the salary for the new people hired to do the work," said Mr. Bakst. Depending on how the financial planning operation is set up, "you could be in the black in four or five months," he said.

Mr. Bakst

Ms. Hammes and others agreed that adding a full-time financial planner works best for large agencies and brokerages.

If the agency generates less than $1 million in annual premiums, adding a full-time financial planner probably is not a good idea, said Mr. Bakst.

However, since financial planning is "becoming more important. . .smaller agencies will have a more difficult time surviving" without it.

Ms. Hammes cited a recent survey by the Independent Insurance Agents of America reporting that of the nation's approximately 50,000 independent agents, more than 80% had annual revenues of $250,000 or less. So, the agencies that could most use a financial planning program to grow are those least able to justify such an investment if it doesn't succeed, she said.

'Financial planning was real trendy a couple of years ago,' says Carol Hammes, a consultant with The Middleton Group. 'But a lot of guys tried it and it wasn't anywhere as easy as it seemed to be.'

This doesn't mean smaller insurance agencies have to be left out of the financial planning business, stressed Ms. Hammes.

For these small to mid-sized entities, she suggests contracting with an outside financial planning expert via a joint venture, even if the agency is just interested in expanding into selling life insurance to individuals.

Patricia A. Borowski, vp-government and industry affairs with the National Assn. of Professional Insurance Agents in Alexandria, Va., advises smaller property/casualty agencies to team up with life/health agencies for limited joint ventures, so both can share their financial planning expertise and profits.

"There is lots of fertile ground to develop good working relationships," Ms. Borowski noted. "You're only limited by your imagination."

An agency determined to diversify into financial planning services also can grow its own expert. An employee already with the agency can study financial planning and obtain a professional designation, such as the Certified Financial Planner or the Chartered Financial Consultant. Clients expect financial planners to hold these credentials, said Mr. Tasker.

Training someone already on staff to become a financial planning expert is particularly appealing to younger agents, Mr. Saenger noted.

An agency offering financial planning services must also train its support staff, said Mr. Morrow. These people will handle the information-gathering and maintenance of records, he said.

An agency offering financial planning services must monitor its planning practices, said Mr. Morrow, in order to reduce its errors and omissions exposure.

An agency's automation system must be up to the challenge of keeping track of all advice disseminated by financial planners, consultants said.

There is a variety of financial planning software on the market, with prices ranging from $800 to more than $10,000, depending on the level of the agency's existing automation system, Mr. Morrow noted.

And, the firm's existing errors and omissions coverage must be upgraded to reflect the fact that the agency is offering financial planning services, said Mr. Saenger.

However, "If you're offering a wide variety of services, you're actually at less exposure" because the agency is covering all eventualities facing a client, Mr. Saenger said.

Agencies that sell securities as part of their financial planning services or provide investment advice also are subject to state and federal regulation.

The Securities and Exchange Commission regulates not only securities dealers but also financial planners that offer advice on securities for a fee.

Mr. Morrow

Such financial planners must register with the SEC.

Agencies that want to sell securities or financial planning advice requiring SEC registration should consult an attorney with SEC experience, consultants point out.

The procedure can be complicated. The registration forms "must be filled out meticulously," otherwise they will be returned and that consumes time, Mr. Morrow said.

The SEC generally holds these forms for 90 days before returning them for corrections.

In determining whether an agency or brokerage should add financial planning services, consultants suggest that principals analyze:

- The existing client base.

In order to fully utilize the client base, the agent must closely study clients' entire potential needs, including personal services and products for principals and employee benefit products for small companies.

This is important, since existing clients will be the first financial planning clients.

As the financial planning department grows, new clients can be gleaned through target marketing and advertising.

- How to establish and manage the department. Will it be an in-house program, a contract with a financial planning expert or a joint venture?

Agencies and brokerages with thriving financial planning services "build their financial services organization as a mirror image of the rest of the agency," said Mr. Tasker.

"The concept has to be to have a full-service firm," said Mr. Bakst, with client retention being the real goal of financial planning. ■

Brokers', insurers' images linked: Pollster

By LAURA MAZZUCA

PEBBLE BEACH, Calif.—Brokers believe their public image is far better than it actually is, according to a public opinion research expert.

Although insurance brokers believe that insurers' public image is deteriorating, they think their own image is staying the same, according to the results of two recent polls.

But, any attempt to distinguish between insurers' and brokers' public opinion ratings is erroneous, according to Peter D. Hart, president of Peter D. Hart Research Associates Inc. in Washington, D.C.

In addressing the 54th annual National Assn. of Insurance Brokers last month in Pebble Beach, Calif., Mr. Hart pointed to the antitrust lawsuits recently filed against insurers, brokers, reinsurers and trade associations by nine states and commercial insurance buyers as an indication of the public's attitude toward the insurance industry in general (*BI*, March 28, April 4).

"Whether you look at your daily newspaper or a public opinion poll, there is a negative feeling out there. And, when you look at the lawsuit, that is public opinion," Mr. Hart said.

"Every attorney general who is filing those suits is saying, 'This is going to get me votes.' There is no such thing as gray hats; we're all black hats at this stage of the game."

To further illustrate his point, Mr. Hart pointed to the results of a public opinion poll his firm conducted in February and an industry poll conducted in May for the NAIB.

The Hart poll questioned both the general public and specific demographic groups on how they felt about six groups: environmental groups, consumer advocate groups, professional medical groups, labor unions, oil companies and insurance companies.

Of the six groups, insurance companies were rated the lowest in public esteem, with 42% negative and 26% positive responses.

Specifically, 45% of the business executives polled gave negative responses, and 23% gave positive responses about the insurance industry; 49% of the blue collar workers polled gave negative responses, and 21% gave positive responses; and men in general were more negative about the insurance industry than women, according to Mr. Hart.

Although insurance brokers believe that insurers' public image is deteriorating, they think their own image is staying the same, according to the results of two recent polls. But, any attempt to distinguish between insurers' and brokers' public opinion ratings is erroneous, says Peter D. Hart.

"That's what you're up against. That's how the American public cross section feels about you," he said.

In the NAIB survey, which polled 30 insurance company executives and 122 members of the NAIB, 81% of the brokers believed the public's opinion of insurance companies was getting worse, 17% thought it was staying the same and 2% thought it was getting better.

However, when the brokers were asked about what they thought the public's perception of their own image was, 60% replied they thought it was staying the same, while 21% thought it was getting better and 19% thought it was getting worse.

The survey also pointed out a wide variance between the opinions of insurers and brokers on some industry-related topics:

- Regarding underwriting, a plurality—46%—of the NAIB members agreed that fiscal history and solvency were the most important considerations in selecting an underwriter. Other factors cited were cost, 32%; dedication and involvement, 21%; coverage, 19%; experience and expertise, 12%; and flexibility, 12%.

However, 43% of the insurance executives said dedication and involvement was the most important consideration in selecting an underwriter, followed by fiscal history and solvency, 37%; cost, 23%; honesty and integrity, 17%; experience and expertise, 10%; and ability to pay claims, 10%.

- While only 3% of the insurance executives believed the industry created an artificial insurance crisis during the mid-1980s, 22% of the NAIB members said the industry had caused the crisis.
- Some 43% of the insurance executives believed that pricing was being based on factors other than underwriting, while 89% of the NAIB members agreed with the statement.
- Sixty-three percent of the insurance executives agreed that brokers were too cost-conscious, as opposed to 31% of the NAIB members who agreed.

However, the two groups seemed to reach a consensus on other issues, including that:

- Brokers fairly represented their clients' interests: 83% of the insurance executives agreed and 87% of the NAIB members agreed.
- Banks should not be allowed to sell insurance, with 87% of the NAIB members and 76% of insurance executives agreeing.
- State governments were doing enough to regulate the industry. Some 62% of NAIB members and 67% of insurance executives agreed.
- Brokerage firms need to be more active in the industry. A whopping 92% of the NAIB members and 83% of the insurance executives agreed.

To remedy the public's poor perception of the industry, Mr. Hart cited suggestions made by brokers and insurers in the NAIB poll, including: using professional standards; eliminating fraud; attracting top-caliber people to the business; improving service quality; and eliminating swings in insurance prices.

A/BT briefs

Commissions raised for new flood accounts

WASHINGTON—The federal government will increase commissions paid to producers for new business written through the National Flood Insurance Program.

Producers' commissions on new flood insurance accounts will increase to 17% from 15%, with a minimum commission of $10 per new account.

But, renewal commissions will be cut to 14% from 15%.

The change, which is effective Oct. 1, was prompted by industry associations that believed commissions should be increased to give producers more incentive to deal with the complexity of the flood insurance program.

However, association representatives have criticized the lower renewal commissions.

"Agents must spend more time to sell a renewal so they should receive the same commission as for new business, not less," said James M. Stevenson, chairman of the National Assn. of Professional Insurance Agents' government and industry affairs committee.

E&O suits balloon

NEW YORK—One in every eight U.S. agents and brokers was named as defendants in errors and omissions lawsuits in 1987, according to a new study.

And, as many as 25% of agents and brokers in some regions of the nation were hit with E&O suits last year, according to statistics recently released by the Insurance Information Institute.

By comparison, one in 50 agents was party to an E&O suit in 1968, and one in 14 faced an E&O claim 1974.

Fifty percent to 75% of E&O claims against agents stem from the placement of faulty or inadequate coverage, which most often goes unnoticed until after a client has suffered a loss, according to the III.

Training program

LOS ANGELES—Wholesale broker Swett & Crawford Group has established a national training program for its employees that features a full range of sales and technical courses.

The courses, known as "Swett University," debuted in January and included more than 200 field brokerage employees as participants.

The first-year curriculum consists of courses aimed at field sales training and technical support services.

"Our intent is to build on the fundamental programs now available" through the Chartered Property & Casualty Underwriter program, the Insurance Institute of America and other industry programs, "and tailor our courses to the specific development needs of our professional and technical people," said Assistant Vp Edward Bordenave, who heads the education project.

Swett & Crawford, a unit of The St. Paul Cos. Inc., operates 50 offices nationwide.

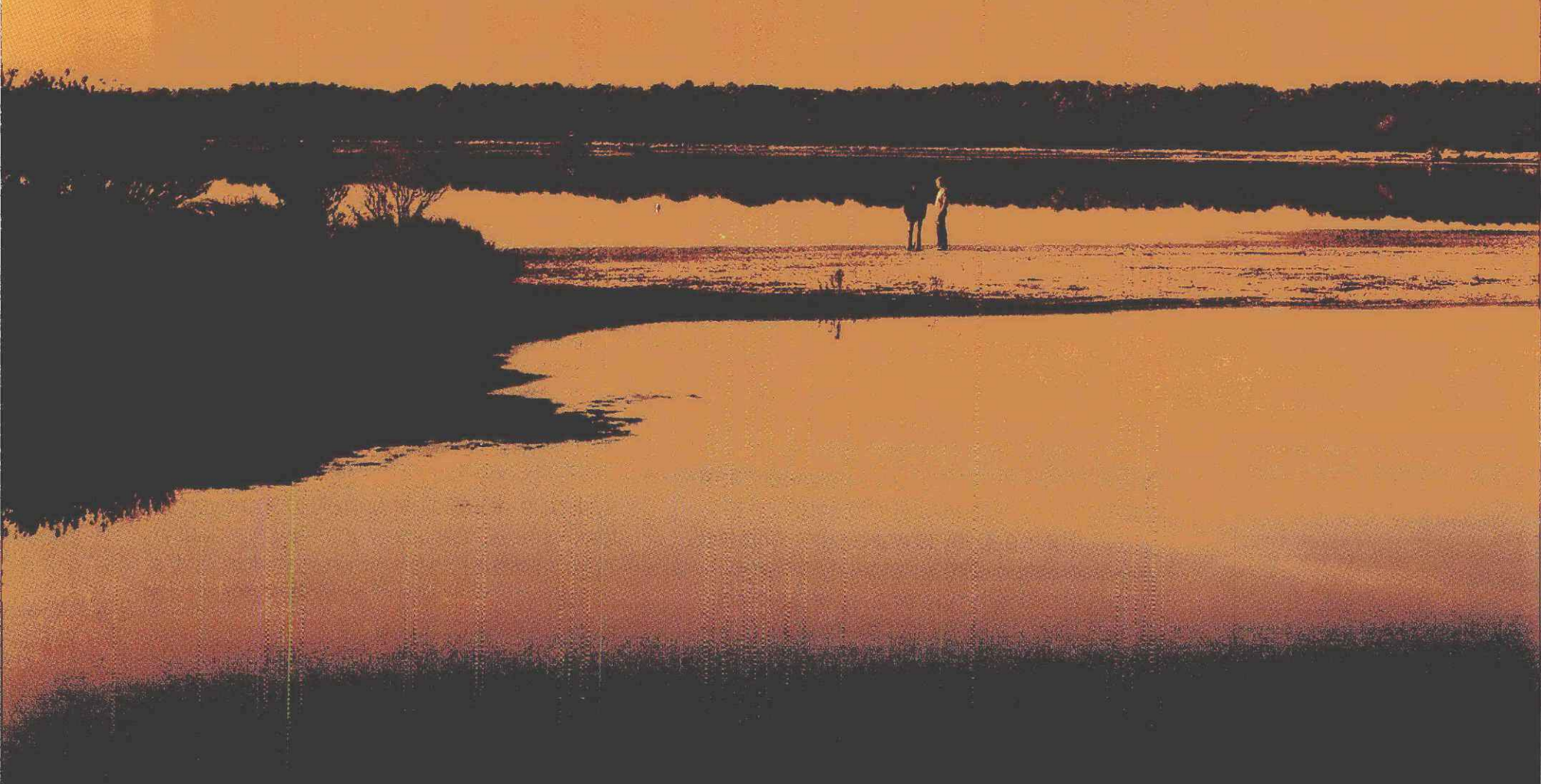
Licensing exams

RICHMOND, Va.—The state of Virginia is conducting its insurance licensing examinations through the Insurance Testing Institute's automated national network following the establishment of four computerized examination centers.

The state Bureau of Insurance has appointed an examination review committee, which is working closely with institute personnel to review examination content outlines, said Norman A. Baglini, the institute's president.

The Insurance Testing Institute, the licensing qualification division of the Insurance Institute of America, currently serves as the licensing examination contractor for Iowa, Missouri, South Dakota, Utah, Connecticut, Pennsylvania and Virginia. ■

"I said *Chubb* and he said *Expensive?* and I said *You get what you pay for.*"



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Agent/Broker Topics Perspective

Fair compensation plan is essential

By CATHERINE C. OAK

A/BT speaking out

The establishment of an equitable producer compensation plan in an agency is vital to agency growth, profitability and fair market value. It also is essential in assuring the continuity of agency ownership.

Despite the many compelling reasons for having an effective compensation plan, most agencies have a producer complacency problem. This occurs when experienced producers—including owners—reach a comfortable income level based on commissions earned from their existing book of business. The producer compensation plan needs to be designed to overcome this complacency problem and to achieve an agency's other goals.

The agency's goals for producer compensation must realistically be competitive with other independent agents and brokers in the surrounding area to help attract and retain producers.

The compensation plan also needs to be designed to encourage new production so lost accounts can be replaced and growth goals can be realized. Lastly, but most importantly, the plan needs to be designed to add to the profitability of the firm.

New production can be expensive if costs are not managed properly. Take, for example, the effect on agencies that broker business (i.e., at a 50% commission rate) with no control of, or ownership interest in, the accounts. The servicing costs allocated to these accounts become very expensive, leaving little room for profit.

Moving to managing costs, it takes an average agency six years to recover the initial costs of writing a new commercial lines account. These initial costs include the production cost (producer commission and selling expenses) and the first year servicing cost (customer service representative payroll and operating expenses). High-performing agencies recover these costs in four years.

Our studies have proven that production costs average $3 to $4 per new commission dollar written in an agency that properly manages its costs. Many agencies, however, do not do a good job of managing costs. Those agencies that don't will have a much longer cost recovery period.

If agencies pay too much to producers—both for new and renewal business—the agency will not be able to earn the kind of profit that is needed to provide an adequate return to owners for their investment in the agency. Also, the agency may not have the income it needs to pay for competent service personnel or to cover ever-increasing operating expenses. In all cases, the profitability of the firm—and thus the value of the agency—is affected. Producers who are paid too much become complacent faster. This is particularly true when renewal commissions are too lucrative.

What is an ideal compensation plan for an agency? There is no cut-and-dried plan that will work for every firm. It must be designed to fit the needs of the individual agency and should take into consideration what specifically motivates that firm's producers.

Based on experience consulting with hundreds of firms and performing studies of our clientele, here are some tips to keep in mind when designing your firm's compensation plan:

- Security needs.

Most non-owner producers want some type of security. Older producers often bring to our attention how important a good retirement plan is to them, especially due to their age and need for income when they retire. Younger non-owner producers want to feel they are building some equity. This can be accomplished in various ways, the most common being vesting in their book of business or being able to purchase agency stock.

Most importantly, the plan needs to be designed to add to the profitability of the firm.

A sale of stock should only be considered if the producer has been with the agency for a minimum of three years. In this time, the owner should be able to tell if this prospective perpetuation candidate has the ability to run the agency profitably—or could at least make a significant contribution—in the owner's absence.

An owner also must be sure that the agency will have the necessary cash to help fund the buy-out of the owner's stock, when he or she wants to retire.

Those producers chosen for succession will be responsible for generating the growth, cash and profits necessary in a perpetuation plan. Many owners do not look at the issue of selling producers a minority interest of stock in this light.

- Producer expenses.

If benefits and selling expenses are paid to producers, the commission split should be less than if the producer were personally covering these costs. On average, the percent of revenues attributable to paying these expenses for a producer is about 5% of revenues.

If paid by the agency, producer selling expenses need to be controlled. Expense accounts can be hard to manage and frequently invite abuse. It is easier and often more equitable to give the producer a percentage of his or her existing book to use for selling expenses (i.e., 3% to 5%).

Producers should be productive with their time and their costs. Those who are most efficient can be rewarded if an additional commission allowance will cover selling costs. While this makes all kinds of sense for the agency and its producers, the Tax Reform Act may have thrown us a curve. A good portion of the producer's expenses may not be deductible if

Continued on next page

Continued from previous page
not directly reimbursed by the agency. You should seek tax guidance on this issue.

- Who is doing the work?

A customer service representative's role varies from agency to agency. Some CSRs act like account executives and handle most service for producers once the account is on the books. Some CSRs are more like processors and handle mostly clerical work on the accounts for producers. Variations exist between these two extremes in every agency and are often based on the experience levels of CSRs and/or the ability and desire of producers to delegate service work on their accounts.

The amount of commissions paid should be based on who is doing the work and upon how well they are doing it. If producers are heavily involved in marketing, renewal information-gathering and day-to-day service of their accounts, then the producers may deserve more commission for these efforts. However, if the additional workload is simply due to an unwillingness to delegate to qualified people, a low renewal commission and high new business commission is in order.

In all cases, little or no renewal commission should be paid to commercial producers for personal lines or small commercial accounts. CSRs handle the majority of the work once these accounts are written, especially if they are written on a direct bill basis, as we suggest.

- Central marketing.

If an agency decides to set up a central marketing department to assist producers with new business marketing and renewal re-marketing, then less producer commission is justified. Central marketing should free up the producer's time for new production. That's what it's supposed to do. This assumes the department is set up properly and the agency has hired the right individual to handle the marketing function.

Promoting the most experienced and respected commercial CSR in the agency to the marketing position can help producers feel confident that their accounts will be marketed properly. Paying marketers a bonus based on new business placed will help as well.

- Compensation methodologies.

Salaries do not motivate producers. If an agency uses the salary-only method, the annual salary should be retroactively based on a commission percentage of the individual's book—such as 25% to 30%—with up or down adjustments to the salary made periodically throughout the year. These adjustments should be based on the retention of the producer's existing book of business and on the new business produced.

If a base salary is utilized and the existing book remains intact, then the producer should periodically receive bonuses for new business production. This will help motivate the producer since his or her efforts will pay off when earned, instead of having to wait until the end of the year for the new annual salary to be established.

Experienced producers with a proven record often feel comfortable on a commission-only compensation plan. Commission-based plans justify a higher percentage paid because the producer is assuming risk and the agency is shedding risk. New business production should be worth more than renewal commission due to the agency's need for new business. Also, in most agencies the majority of renewal work is handled by CSRs.

Variations of the "salary plus incentive" plan or "commission only" plan described exist;

Experienced producers often feel comfortable on a commission-only compensation plan.

however, we feel these two options are the most effective. It is generally true that producers who are willing to assume risk in a compensation plan are most capable of taking risk in a perpetuation plan.

- New producers.

Production efforts of new producers need to be monitored to make sure the investment the agency has made—both in salary and time spent with the producer—is paying off.

Most agency owners do not know

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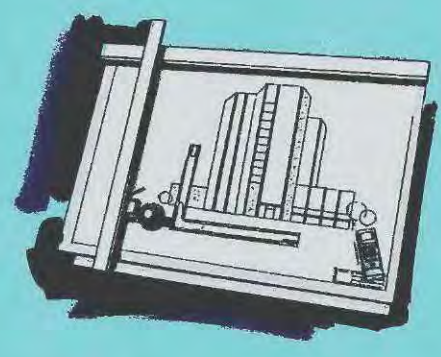

Compensation

Continued from previous page
what is an acceptable level of performance for either new or experienced producers. They feel guilty when new producers do not succeed. New producers are usually promised that they will be trained by one of the owners or experienced producers. Passing at least a small book of business to the producer to service and develop and supplying him/her with some leads (at least in the beginning) would be helpful. A new producer needs direction and some assistance to get started, especially if the producer is new to insurance sales.

A new producer might typically be put on a salary for the first two years but should be required to validate that salary with a certain amount of production. The producer should be passed $30,000-$40,000 of commercial commission volume from experienced producers to service and round out over a three-year period. If the producer can also write $20,000 to $25,000 of new business per year, then he or she should have a $100,000 commission book of business after three years.

The experienced producers—including owners—who pass their smaller commercial accounts on to new producers should then have more time available to produce new business to replace those accounts passed on to the new agent.

- Performance standards.

Experienced producers in average agencies should handle a book of business of at least $250,000 to $350,000 of commission income. With a book this size, these producers should also have time to produce some new business if the producer can delegate a good deal of the service work to competent CSRs.

Experienced producers in high-performing agencies service books of business in the $350,000 to $500,000 commission income range. At this level they are delegating service regularly to competent CSRs, handling fewer customers and writing larger accounts than the average agency.

- Keep producers out of smaller accounts.

The agency should keep commercial producers out of personal and small commercial lines production and service. CSRs in any agency should be able to handle the writing and servicing of these accounts. This is usually much more cost-effective for the agency involved vs. paying producers for the work done by CSRs, especially renewal work. It will also free up the producer's time, enabling him to write new accounts.

- Grandfathering.

If the agency's existing producer compensation plan is changed, it may be necessary to "grandfather" the existing arrangement for at least a period of time. This would enable producers to make up the commissions lost with new production. Any new arrangement can begin for new business produced after a specified date.

Over time, the producer's entire book would be under the new plan due to attrition, which averages 8% to 12% in most agencies.

Some agencies only grandfather existing business for two or three years. This depends on how profitable the agency is and how drastic a change is necessary.

- How much can you afford?

The average well-run agency is not able to afford or willing to pay more than a range of 25% to 35% commercial renewal commission, depending on whether benefits and/or selling expenses of the producer are paid by the agency. This range assumes that the agency would like to make at least a 20% profit, which serves as a return on investment to the owners.

Agencies that are not well-run usually can afford less but most likely would not be able to attract or retain good producers. Therefore, their return is less, which is probably what you would expect in a poorly run agency. High-performing agencies often pay the producers an added commission or incentive for new business production. This helps motivate producers to write new accounts and encourages them to delegate service work to the CSRs, due to the lower renewal commission paid.

It is imperative that owners consider all of the key points outlined above to determine what the agency can afford to pay; what should be paid based on the amount of service work the producers are performing; and what the competition is paying in the agency's locale.

In any case, the important issue is: Can the agency make a profit on the producer compensation plan in place? If not, then the agency would be better off without employed producers or brokered business.

Without the non-owner producers, owners would have to carry the burden of all new business production. This could especially be a problem as the owners get older and/or when they are already handling a significant book of business.

What motivates your agency's producers? How much can you afford to pay? What contribution to the agency's profitability are producers making in light of the costs involved? These are all key questions that need to be answered in designing the ideal producer compensation plan for the agency, taking into consideration each of the issues we have addressed.

In the final analysis, the key to motivation will lie with the individual. If the agency provides a motivating climate for its producers, has a good compensation plan in place and properly manages producer performance, then there should be no problem. If there is still a problem, then the key issue becomes whether or not you hired the right person for the sales position in the agency.

Testing of new producers by the agency is key before hiring. This will help determine if the producer has the necessary characteristics to be a good salesperson: ego drive, empathy, leadership, delegation, etc.

Each agency situation is unique. The key issues discussed in this article will help you in your thinking as you design the ideal compensation plan for your agency. As you do, remember that you are running a business. As the owner of that business, you deserve a fair return. If a producer compensation plan prevents that return, or fails to achieve it, the time has probably come for change: Change the plan or change the producers.

Catherine C. Oak is a partner and consultant for Marsh, Berry & Co. Inc., a Mentor, Ohio-based national consulting firm for independent agents. Ms. Oak opened the firm's San Francisco office and specializes in financial management, appraisals, agency operations, compensation and strategic planning consulting services.

Ms. Oak

Lloyd's liability

Continued from page 3

"I don't see that. The Council doesn't see that," Mr. Lawrence said.

The issue of limiting liability is being raised because of the huge losses some syndicates are suffering and concern over whether Lloyd's "can continue to attract names," Mr. Lawrence explained.

Suggesting that Lloyd's limit members' liability is "a nice, easy" solution, but "I don't know if many have thought through what it would mean," he said.

The Lloyd's chairman listed problems that would have to be solved before Lloyd's could limit liability for names. For example, "what do you do with 300 years of trading with unlimited liability? You would have to run off all the unlimited liability syndicates."

Also, limiting members' liability and then switching to a one-year accounting system and eliminating reinsurance to close the previous year's account would "change forever our tax position worldwide," Mr. Lawrence said. Lloyd's would be treated as any other insurance company for tax purposes. However, he said, this would not necessarily increase the taxes paid on business conducted at Lloyd's.

Also, Mr. Lawrence said, under a limited liability system, would liability be limited at the syndicate level or at the name's level? If one syndicate exhausted its capital, could a name trade on other syndicates? And would there be a Lloyd's Central Fund?

And how would Lloyd's "prove to policyholders that they were in an equally good position with limited liability" as under unlimited liability, Mr. Lawrence questioned.

"I am not saying that it isn't resolvable, but it raises major problems," he said.

Paul Archard, managing director of Murray Lawrence & Partners, who has "mixed views" about limiting liability, observed: "I don't think it would do Lloyd's perception much good in America."

Nevertheless, serious discussions are going on at conferences, market meetings and in the hallways of the world's oldest insurance institution on changing the basis of Lloyd's security.

In fact, Messrs. Hiscox, Cooper and Springbett say they will advocate limited liability openly at a conference on the future of Lloyd's to be held by Insurance Risk & Research Group on June 20.

At the moment, the security behind Lloyd's policies consists of two main elements: The financial resources of Lloyd's members and the controls exercised by Lloyd's that come into play when Lloyd's members' financial resources are not available.

When a claim is filed, it is first paid by the technical reserves of the syndicates, which are technically owned by the members. The reserves include the reinsurance premiums paid to close prior years and the underwriting balances of the last two underwriting years, which remain open under Lloyd's accounting system.

The reserves are held in trust for members and pay for underwriting losses and expenses of the members' underwriting business.

Once the reserves are depleted for each member, a member's deposit, which is held in trust by Lloyd's "as security," pays the loss. The amount of each Lloyd's members' deposit is determined by the amount of premium the member underwrites.

Currently, a member must deposit between 28% and 40% of his or her annual premium income. However, Lloyd's plans to increase required deposits this year.

Members also have personal reserve funds held in trust by members' agents to pay for losses once reserves and deposits are depleted. The fund size is based on the member's premium income.

If the technical reserves, deposits and personal reserve funds are wiped out by losses, the member becomes unlimitedly liable for any added losses in proportion to his share of the syndicate's business.

Each prospective member must provide independent verification to the Council of Lloyd's that he or she has a minimum level of wealth of at least 100,000 pounds to pay for losses, although Lloyd's will review that amount.

Should a member's assets or personal wealth prove insufficient to meet liabilities, the Lloyd's Central Fund and the assets of the Corporation of Lloyd's will pay claims.

The Central Fund, however, is the ultimate safeguard for the policyholder—not the Lloyd's member—and theoretically does not pay claims until all other avenues to pay the losses are depleted.

The Central Fund will pay unmet claims whether or not the claims are made by other Lloyd's syndicates or policyholders outside Lloyd's.

Not in living memory, according to Lloyd's, has a name gone bankrupt due to losses at Lloyd's.

However, two past settlements and current losses show just how vulnerable the unlimited liability system is when losses exceed the expectations of Lloyd's members, proponents of limited liability say.

Twice since 1980 Lloyd's has been obliged to bail out members and pay claims in unprecedented settlements because the members refused to meet their unlimited liability responsibilities.

In 1980, the Corporation of Lloyd's paid 16 million pounds ($29.4 million at current exchange rates) of losses from the 1976 and 1977 accounting years of Sasse syndicate 762 in a settlement with Sasse syndicate members. The members had sued the Corporation of Lloyd's, charging that Lloyd's had not properly regulated Sasse's activities. In return, the members paid 6.25 million pounds ($11.5 million) and dropped the suit.

And, last year, to avoid long litigation, Lloyd's paid members of non-marine syndicates formerly managed by PCW Underwriting Agencies Ltd. a 103 million-pound ($165.8 million at the appropriate exchange rate) settlement and granted them immunity from any further losses.

Lloyd's contributed 45 million pounds ($72.5 million) from its Central Fund and 37 other organizations contributed 55 million pounds ($88.6 million) of the settlement.

In return, the PCW members paid 34 million pounds ($54.7 million) and relinquished their rights to sue Lloyd's and other parties to the settlement (*BI*, April 13, 1987).

Current problems in the market also make the viability of unlimited liability for Lloyd's members questionable, proponents of limited liability point out.

For example:

- Lloyd's may seize the deposits of members of loss-riddled syndicates formerly managed by Oakeley Vaughan (Underwriting) Ltd. unless the members pay assessments within the next month to cover losses dating from the early 1980s. Losses from Oakeley Vaughan total at least 20 million pounds ($36.8 million at current exchange rates), and many of the 190 syndicate members are refusing to pay. About 50 members are embroiled in litigation with Lloyd's over the losses (*BI*, May 9).
- As much as $150 million of losses on runoff reinsurance policies are plaguing members of the open 1982 year of syndicate 317/661, which is managed by R.H.M. Outhwaite (Underwriting Agencies) Ltd.

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Lloyd's liability

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The magnitude of the losses—which primarily stem from U.S. pollution and asbestosis claims from years prior to 1982—prompted 102 Lloyd's members' agencies to investigate whether a court or arbitration tribunal is likely to hold that Outhwaite was in breach of duty or in breach of contract.

The report, prepared by London law firm Freshfields, advised that the members would be unlikely to win a judgment against syndicate managers for breach of duty (*BI*, May 23).

Nevertheless, more than 50 members last week appointed law firm Richards Butler in London to advise them of their options.

• The 1,452 members of the 1984 underwriting year of syndicate 553, formerly underwritten by Cyril Warrilow and managed by C.J.W. (Underwriting Agencies) Ltd., face total losses of more than 71 million pounds ($130.6 million) and have been asked to pay 22.3 million pounds ($41 million) this year to help cover losses on the open account.

The 1985 year also will be left open. About 200 members have agreed to commission London law firm Elborne Mitchell & Co. and accountants Peat Marwick & McLintock to study the losses.

The advocates of a limited liability membership say that limiting liability of Lloyd's members would encourage Lloyd's to move from its three-year accounting system to a one-year accounting system and allow more Lloyd's syndicates to close their accounts each year.

Because of unlimited liability, underwriters keep syndicate accounts open for three years before determining profits or losses are for each year. However, Lloyd's underwriters point out that in light of pollution and asbestos losses, three years is not long enough to determine the ultimate losses or profits for one accounting year.

As a result of this uncertainty, more and more Lloyd's underwriters are keeping their accounts open and leaving the members exposed to endless losses stemming from that year.

As of Dec. 31, 1986, 90 syndicate account years were open through the 1984 account year, according to Mr. Lawrence.

To date, at least 11 Lloyd's syndicates are keeping their 1985 accounts open, and a Lloyd's spokesman predicts that as many as 60 syndicates will leave their 1985 accounts open (see story, page 26).

However, if Lloyd's limited the liability of members, many of Lloyd's current problems could be eliminated, the advocates say.

A Lloyd's member would invest a certain amount of money into a syndicate, such as 10,000 pounds or more, and would maintain deposits and personal reserves.

And, instead of investing individually in as many as 38 syndicates, as some members do now, Lloyd's members could invest in a portfolio of syndicates managed by a member's agency, said Mr. Cooper.

As a result, more members would invest because they would know that they would not lose more than their stated investment in Lloyd's.

This would increase the capital base of Lloyd's and allow syndicates to write more non-marine business, executives say.

"Should they lose their capital in Lloyd's they would be more likely to put in more capital with limited liability than the current membership with unlimited liability," Mr. Hiscox said.

"Today, there may not be a need for new capital, but there will be a time when there is a need for new capacity," said Ray Pettitt, chairman of Lloyd's brokerage Minet Holdings P.L.C.

The security of Lloyd's policy would "also be strengthened" by limiting liability because more people would invest in Lloyd's, which would strengthen its capital base, said Mr. Hiscox.

"I believe that buyers of insurance are impressed by the security of the Lloyd's policy, because Lloyd's has consistently paid claims and not because of unlimited liability," he said.

There would be a "marginal effect" on the security of Lloyd's policy, Mr. Pettitt said.

He explained that Lloyd's, which writes only 2% of the world's premium income, is the only market that writes with unlimited liability and would survive with limited liability because it already is "writing on a proper solvency basis."

In addition, Lloyd's syndicates would be able to close their accounts annually and would be less likely to keep their syndicate accounts open, the executives agree.

Even if Lloyd's retained its three-year accounting system and syndicates left accounts open, at least Lloyd's members would know their ultimate losses.

"With the U.S. litigation and liability climate at the moment, at the very minimum limited liability should be considered," Mr. Pettitt said. "There should be a study in what the problems would be. It needs a lot of thought and examination.

"But there should be no argument to say that after 300 years, it shouldn't be considered." ■

At least 11 syndicates won't close '85 accounts

By STACY SHAPIRO and CAROLYN ALDRED

LONDON—The practice of keeping open Lloyd's of London syndicate accounts is becoming "epidemic," Lloyd's executives say.

More and more syndicates are unable to close their accounts on time, primarily because of new U.S. pollution and asbestosis claims coupled with disputes between syndicates over runoff reinsurance policies.

And, the new losses will mean a significant drop in profits for Lloyd's syndicates, an analyst predicts.

The losses and disputed runoff policies will force at least 11 syndicates to keep their syndicate accounts open for 1985—the underwriting now closing under Lloyd's three-year accounting system.

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However, a Lloyd's spokesman predicts that as many as 60 of Lloyd's 400 syndicates may leave their 1985 accounts open.

At Dec. 31, 1986, 90 syndicate account years had been left open through 1984, the year which closed in 1986, said Lloyd's Chairman Murray Lawrence.

He noted that the 90 account years included syndicates that had left open more than one account year.

Because of the losses that are forcing the syndicates to keep their accounts open, independent syndicate analyst Chatset Ltd. predicts that Lloyd's profits for 1985 will fall 39% to 125 million pounds ($236.3 million at year-end 1987 exchange rates), net of profit commission that managing agencies charge members, from 205 million pounds ($297.3 million at year-end 1986 exchange rates) in 1984.

Heavy losses, particularly those suffered by syndicates managed by C.J.W. (Underwriting Agencies) Ltd. and R.H.M. Outhwaite (Underwriting Agencies) Ltd., are responsible for the lower profits, Chatset says.

Leaving a syndicate account open means that losses or profits in the year left open and from past years will be deducted from or added to the profits of Lloyd's members of the syndicate during that year.

Leaving a syndicate account open also means that the past years' assets and liabilities are not rolled over into future accounts through reinsurance-to-close premiums. Leaving a syndicate account open means that an underwriter can start a new underwriting year with a clean slate, with no past obligations to worry about.

"No one wants to keep a year open" because members do not like it, Mr. Lawrence said. Accounts are kept open only to create "equity between names" because closing an account when claims cannot be accurately estimated would not be fair to that year's syndicate members or the syndicate's members in subsequent accounting years, he explained.

"The policyholder is totally and utterly unaffected," Mr. Lawrence said. "The question is only which names will pay."

Previously, members angry over the huge losses they faced when syndicate accounts were left open have disputed the payment of claims and some have refused to pay.

In light of the problem of leaving syndicate accounts open and the subsequent concern of members facing such huge losses, several Lloyd's executives want Lloyd's to limit members' liability (see story, page 3).

The syndicates that are keeping open their 1985 accounts are:

- Syndicate 418/417, Lloyd's largest syndicate, underwritten by Stephen Merrett and managed by Merrett Underwriting Agency Management Ltd. Although the syndicate's accounts will break even, MUAM is questioning the loss estimates on 11 runoff policies that reinsure eight Lloyd's syndicates and three insurance companies for accounting years prior to 1985.

MUAM already has reserved $100 million to pay for the estimated losses, but has discovered during several audits on the contracts that the loss estimates from the ceding companies may have been too high, according to MUAM Managing Director Ken Randall. As a result, Merrett's members may receive a credit next year when the 1985 account is expected to close.

- Marine syndicate 334, managed by Pulbrook Underwriting Management Ltd., a subsidiary of Merrett. Pulbrook ceded an unlimited reinsurance policy written in 1981 to syndicate 418/417.

The policy protects the syndicate for all liabilities excess of $12 million that may arise from the 1975 and earlier accounting years.

However, MUAM is questioning whether the syndicate disclosed material information at the time the policy was placed.

Until the matter is resolved, "the only course of action is to leave the 1985 account open pending further clarification of the position from the reinsurer," said John Robson of Merrett Syndicates Ltd. in a May 12 letter.

- Syndicate 553, formerly underwritten by Cyril Warrilow and managed by C.J.W. (Underwriting Agencies) Ltd., which shut down operation last year. Losses for 1985 are estimated at 2.2 million pounds ($4 million at the current exchange rate), or about 8% of 1985's 27 million pound stamp capacity.

The agency is asking members of the syndicate for the 1984 accounting year to pay a further 22.3 million pounds ($41 million) by the end of June to help cover losses now estimated at more than 71 million pounds ($130.6 million) (*BI*, May 23). The 1,452 members were hit with a 4.5 million cash call ($8.5 million at the year-end 1987 exchange rate) last year.

- Non-marine syndicate 384 underwritten by Graham Potter, who resigned in April, and managed by Aragorn Agencies Ltd. Aragorn will ask members for about 2 million pounds ($3.7 million), or 20% of members' premium capacity, to help pay losses believed to total 40% of the syndicate's 1985 premium capacity.

The syndicate suffered severe losses on a retrocessional contract covering risks underwritten by Mr. Warrilow in 1984 (*BI*, May 2).

- Four syndicates that placed disputed runoff policies with syndicate 217/661, which is managed by Outhwaite. They are: non-marine syndicate 33, underwritten by I.N. Thomson and managed by Roberts & Hiscox Ltd.; marine syndicate 406, underwritten by Seamus Cowley and managed by Wellington Underwriting Agencies Ltd.; marine syndicate 448, underwritten by David A. Beaumont and managed by Wellington, which reached a settlement with Outhwaite concerning the runoff policies after the accounts were kept open (*BI*, May 2; April 25); and non-marine syndicate 484, underwritten by R.E. Thomson and managed by Methuen (Lloyd's Underwriting Agents) Ltd.

- Non-marine syndicate 105, underwritten by K. Theobald and managed by John Poland & Co., which is asking members to pay about 4 million pounds ($7.4 million) to help cover losses of about 9 millions pounds ($16.6 million) for the 1985 underwriting year.

- Motor syndicates 647 and 325. ■

Section 89

Continued from page 3

"It is difficult to expect employers to comply if the Treasury hasn't even released all of the guidelines," said Massachusetts Mutual Life Insurance Co. in Springfield, Mass.

"Without regulations (i.e., values, etc.) it is impossible to accurately perform the tests," said Southeast Banking Corp. in Miami.

"Without further guidance on separate lines of business, we find it difficult to determine how best to comply with the regulations," said United Technologies Corp. in Hartford, Conn.

"Compliance should not be required until the regulations are complete and final and with appropriate lead time," the company said.

Many of the 80 employers responding to the APPWP survey said it would only be fair to delay Section 89 until after the Treasury Department has published compliance rules.

"Three to six months (after publication of regulations) with nothing else on our plates," said Xerox Corp. in Stamford, Conn.

"To set up systems and compile extensive data from multiple division locations, we estimate it will take over one year," said United Technologies.

"There must be a minimum of six to eight months as a window for implementation after the regs are issued," said Stouffer Foods Corp. in Solon, Ohio.

'Without further guidance on separate lines of business, we find it difficult to determine how best to comply with the regulations,' says United Technologies Corp. in Hartford, Conn. 'Compliance should not be required until the regulations are complete and final and with appropriate lead time.'

So far, employer pleas for delaying Section 89 have fallen on unsympathetic ears at the Treasury Department.

Treasury Department staff members have pointed out that Section 89 was made part of the Tax Reform Act of 1986, and, as a result, employers have had more than two years to prepare for the law.

Those observations have angered employers responding to the APPWP survey. Employers note that their hands have been full trying to comply with the mass of other benefit laws that Congress has enacted recently, giving them little time to focus on a new section of the tax code for which the Treasury Department has yet to issue regulations.

For example, Occidental College in Los Angeles said it hasn't begun to focus on Section 89 yet because it has been waiting for Treasury Department regulations and because it has been concentrating on the Tax Reform Act's non-discrimination rules for retirement plans.

One of the major problems employers face in complying with Section 89 is that the rules enormously expand what is considered a "benefit plan."

For example, under Section 89, each benefit option—such as family or individual coverage, different deductible and coinsurance levels and different health maintenance organizations—are considered distinct plans and will have to be tested separately.

Indeed, the 80 companies said they have a total of 3,431 welfare plans. However, for purposes of Section 89, the surveyed firms estimated that they might have as many as 13,989 plans for which they will have to compile data and run the non-discrimination tests, according to the APPWP.

For example, Kraft Inc. in Glenview, Ill., estimated that it has 380 welfare-type plans under Section 89, compared with 95 plans without regard to Section 89.

In addition, Litton Industries Inc. in Beverly Hills, Calif., says it has 450 plans for Section 89 purposes and 260 plans without regard to Section 89.

Employers should use muscle to control health costs: Duva

By JERRY GEISEL

WASHINGTON—Employers have to use their buying clout to put the brakes on soaring health care costs, a benefit manager says.

"To escape the cost avalanche, we've got to take a wholly new approach to purchasing medical benefits—an approach aimed at increasing market pressure on the health care providers," said Joseph Duva, corporate director of employee benefits at Allied-Signal Inc. in Morristown, N.J.

Speaking last month before the annual Washington conference of the Assn. of Private Pension & Welfare Plans, Mr. Duva said that most company cost containment programs have fallen short because they have focused exclusively on attempting to influence employee consumers of health care.

Allied-Signal, for example, has given employees incentives to use cost-efficient health care services, such as outpatient surgery for minor procedures.

"But we soon learned that the only way to achieve meaningful cost control was to give providers themselves a reason to work for this goal," Mr. Duva said.

Allied-Signal has done just that.

It has joined forces with CIGNA Corp. to create a single, nationwide plan administered by CIGNA that guarantees to contain the company's health care costs over the next three years (*BI*, Feb. 22).

Under the arrangement, CIGNA guarantees that Allied-Signal's health care costs will not increase more than a stipulated percentage in each of the next three plans.

If Allied-Signal's health care costs increase by a greater amount, CIGNA will absorb the added cost.

Under the program, Allied-Signal employees will be enrolled in CIGNA Healthplan HMOs nationwide, though employees also can use non-network providers with significantly reduced coverage.

Allied-Signal's "Health Care Connection" managed health care network will replace more than 100 HMOs and indemnity plans the company had been offering to employees at various units.

By offering this huge volume of business to CIGNA, Allied-Signal was able to negotiate more reasonable terms in the health care marketplace, Mr. Duva said.

CIGNA, in turn, is able to share Allied-Signal's health care risk because it has contracted with a network of health care providers to provide services on a more favorable financial basis, he said.

"The new plan shields our company from dangerously ballooning costs for the three-year period. We're not looking for reductions in our health care bill, but we do expect to slow its growth enough to generate savings in the $200 million range over the next three years," Mr. Duva said.

Previously, Mr. Duva had projected that Allied-Signal's health care costs would climb 58.9% over the next three years if no changes were made. In 1987, Allied-Signal's health care costs were $355 million, or about 3% of estimated 1987 sales of $11 billion.

Mr. Duva noted that while the new Allied-Signal program provides a complete package of high-quality health care, it does have one shortcoming: In some areas of the country, providers that employees want to use have not joined the CIGNA network.

"This will take time. The only way to get the majority of providers participating in cost-effective networks is for many more organizations to demand such arrangements," Mr. Duva said.

Indeed, the momentum is building in that direction, he said.

For example, several large Milwaukee-area employers, including Allis-Chalmers Corp., the city of Milwaukee and Miller Brewing Co., have banded together to negotiate favorable rates with 13 hospitals in a four-county area (*BI*, April 4). In addition, at least 15 other companies are considering adopting Allied-Signal's approach to purchasing an insurer's provider network, Mr. Duva said.

"Companies throughout industry need to start making better use of their bargaining power—to stop watering it down by dealing with many diverse insurers and HMOs," Mr. Duva said.

"We need to make U.S. industry a customer that has to be reckoned with in the health care marketplace. If we're serious about this goal, it shouldn't take handstands to accomplish it. After all, collectively, we pay the health care insurance bill for 69% of the population," he added.

Continued on next page

APPWP draws 200

WASHINGTON—More than 200 people attended the Assn. of Private Pension & Welfare Plans' conference held May 25-26 in Washington.

The APPWP is a Washington-based benefits lobbying organization whose more than 400 members include employers, benefit consultants, attorneys, actuaries and insurers. Howard Weizmann is the organization's executive director.

For more information, contact the APPWP, 1331 Pennsylvania Ave. N.W., Suite 719, Washington, D.C. 20004; 202-737-6666.

Quayle suggests alternatives to Kennedy bill

WASHINGTON—Congress should consider alternatives to mandatory group health care coverage before taking the drastic move of requiring all employers to offer health care plans, a U.S. senator says.

Congress should launch several experimental projects to try to increase access to health care, suggested Sen. Dan Quayle, R-Ind.

"Let's try to figure out what works and what does not," said Sen. Quayle during a speech at the annual meeting of the Assn. of Private Pension & Welfare Plans last month.

The Republican senator from Indiana suggested several alternatives to mandatory employer-provided health care coverage, including:

- Expanding the Medicaid program to give workers the opportunity to buy coverage. Currently, only the very poor are eligible for Medicaid.
- Giving the self-employed the opportunity to deduct 100% of their health care costs as a business expense. Currently, the self-employed can only take a tax deduction for 25% of their health care expenses.
- Making it easier for employers in different industries to band together to self-fund their health care risks through multiple employer trusts, or METs.

The Labor Department, however, has issued a series of advisory opinions saying that it would not recognize a self-funded MET if, among other things, group members lack a common business relationship.

'Let's experiment. Let's find out what works. We have to provide incentives for the private sector to expand coverage,' Sen. Quayle told those attending the APPWP's meeting last month.

The department issued these opinions after several self-funded METs comprised of small employers in different industries collapsed in the 1970s leaving thousands of people with unpaid health care claims (*BI*, Aug. 6, 1979).

"Let's experiment. Let's find out what works. We have to provide incentives for the private sector to expand coverage," Sen. Quayle told those attending the APPWP meeting.

Sen. Quayle, who has been one of the strongest critics of legislation introduced by Sen. Edward Kennedy, D-Mass., that would require employers to offer group health care coverage, said consideration of the bill is premature.

"There is no data to see if this (federal benefit) mandate will work," he said.

Sen. Quayle dismissed as irrelevant the fact that universal health care coverage now exists in most European countries.

"Why should we start to copy Europe?" he asked, noting that European countries tend to have much higher unemployment rates than the United States.

Sen. Quayle, though, said employers will help to decide the outcome of the battle in Congress over mandated benefits.

"The battle over mandated benefits is much more in your hands than mine. Public officials respond to pressure. Congress will be influenced by what it hears from employers and others," he said.

—By Jerry Geisel

Allied-Signal cost control

Continued from previous page

Employers shouldn't expect health care providers—without pressure from employers—to lead the charge for health care cost containment.

"We hear talk about cost control from doctors and hospitals—but let's face it: We're not likely to get real help from that quarter. So we've got to help ourselves," Mr. Duva said.

Mr. Duva does not believe surging health care costs are the result of new problems, such as the increased use of expensive medical technology, the growing numbers of older people or the spread of acquired immune deficiency syndrome.

Instead, the key problem of health care inflation is a familiar one: "Medical providers have such a marketplace advantage over consumers that they can virtually dictate what services are delivered at what price," Mr. Duva said.

In some areas of the country where there is a surplus of doctors and hospitals it's possible to negotiate lower rates, he noted.

"But, unfortunately, most companies purchasing health care still aren't cost-conscious buyers and those who are haven't taken the steps to use their bargaining power effectively," Mr. Duva said.

The result: Health care providers aren't offering more financial arrangements, while those that do often recover those discount arrangements by increasing services and charges for other consumers, he said.

For example, after Medicare in 1983 began to set fixed fees it would pay hospitals based on patient diagnosis, a factor that has led to shorter hospital stays, hospitals made up the lost funds by raising charges for private patients, Mr. Duva said.

At the same time hospitals and doctors have increased their volume of services delivered on an outpatient basis because there are fewer controls on those kinds of services, he said.

Health care providers will join in the cost containment movement only if they are prodded by buyers using their purchasing clout more effectively.

"Then we will be able to bring health care cost inflation more in line with that for products and services in other sectors," Mr. Duva concluded. ■

Insurers' first-quarter results

Continued from page 1

in underwriting profits for the corresponding period.

Multiline insurers' bottom lines were further depressed by continuing group health insurance losses.

Including other operations, the insurers surveyed by *BI* reported that aftertax operating income declined by 7.4% in the first quarter to $1.7 billion from $1.9 billion. This compares with a 37.6% increase in aftertax operating earnings in all of 1987 and a 72.3% increase in last year's first quarter (see chart).

Overall, the U.S. property/casualty industry's aftertax net income fell 15.4% to $3.3 billion in the first quarter of this year from $3.9 billion in the first quarter of 1987, according to the Insurance Services Office Inc. and the National Assn. of Independent Insurers.

Some observers say the property/casualty insurance market softened more than they thought it would during the first quarter and at least one predicts that competition will heat up as the year unfolds.

"There was evidence of a more competitive underwriting cycle than we expected," commented John Snyder, an analyst with Smith Barney Harris Upham & Co. in New York. However, "We still are not concerned that there is going to be all that bloodshed in the underwriting cycle."

The underwriting trends "were worse than we had hoped," said David Seifer, vp with the First Boston Corp. in New York. "It's a negative set of trends."

'There was evidence of a more competitive underwriting cycle than we expected,' says Smith Barney's Mr. Snyder. 'We still are not concerned that there is going to be all that bloodshed.'

"You've certainly seen a deceleration in momentum in commercial lines results," said Udayan D. Ghose, an analyst with Shearson Lehman Hutton Inc. in New York.

"There's really only handful of companies that showed strong earnings growth in the quarter," Mr. Ghose said, referring specifically to American International Group Inc., Chubb Corp. and General Re Corp., which reported operating income increases of 31.3%, 28.5% and 17.4% respectively.

Others' results, Mr. Ghose said, were "much more lackluster."

"I think that competition is worse than company managements are willing to admit," said Jeffrey Cohen, senior analyst with Goldman Sachs & Co. in New York.

"More of the same" is in store for the rest of the year, with prices continuing to remain under pressure, according to Mr. Cohen. "I certainly don't see a turn up in the cycle in '88."

"I think it will get progressively worse as the year goes on," agreed Myron M. Picoult, senior vp and senior insurance analyst with Oppenheimer & Co. in New York.

Among other results posted in the first quarter by the 27 insurers surveyed by *Business Insurance*:

- With price competition intensifying, net premiums written increased a mere 2.2% to $2.2 billion, less than a third of the 7.6% premium boost reported for all of 1987.

Premium growth among individual companies varied widely, with Reliance Insurance Co. and its subsidiaries posting a 19.3% increase in premium growth and Fireman's Fund Corp. posting a 19.1% decline.

- Investment income increased 11.2% to $2.8 billion.

This compares with a 12.3% increase in all of 1987.

- The aggregate combined ratio stood at 105.8% for the first quarter, a slight deterioration from both the 105.3% combined ratio reported for first quarter of 1987 and the 105.1% combined ratio reported for all of 1987.
- Policyholder surplus for the 21 insurers reporting the data for the first quarters of both 1988 and 1987 increased 4.4% to $26.5 billion from $25.4 billion. Policyholder surplus had increased 8.5% in 1987.

Continued on next page

Summary of major property/casualty insurers' first-quarter results

(All amounts in thousands of dollars)

(Ranked by change in aftertax operating income)

		Corporate			Property/casualty operations									
Rank 1988		Consolidated revenues 1988	Aftertax[1] operating income 1988	Percent increase (decline) 1987-1988	Combined[1] ratio 1988	Combined[1] ratio 1987	Net premiums written 1988	Percent increase (decrease) 1987-1988	Pretax underwriting income (loss) 1988	Percent increase (decline) 1987-1988	Pretax investment income 1988	Percent increase (decrease) 1987-1988	Policyholders surplus 1988	Percent increase (decrease) 1987-1988
1	CIGNA Corp.	4,252,700	51,300	55.0	106.5	108.0	1,545,000	4.9	(93,100)	16.4	196,100	2.9	2,040,000	10.7
2	Fremont Insurance Group	77,778	6,001	37.7	106.5	105.3	68,151	3.6	(4,326)	(31.4)	11,074	33.4	112,810	13.7
3	American International Group	3,223,000	272,425	31.3	99.5[2]	100.6[2]	2,120,647	11.9	18,071	182.1	198,003	28.5	N/A	N/A
4	CNA Financial Corp.	1,929,000	103,900	30.5	106.0[2]	112.3[2]	1,299,000[2]	8.8	(101,000)[2]	38.0	203,300	14.3	2,144,000	12.4
5	Chubb Corp.	969,100	101,100	28.5	96.0	97.9	674,300	5.5	26,800	125.2	85,300	36.0	1,300,000	18.2
6	The St. Paul Cos. Inc.	847,701	83,312	18.9	103.7[2]	106.8[2]	648,262	(0.4)	(25,150)	37.7	130,058	8.8	1,284,609	18.4
7	Crum & Forster Inc.	1,074,700	91,400	18.5	108.4	108.2	820,500	5.9	(65,600)	12.2	131,000	9.7	1,249,800	(2.1)
8	General Re Corp.	843,390	131,450	17.4	99.0[2]	100.9[2]	512,400	(14.3)	(3,083)	23.6	129,248	14.1	2,064,975	(1.5)
9	Hartford Steam Boiler	107,417	14,445	10.5	84.1	85.3	70,640	0.2	11,384	10.7	8,185	9.3	231,287	5.0
10	Hartford Insurance Group	2,553,635	73,529	6.1	104.5	103.6	1,634,957	0.6	(79,946)	(0.6)	174,917	18.0	2,618,324	16.3
11	SAFECO Corp.	695,458	55,612	2.7	99.3	98.8	374,130	5.8	2,424	(40.8)	51,450	23.1	762,969	4.9
12	Reliance Ins. Co. & subs.	875,205	37,979	2.4	100.1[2]	104.0[2]	427,201	19.3	(5,945)	63.0	48,765	3.9	N/A	N/A
13	Continental Corp.	1,374,500	82,000	(3.5)	103.7[2]	102.1[2]	1,184,900[2]	(1.8)	(49,900)	(132.1)	139,900	8.3	1,602,300	N/A
14	Kemper Corp.	1,003,416	53,760	(3.6)	103.7[2]	98.6[2]	202,050	3.3	(9,394)	(223.4)	20,590	9.4	473,587	18.1
15	Old Republic Int'l (incl. life)[3]	250,100	21,400	(7.0)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
16	Ohio Casualty Corp.	391,815	23,579	(9.3)	104.1[2]	100.5[2]	336,262[2]	(4.8)	(18,216)	(358.1)	42,655	14.6	452,741	(13.0)
17	Travelers Corp.	6,108,000	90,200	(17.1)	105.3	103.0	1,369,500	(1.4)	(66,000)	(58.3)	149,800	13.7	1,822,000	1.9
18	The Home Group Inc.	674,000	24,900	(20.7)	106.0[2]	109.9[2]	556,100	3.4	(42,600)	26.9	85,300	(14.2)	769,200	(8.2)
19	American General Corp.	1,891,000	113,000	(23.6)	107.1[2]	104.2[2]	462,000	18.4	(30,000)	(172.7)	44,000	7.3	893,000	(7.2)
20	USF&G Corp.	1,321,989	71,902	(24.2)	106.2[2]	104.5[2]	881,317[2]	(6.0)	(58,635)	(93.7)	156,020	6.4	1,311,800	(1.3)
21	Aetna Life & Casualty Co.	5,969,600	127,500	(29.9)	111.8	108.7	1,611,700	-	(186,600)	(46.4)	217,100	11.0	2,139,174	8.2
22	Royal Group (U.S. subs.)[2]	N/A	19,900	(42.8)	109.7	101.6	539,600	0.7	(37,300)	(6,116.7)	70,200	3.7	N/A	N/A
23	Fireman's Fund Ins. Cos.	956,622	75,629	(48.7)	107.5	107.7	772,488	(19.1)	(59,741)	12.8	115,731	3.2	1,376,471	(13.9)
24	Sentry Insurance Cos.[2]	321,988	1,141	(90.7)	107.4	103.6	297,499	5.4	(28,683)	(79.1)	31,622	8.8	489,702	22.2
—	Nationwide Mutual Ins. Co.[2]	N/A	N/A	N/A	106.2	104.8	1,426,557	1.7	(75,746)	(48.5)	151,425	10.6	2,455,168	2.3
—	Commercial Union Ins. (U.S.)[2]	N/A	N/A	N/A	106.8[3]	107.9[3]	318,700	11.6	(30,200)	5.9	37,200	(5.0)	529,400	2.9
—	Liberty Mutual Ins. Co.[2]	N/A	N/A	N/A	116.0	111.7	1,862,696	3.9	(212,092)	(31.4)	216,969	18.0	N/A	N/A
	Cumulative	37,712,114	1,727,364	(7.4)	105.8	105.3	22,016,557	2.2	(1,224,578)	(9.7)	2,845,912	11.2	26,521,017	4.4

[1] After dividends. [2] Statutory. [3] Before dividends. N/A—Company did not provide data

Continued from previous page

Tax reform is influencing many insurers' investment portfolios.

Since insurers now are subject to the alternative minimum tax, some are switching to higher-yielding taxable investments from tax-exempts since they must pay some tax, even if they have no "taxable" income.

"To avoid being penalized by the AMT, a lot of companies need to generate taxable income," said Shearson's Mr. Ghose.

"Companies are putting more into taxables at this point than they ordinarily would be," said Brown Bros.' Mr. Luce.

"There's more of a tendency towards taxables than tax-exempts," agreed David P. Wells, an insurance analyst with Merrill Lynch Pierce Fenner & Smith Inc. in New York.

Insurers also are seeking flexibility in their investment portfolios.

"I think they want to become more liquid so in case they want to go from tax-exempts or taxables they can do so more easily," said First Boston's Mr. Seifer.

"Everyone's going more short-term and, in fact, lots of companies are sitting on cash right now," according to Gloria Vogel, associate director at Bear, Stearns & Co. in New York.

"Because of the change in the tax law they've got to be more flexible," said Goldman's Mr. Cohen.

The October stock market crash has also had an impact on companies' investment strategy.

"A lot of companies are a lot more cautious about their equity investments in light of the stock market crash," said Mr. Ghose.

"People are just too scared of the stock market," agreed Joanne Morrissey, a principal with Firemark in Morristown, N.J.

"We're still very cautious on the equity portfolio, and we continue to hedge that portfolio," said the USF&G spokesman. About $2 billion of the company's $8.5 billion portfolio is now in equities.

The tax law is expected to have consequences for the property/casualty market far beyond affecting investment strategy.

"I think we're going to see a lot of changes taking place" to lessen the impact of the tax act, noted Robert Branche, a principal at Branche Insurance Research Group in Morrisville, Pa.

Since the tax law increases insurers' tax liability, it will have a negative impact on cash flow, said Ms. Vogel.

The tax law also will require insurers to produce a larger underwriting profit to achieve the same bottom-line results, she said.

"I think in order for companies to have satisfactory underwriting results going forward, prices will have to be increased to reflect the taxes the industry now has to pay," said the CIGNA spokesman, adding: "It's part of the cost structure."

While tax reform's impact on insurers has not been very noticeable so far, "It's going to mean a major increase in our income tax bill over the years," said Bernard C. Hlavac, vp and treasurer at Sentry Insurance Cos., adding that Sentry is trying to layer in additional price adjustments "to reflect the increase in income taxes we're going to be paying."

Another factor that could influence insurers' 1988 results is the weather. The U.S. property/casualty industry reported an unusually low level of natural catastrophe losses last year.

"We just haven't had any catastrophes," said Firemark's Ms. Morrissey. "Once it gets back to a normal incidence of catastrophe losses, it's going to have a major impact on the bottom line."

"In general, weather is going to be less helpful," said First Boston's Mr. Seifer. "I would think that catastrophes and weather-related losses have to trend higher for the industry."

Stock buyback programs introduced last year generally will continue, most analysts predict.

"I think it's a great opportunity for most companies that are overcapitalized to reduce their capital base and enhance their returns," said Smith Barney's Mr. Snyder.

Insurers buying back their stock have made the judgment that their own stock is worth more than that of other companies, said Ms. Vogel, adding she considers these programs a plus because otherwise "they would be using that capital to chase after market share."

"It doesn't make sense for someone else to buy them," commented Firemark's Ms. Morrissey.

"I think the (buyback programs) that are in place will probably continue. The market has been so dull in these stocks," said Mr. Branche. Insurers that should continue to buy back their stock include those whose stock is selling below book value, he said.

However, he pointed out that some insurers introduce buyback programs merely to prop up the price of their stock but without any economic justification. "I don't know if they should continue," he said.

While SAFECO, Continental Corp. and Fireman's Fund have introduced "very significant" stock buyback programs that will continue, most insurers' buyback programs are only "token efforts" that account for no more than 5% of the company's stock, commented Shearson's Mr. Ghose (*BI*, Oct. 26, 1987; Aug. 31, 1987).

Analysts disagree over how serious the issue of unrecoverable reinsurance is, with some believing the problem has largely been contained, particularly among the larger, well-managed insurers.

"For the major players, reinsurance recoverables are a problem that's been around long enough. At this point I think it's no longer a material item," said Mr. Snyder.

Mr. Luce said that while unrecoverable reinsurance may be a problem for smaller insurers, but for the larger insurers whose results he follows, "I don't think it's a major problem at all."

Others, however, believe unrecoverable reinsurance remains a major industry issue.

"I don't think the reinsurance recoverable problem has gone away at all. I think it's still looming out there," said Mr. Branche.

"There's still a lot of uncollectible reinsurance out there," said Ms. Morrissey.

Most analysts, however, believe loss reserves are relatively adequate.

"If they can just maintain their present level of reserving, it would be a good sign" in light of the softening market, said Mr. Snyder.

"I'm more comfortable with the reserves than I've been for a long time," said Firemark's Ms. Morrissey.

Toxic tort and environmental claims, however, remain potential problems.

"I think we're going to see a lot more claims coming down the road," said Shearson's Mr. Ghose, referring to these two areas.

"I'm not sure we'll see additional reserves slow down by as much as people expect because certain companies have to reserve for environmental hazards," Mr. Ghose said.

Mr. Cohen believes the insurance industry is still underreserved for losses, but in light of the softening market, reserves are "probably in as good a shape as they're going to get this cycle."

Insurers have added significantly to reserves for claims prior to the mid-1970s and also have strengthened reserves substantially for the "bad" years of the down cycle, particularly 1982-85, he said. But, "Our analysis suggests the industry is still underreserved," Mr. Cohen added.

"It's a meaningful amount," he added.

Meanwhile, group health insurance losses could worsen for multiline insurers, predicted First Boston's Mr. Seifer (*BI*, March 21). "In '89, we would hope it would get better, but not dramatically so," he said, adding, "We're very nervous."

"There are some signs things should be getting better," said Mr. Cohen. "I'm concerned the recovery may not be as sharp as people are hoping."

Ms. Vogel was more optimistic, noting that group health insurance rates have improved dramatically. "It's only a question of time before it begins to be reflected."

Insurers also believe that group health insurance results should improve next year.

"We, like everyone else in the industry, were chasing medical cost inflation," said the spokesman from CIGNA, whose employee life and health benefits segment posted a $55.7 million operating loss for the first quarter of 1988 compared with $14.2 million in operating income for 1987's first quarter.

But while results in this segment this year are expected to continue to be worse than last year's, results in 1989 "have a fighting chance to be good," the spokesman said. ■

California insurance reform

Continued from page 3

hikes largely to a 29% statewide surge in lawsuits involving auto accidents during 1986, responded with a no-fault auto insurance petition of its own. Dubbed "No-Fault Two," the initiative would cut auto insurance premiums an average of 20% under a new no-fault system.

The insurers' initiative, which was bolstered with an $8.5 million lobbying budget, was delivered to county recorders' offices throughout the state late last month with approximately 700,000 signatures—far more than the 341,000 needed to place the issue on the Nov. 7 general election ballot.

A separate insurer-sponsored initiative that would limit attorneys fees in auto cases also was filed last week with about 560,000 signatures. It would limit fees to 25% of the first $50,000 of an award, 15% of the next $50,000, and 10% of amounts more than $100,000.

The trial lawyers' association, which dropped its own Good Driver Rate Reduction Initiative several months ago (*BI,* April 18), has thrown its support behind a similar measure presented by the Insurance Consumers Action Network.

While the trial lawyers' initiative would have cut premiums 25% for "good drivers" on Oct. 31, 1988, the ICAN initiative would mandate a minimum 20% discount for drivers with good records and roll back rates to 20% below January 1988 levels. It also would require prior approval for rate changes that exceed 7.5% for personal lines and 15% for commercial lines.

The initiative also calls for repeal of insurance company exemptions from state antitrust laws and would allow banks to underwrite insurance.

The ICAN initiative received about 680,000 signatures and has generated broad support from attorneys, consumer groups, labor organizations and bankers, Mr. Glennon said.

Other initiatives for which petitions have been filed with the state include:

- An initiative sponsored by state Assemblyman Richard Polanco, D-Los Angeles, that would cut auto bodily injury insurance rates in half and limit rate increases to annual increases in the Consumer Price Index, which received 715,000 signatures.
- A sweeping proposal called Voters Revolt to Cut Insurance Rates presented by Santa Monica-based Access to Justice, which was filed May 18 with 525,000 signatures.

The initiative calls for rolling back all property/casualty insurance rates in the state for one year to 20% below November 1987 levels unless an insurer can prove serious financial hardship. After the rollback, insurers would be subject to a modified prior approval rating system.

Support for the Access to Justice initiative was boosted by a recent California appearance by consumer advocate Ralph Nader, said Harvey Rosenfield, executive director of the group.

Two other initiatives that were proposed earlier this year failed to gain enough support to be circulated for signatures to put them on the ballot:

- The Consumers Union Initiative, which would have removed insurers' antitrust exemptions and created a state-administered automobile liability insurance program financed by fees collected with vehicle registrations.
- The Burton initiative, sponsored by Los Angeles resident Adam Burton, which would have given the Insurance Department authority to regulate auto insurance rates. It also would have rolled back auto rates to July 1987 levels and prohibited insurers from charging rates based on where policyholders live.

Mr. Burton also had proposed that the insurance commissioner be elected and that insurers be subject to state antitrust laws.

Launch insurance

Continued from page 3

which will show that "damages in space are relatively minor," said Mr. Stadd. The analysis, which has never before been conducted by the government or underwriters, will show that there have never been any third-party claims from commercial space launches.

The analysis "gives us comfort that the probable maximum loss is well within $500 million for third parties and $100 million for government damage," he said.

Meanwhile, the Senate Commerce, Science and Transportation Committee is examining the availability and cost of liability insurance for commercial space launch companies. The conclusions, expected this month, could affect the Senate committee's decision on the bill, according to Mr. Stadd.

Commercial space launch companies are new ventures created after the shuttle Challenger exploded on Jan. 28, 1986, killing all seven astronauts on board. Seven months after the tragedy, the president announced that the National Aeronautics and Space Administration would no longer provide launch services for commercial satellite customers. According to Senate testimony, President Reagan's decision left stranded 44 commercial satellites.

Several U.S. companies responded to this problem by moving into the private-sector launch market, including McDonnell Douglas Astronautics Co. of Huntington Beach, Calif., which builds Thor Delta rockets, and Martin Marietta Commercial Inc. of Denver, which builds Titan rockets.

Both companies hope to launch satellites on a commercial basis by 1989 (*BI,* Dec. 14, 1987).

At a Senate Commerce, Science & Transportation Committee subcommittee hearing May 17, commercial launch industry representatives said that without a liability cap and indemnification from the government, the costs of insurance and potential losses would be too high and might force them out of business.

"Faced with the requirement to compete in an international market where our competitors received substantial direct and indirect support from their governments, U.S. commercial launch contractors, such as McDonnell Douglas, may be forced out of the commercial space transportation market," said John Yardley, president of McDonnell Douglas Astronautics.

"If such legislation is not enacted, we may be forced to reassess our decision to expand our business in this market," said Roger Chamberlain, a vp with Martin Marietta.

Sen. Wirth warned when he introduced the legislation that without indemnification, the commercial launch companies will lose business to launch programs in other nations, whose governments have agreed to pay third-party and government damage claims.

That would mean losing an $800 million annual contribution to the U.S. balance of payments, he said. It also could mean the loss of 8,000 new jobs that the commercial launch industry will provide, he added.

"Our domestic ELV (expendable launch vehicle) manufacturers must be able to compete successfully with the growing number of overseas competitors," said Sen. Wirth.

Commercial launch companies will find it difficult to 'entice casualty underwriters to enter this business with any degree of enthusiasm,' says Donald Kenney of A&A.

"By providing indemnification for losses above this reasonable insurance limit, we can help make both the providers of launch services and the payload manufacturers more competitive, guarantee the continued growth and development of this essential industry, and strengthen our national security by insuring a continued U.S. access to space," he said.

In addition, insurers are reluctant to assume the risk of an industry that could destroy years of underwriting profits with one accident, as well as an industry that could go bankrupt because there was not enough insurance to cover the losses.

In a prepared statement, Donald Kenny, vp with broker Alexander & Alexander Inc. in New York, told the Senate committee that insurers "need to know that there will be a future commercial space industry."

"Even with the cap in the legislation, underwriters might stand to lose as much as $500 million for each loss. It would take them over 16 years to have sufficient premium to pay for any one loss," the statement said.

Mr. Kenny said that commercial launch companies will find it "extremely difficult, if not impossible, to entice casualty underwriters to enter this business with any degree of enthusiasm."

However, government officials are balking at the thought of indemnifying the new launch industry for any risks despite the fact that NASA had offered this kind of indemnification to satellite launch manufacturers before the 1986 Challenger explosion.

"We believe that the most effective way to (promote the U.S. commercial launch industry) is through policy initiatives that will allow the commercial motive to predominate," Mr. Stadd told the Senate committee.

"Companies have been able to sign contracts. It is not apparent that the absence of this indemnification is a show stopper," he said.

Furthermore, Mr. Stadd pointed out that the DOT has regulatory authority over the hazardous shipping and aviation industries, both of which operate without a government indemnification program.

"The government should not expose the U.S. Treasury to claims," Mr. Stadd said.

Edward Frankle, deputy general counsel for NASA, added: "I have not seen it demonstrated that (indemnification) is what needs to be done,"

One senator pointed out that supporters of the bill have to convince Congress of the need for the law.

"I think two things have to be established if this legislation is to become law," said Sen. John Danforth, R-Mo. "One is that but for governmental indemnification, the industry will not be able to compete. (Also), it has to be established that indemnification is not a slippery slope that is going to be applied to a whole variety of industries." ■

New regulators appointed in two states

New insurance regulators have been named by governors in two states, while a state insurance commission re-elected a veteran regulator in a third state.

- Susan Gallinger is Arizona's new director of insurance. Ms. Gallinger, who served as deputy director for the department in 1986-87, was previously an attorney with the firm of Jones, Skelton & Hochuli in Phoenix, Ariz. Her six-year term expires in January 1994.

Ms. Gallinger replaces Vern Pierson, who will remain with the department as acting deputy director during a transition period.

- Fabian Chavez Jr. was recently named superintendent of insurance for New Mexico. Mr. Chavez previously served as a federal tourism official and the New Mexico secretary of economic development and tourism. He is a former state senator and representative.

Mr. Chavez replaces Vicente Jasso, who retired.

- The South Carolina Insurance Commission recently re-elected John G. Richards to a four-year term, which begins July 10. Mr. Richards was first selected for the post in March 1985.

—By Meg Fletcher

Missouri guaranty fund

JEFFERSON CITY, Mo.—The Missouri General Assembly passed an insurance-industry supported bill that would establish a life and health insurance guaranty fund and set mandatory continuing education requirements for insurance agents.

The bill, S.B. 430, would establish a life and health guaranty fund effective Aug. 13, said Calvin Call, associate executive director of the Life Insurance Assn. of Missouri. The association worked closely with the Missouri Division of Insurance in drafting the bill.

Under S.B. 430, the fund would assess insurers operating in the state for funds to pay claims against an insolvent company, said Mr. Call. However, the mechanism would be divided into life, health and annuity sections, so that if a life insurer became insolvent, only companies writing life insurance in the state would be assessed.

Gov. John D. Ashcroft, who is expected to sign the bill, has until June 29 to take action.

If approved, the proposed guaranty fund, like the state's existing FAIR—Fair Access to Insurance Requirements—and its property/casualty guaranty fund, would be administered by the Insurance Department unit a board is appointed to administer the fund, said a spokesman.

In addition, the bill would establish continuing education requirements for agents, effective in 1990.

Those licensed to sell only life/health or property/casualty insurance would be required to take 15 hours of class work every three years, while producers with multiline licenses would have to take 24 hours of courses every three years.

—By Laura Mazzuca

Around the states

Iowa malpractice fund

DES MOINES, Iowa—A proposal that would have created a state medical malpractice insurance fund was vetoed by Gov. Terry Branstad for "philosophical reasons."

The governor rejected the bill last month primarily because it did not limit the size of malpractice awards, a spokesman for the governor said.

"The governor believes the passage of that proposal would have weakened tort reform," the spokesman said.

The fund, which would have covered claims between $500,000 and $5 million, would have been financed through a 1% surcharge on all hospital bills and on medical malpractice insurance premiums paid to commercial insurers by doctors and hospitals (*BI,* May 16).

The surcharge would have raised $7 million from hospital consumers, which the spokesman said the governor regarded as "fiscally unwise."

The governor had pointed out that if the fund ran dry, the state would have to tap general revenues to cover claims.

The governor also cited five of 10 states with malpractice funds that are "actuarially insolvent." The problem with the five troubled state funds is that they also lack a cap on damage awards, he added.

Regarding a possible reintroduction of the proposal in next year's session, the spokesman said, "We will be working with the legislature discussing the governor's recommendation of a $250,000 cap on non-economic injuries."

—By Brigitte Maxey

Hawaii's captive law

HONOLULU—The Hawaii Legislature has passed a package of revisions to the state's captive law in April.

Gov. John Waihee is expected to sign the law.

"We think we have a fairly competent set of laws for anyone interested in doing business in Hawaii," said Robin Campaniano, Hawaii's insurance commissioner.

The revisions establish a premium tax of 0.25% for single-parent captives and a 1% premium tax for group captives and risk retention groups. Under the previous law, captives were required to pay the same premium taxes as commercial insurers.

In addition to the premium tax provision, under the revised law:

- Captives can write only parent-company risks.
- The assumption and cession of reinsurance by captives is subject to approval by the insurance commissioner.
- Captive insurers may write credit life and credit disability insurance related to loans or other credit transactions between parent companies and affiliates.
- For regulatory purposes, risk retention groups will be treated the same as association captives.

—By Glenn Huntley

ACIC arbitrations

Continued from page 2

book included:

- Unione Italiana Reinsurance Co. of America Inc. of New York.
- Arion Insurance Co. Ltd. of Bermuda.
- Bluewater Insurance Ltd. of Bermuda.
- Chiyoda Fire & Marine Insurance Co. Ltd. of Tokyo.
- Crum & Forster Insurance Co. (Bermuda) Ltd.
- Dowa Fire & Marine Insurance Co. Ltd. of Tokyo.
- Employers Insurance of Wausau of Wausau, Wis.
- First Horizon Insurance Co. of Minneapolis, now known as Cargill Reinsurance Co.
- Imperial Casualty & Indemnity Co. of Omaha, Neb.
- Nippon Fire & Marine Insurance Co. Ltd. of Tokyo.
- Paladin Reinsurance Corp. of New York.
- Republic Western Insurance Co. of Phoenix, Ariz.
- River Plate Reinsurance Co. Ltd. of Bermuda, which is now in liquidation (*BI*, March 14).
- Universal Marine Insurance Co. Ltd. of Bermuda, which was placed in liquidation in April (*BI*, April 18).

All of the above reinsurers, with the exceptions of Unione and River Plate, were represented by the law firm of Kroll & Tract in New York City.

Unione accounted for between $24 million and $32 million of reinsurance recoverables on The Underwriters book, including incurred-but-not-reported loss reserves, while the other reinsurers demanding arbitration on the MGA's business were estimated in court papers to account for as much as $40 million in recoverables.

Actual paid losses owed to ACIC amount to far less, however. Court papers show that 10 of the reinsurers represented by Kroll & Tract paid roughly $3 million —representing paid losses and loss adjustment expenses due to ACIC as of June 30, 1987—into escrow accounts in February, pending the outcome of the arbitrations.

Arbitration hearings for five of the reinsurers represented by Kroll & Tract are scheduled to begin June 13.

The rest of Kroll & Tract's clients have either settled their disputes with ACIC or have been ordered by arbitrators to make payments to the ceding company, Mr. Brandes reported.

Before arbitration hearings got underway, Unione agreed in April to pay ACIC $15.3 million to settle all claims arising from The Underwriters book.

The payment was part of a global settlement of all business between Unione and ACIC, according to John Nonna, a lawyer with the New York firm of Werner, Kennedy & French, which represented Unione.

The net amount of Unione's settlement—including loss payments on The Underwriters business and amounts owed to Unione by ACIC —was $14.9 million, said Mr. Nonna.

The Underwriters book consisted mainly of reinsurance, including the AEGIS business, and high-excess casualty insurance business.

In addition:

- First Horizon and Crum & Forster last June agreed to commute their obligations to ACIC, according to Mr. Brandes, who would not disclose the amount of the commutation payments, citing confidentiality agreements.
- Chiyoda, Dowa and Nippon have agreed to withdraw their arbitration demands and bring balances due to ACIC current. ACIC may discuss commutations with the Japanese reinsurers in the future, Mr. Brandes said.
- Paladin has also withdrawn its arbitration demand and brought its balances current, though the reinsurer has said it does not want to commute its participations, according to Mr. Brandes.
- ACIC won a judgment of $425,000 against Universal Marine, which it will try to collect through the reinsurer's liquidator.
- River Plate lost its arbitration against ACIC in February 1987 and was ordered to pay $48,799 in paid losses and interest and post a $120,644 letter of credit (*BI*, Aug. 31, 1987).

Mr. Kerstein said that ACIC received payments from River Plate before it entered liquidation, though he would not say how much ACIC received.

Elliott M. Kroll, a partner with Kroll & Tract, refused to confirm any of the judgments and settlements or discuss details of the upcoming arbitrations, saying he did not want to try his cases in the press.

The five reinsurers represented by Kroll & Tract still pursuing arbitrations are Arion, Bluewater, Employers of Wausau, Imperial Casualty and Republic Western, according to Mr. Brandes.

Together, these reinsurers represent roughly $7.1 million in recoverables for ACIC, including paid and outstanding losses and IBNR losses, with Employers of Wausau and Imperial Casualty accounting for the largest amounts recoverable, Mr. Brandes said.

The arbitrations were triggered by ACIC's own lawsuit against The Underwriters and others involved in the AEGIS program. That lawsuit, still in discovery proceedings, charges that the MGA and others conspired to bind ACIC to portions of the AEGIS risk without the insurer's knowledge and to divert AEGIS premiums by raking off excessive brokerage commissions and by placing ACIC's own retrocessions with reinsurers the defendants controlled.

ACIC's Mr. Kerstein said the five reinsurers still pursuing arbitration are seeking recission of their treaty participations on several grounds, including that ACIC:

- Was fraudulently induced to accept portions of the AEGIS risk by The Underwriters, which submitted false loss information.
- Improperly accepted and ceded risks through The Underwriters that were prohibited under the treaties.
- Concealed the fact that The Underwriters was writing risks that were beyond the scope of its MGA agreement.
- Accepted business at less than market rates, failed to collect and pay premiums and failed to cancel policies for which premium was not received.

However, in its arbitration with the five reinsurers, ACIC notes that it participated on three layers of the AEGIS program: It reinsured 100% of a first layer of $1.5 million excess of $1 million and acted as a retrocessionaire of Swiss Reinsurance Co. on portions of a second layer of $2.5 million excess of $2.5 million and a third layer of $5 million excess of $5 million.

None of the five reinsurers in the arbitrations assumed any of the first- or second-layer AEGIS business, Mr. Brandes said. Four of the five had small participations on the third layer, and Bluewater assumed no AEGIS-related risks at all, he said.

ACIC—which alleges in its lawsuit against The Underwriters that it was fraudulently induced to reinsure the first AEGIS layer—has never argued that it was similarly induced to write the second- and third-layer retrocessions, he said.

In addition, only two paid losses for the policy years in question had penetrated the third layer as of April 1, with three other losses reserved for, Mr. Brandes said.

Mr. Brandes also denied that ACIC lost control of The Underwriters, maintaining that ACIC supervised its MGA on a daily basis to the point where The Underwriters' Mr. Kraeutler accused the insurer of "harassment."

ACIC's reinsurers also received all the premium due them under the treaty agreements regardless of whether ACIC itself received premiums due from The Underwriters, Mr. Brandes said.

While arbitration hearings with the five reinsurers go forward, ACIC is also facing two separate arbitrations with Commonwealth over its refusal to pay losses arising from business produced by The Underwriters and another MGA, Barrett Treaty Corp. of Huntington, N.Y.

The Barrett book of business included a large volume of excess-of-loss reinsurance.

No date has been set for arbitration relating to The Underwriters business. Arbitrators have been chosen for the Barrett arbitration —which involves the larger amount of losses—and oral arguments are scheduled for mid-July, Mr. Brandes said.

Meanwhile, ACIC has demanded arbitration with Kansa General Insurance Co. Ltd. of Finland, which reinsured ACIC on the Barrett book and retroceded the bulk of the business to Commonwealth through Commonwealth's Bermuda-based MGA, Fordingbridge International Underwriters Ltd.

Kansa owes ACIC about $3 million on paid and some outstanding losses, a figure that could balloon to about $13 million if IBNR losses is included, according to Mr. Kerstein.

After ACIC demanded arbitration, Kansa earlier this year filed a lawsuit in Bermuda Supreme Court against ACIC, Commonwealth and Fordingbridge, seeking recission of the reinsurance agreement, according to Mr. Brandes.

ACIC last week filed a motion to stay the Bermuda litigation pending arbitration between ACIC and Kansa, Mr. Brandes said.

Separately, ACIC won another arbitration in April with CNA Reinsurance Co. of London Ltd., which was denied recission of its quota-share participation on the Barrett book. ■

Florida benefit trust

Continued from page 2

said. The suits charge, in part, that the Longwood, Fla.-based company mismanaged the fund.

A suit filed by the association in February in Leon County Circuit Court seeks $25 million in compensatory damages and $100 million in punitive damages from Hill, Richards and other defendants. Charges in the suit include breach of contract, negligence, theft of proprietary information and violation of the Florida Racketeer Influenced and Corrupt Organization Act.

A class-action suit on behalf of the trust and other plaintiffs, including policyholders, was filed in May in U.S. District Court in Orlando. That suit—which seeks an unspecified amount of damages from Hill, Richards and the other defendants—contains allegations similar to those in the suit filed in state court.

Hill, Richards, in turn, has sued the business association, charging AIF interfered with business relationships. That suit seeks $10 million.

Officials at Hill, Richards could not be reached.

Florida requires vendors like Hill, Richards to purchase errors and omissions coverage with limits equal to 10% of the value of funds handled by the company and a fidelity bond with the same limits. ■

Update

Westinghouse appeals ruling

TRENTON, N.J.—Westinghouse Electric Corp. and Thermo King Corp. are appealing a state court ruling breaking up their massive coverage litigation against more than 140 insurers.

Union County Superior Court Judge Lawrence Weiss in March dismissed all parts of the litigation not involving New Jersey hazardous waste sites or bodily injury claims (*BI*, March 28).

"Against the wishes—explicit or implied—of an overwhelming majority of the 146 parties, the (court) has fractured this litigation into 28 duplicative pieces," said Westinghouse and Thermo King in their May 27 appeal. "For virtually identical toxic tort and environmental claims, Westinghouse will now have to conduct simultaneously 28 duplicative contract actions—each involving most or all of the same 400 insurance policies, most or all of the same 146 parties, most or all of the same legal issues and most or all of the same factual issues."

Westinghouse and Thermo King also argue that splitting the case would tie up courts around the country without relieving the burden on the New Jersey court and could deter policyholders from suing their insurers in the future.

In an amicus curiae brief, SCM Corp., AT&T Technologies Inc., Allied-Signal Inc., Avco Corp., Chemical Manufacturers Assn., International Business Machines Corp., Monsanto Co., NL Industries Inc., Textron Inc. and United Technologies Corp. also argued that the decision to split the case should be reversed because it "will severely inconvenience litigating parties and witnesses, significantly increase the burden of coverage litigation on courts in New Jersey and across the country and significantly discourage policyholders from enforcing their contractual rights."

EPIC mortgage insurer settles

CHICAGO—Republic Mortgage Insurance Co. has reached a court-approved settlement on the coverage it will pay home mortgage lenders involved in the Equity Programs Investment Corp. debacle, says A.C. Zucaro, president of parent Old Republic International Corp.

Mr. Zucaro refused to reveal the settlement figure but noted that it was less than the $47.8 million that Old Republic International reported as extraordinary losses in 1985 and 1986.

Republic Mortgage was one of three primary mortgage insurers that insured the lenders issuing mortgages to EPIC. Another was TMIC Insurance Co., whose liquidation earlier this year was attributed in large part to the EPIC bankruptcy (*BI*, Feb. 29).

EPIC, a defunct real estate syndicate, sold tax shelters through 352 partnerships that bought about 22,000 homes. The partnerships filed for bankruptcy in 1985 after defaulting on $1.4 billion in mortgages on the properties.

Judges consolidate PCB cases

CHICAGO—For the first time in a massive hazardous substance case, a multidistrict panel of federal judges has ordered the consolidation of pre-trial proceedings.

The Judicial Panel on Multidistrict Litigation in Chicago last week ordered that litigation between Texas Eastern Transmission Corp. of Houston and 29 of its insurers over the costs to clean 89 PCB-contaminated sites be heard in a Pennsylvania federal court.

Of the 89 sites, Pennsylvania has the largest number, said Leonard Rivkin, an attorney with Rivkin, Radler, Dunne & Bayh in Uniondale, N.Y., who represents Aegis Insurance Co. He said it will cost more than $100 million to clean the Pennsylvania sites.

Texas Eastern, which has agreed to pay $400 million for the government-mandated cleanups, argued that while the case did not belong in federal court, federal court in Houston would be more appropriate than Pennsylvania.

Legal malpractice suit settled

SAN ANTONIO, Texas—A Texas insurer has agreed to pay $4.3 million to settle legal malpractice litigation filed by a widow who claimed her late husband's estate was mismanaged by a San Antonio law firm.

Texas Lawyers Insurance Exchange, an Austin-based reciprocal formed in 1978 by the State Bar of Texas, agreed to pay the award for the defendant law firm, Foster, Lewis, Langley, Gardner & Banack, rather than face the possible appeal of a $16.7 million court award. That award was reduced from $24.4 million, which a jury awarded in March 1987 to the plaintiff, Emma Willeford.

Ms. Willeford charged in her original suit that Foster, Lewis acted negligently in drafting her husband's will by allowing its own lawyer to act as executor. She charged that mismanagement of Mr. Willeford's estate led its value to fall $13 million.

But, Oliver Heard Jr., a San Antonio attorney who represented the law firm, said: "It is standard practice in Texas for an executor to be a member of the law firm that draws up the will." He also pointed out that Mr. Willeford insisted on naming his executor.

Mr. Heard also said the decline in value of Mr. Willeford's estate was due to the deterioration of prices for Texas real estate and oil and gas, which made up a large portion of the estate.

Briefly noted

The state of Missouri on May 26 asked the U.S. Supreme Court to review a decision by the entire 8th U.S. Circuit Court of Appeals that Continental Insurance Co. does not have to pay for the cleanup of a dioxin-contaminated site in **Times Beach, Mo.** (*BI*, March 7). . . .Consumers Union of U.S. Inc., publisher of Consumer Reports magazine, asked the federal government last week to recall the **Suzuki Samurai** four-wheel-drive utility vehicle, charging that the Samurai is prone to roll over. . . .The members of the **Asbestos Claims Facility** postponed a vote on a proposal to dissolve the facility until June 15 to fine-tune the proposal's wording (*BI*, May 30). London members will have until June 30 to vote.

Guaranty fund bled by $124 million: Suit

By JUDY GREENWALD

ALBANY, N.Y.—New York's general revenue fund siphoned more than $37 million from the state's guaranty fund between 1979 and 1982 in addition to the $87 million it appropriated in 1982, according to court papers filed by insurers seeking return of the funds.

A suit filed by six insurance associations and more than 60 insurers in New York Supreme Court in Albany is asking for return of the roughly $124 million, as well as interest the state's Property/Casualty Insurance Security fund would have earned if the money had not been appropriated.

In addition, a separate suit filed last week in Albany by three State Farm Group units seeks the return of the $87 million plus interest.

Both suits also seek the return of a $15 million assessment insurers were required to pay last month because the guaranty fund had fallen below its required $150 million minimum—partly as a result of the state's appropriations (*BI*, May 23; May 9).

Named as defendants in both suits are James P. Corcoran, New York's superintendent of insurance, and Roderick G. W. Chu, commissioner of New York's department of taxation and finance.

A spokesman for the Insurance Department said: "The department feels what it's done is its responsibility under the law as it's written."

New York is the only state that maintains a pre-assessment guaranty fund.

Insurers unsuccessfully sued six years ago for the return of the $87 million (*BI*, April 19, 1982).

The appropriation of the $37 million was not discovered until legal research began in preparation for the most recent suit, said Kenneth Feinberg, with Kaye, Scholer, Fierman, Hays & Handler in Washington, who is handling the suit filed by the six associations and 60 insurers.

Mr. Feinberg explained that under a 1979 statute, when the guaranty fund exceeds $240 million, the state can claim revenues that exceed that level.

The state "skimmed" off the $37 million between 1979 and 1982, Mr. Feinberg said. "Apparently, it was just done," he said. "It wasn't until the $87 million (appropriation) that this became a real problem."

Insurance associations bringing the suit are the Alliance of American Insurers, the National Assn. of Independent Insurers, the New York State Insurance Assn., the National Assn. of Mutual Insurance Cos. and the New York Cooperative Insurance Assn.

The suit brought by the State Farm units is similar to the associations' suit, except that it focuses solely on the $87 million appropriation, says Jim Tuite, State Farm's counsel.

Mr. Tuite pointed out that one of the State Farm companies—State Farm General Insurance Co.—did not pay last month's guaranty fund assessment. This presents the court with a "cleaner test case" by putting the insurer's license at risk, he explained.

The two other State Farm companies that are plaintiffs in the suit, State Farm Mutual Automobile Insurance Co. and State Farm Fire & Casualty Co., paid their assessments under protest, he said. ■

Datebook

JUNE 11-12. International Reinsurance: Collections and Insolvency seminar in New York City, sponsored by the Tort & Insurance Practice Section of the American Bar Assn.; $395 for TIPS members; $425 for ABA members; $450 for non-members; $345 for ABA Young Lawyers; $100 for government employees/academics; $75 for law students. American Bar Assn., Division for Professional Education, Dept. N1504, 750 N. Lake Shore Drive, Chicago, Ill. 60611; 312-988-6200.

JUNE 13-14. Ergonomics: Building Efficiency and Safety in the Workplace course in Los Angeles, sponsored by the University of Southern California, Institute of Safety and Systems Management, Professional Programs; $300. The University of Southern California, 3500 S. Figueroa St., Suite 202, Los Angeles, Calif. 90007; 213-743-6523.

JUNE 13-14. E&O Risk Management: A Procedural Approach seminar in New York City, sponsored by the National Assn. of Professional Surplus Lines Offices Ltd.; $135. Julia Green, National Assn. of Professional Surplus Lines Offices Ltd., 5746 N. Broadway, Kansas City, Mo. 64118; 816-455-3210.

JUNE 13-15. Techniques of Risk Management course in Seattle, sponsored by the Risk & Insurance Management Society Inc.; $540 for RIMS members; $640 for non-members. Risk & Insurance Management Society Inc., Education Department, 205 E. 42nd St., New York, N.Y. 10017; 212-986-9716.

JUNE 13-17. Modern Safety Management course in San Francisco, sponsored by the International Loss Control Institute; $675 for ILCI members; $750 for non-members. International Loss Control Institute, P.O. Box 345, Loganville, Ga. 30249; 404-466-2208; 800-554-6001.

JUNE 14. Making the Right Benefit Choices for the 1990s symposium in Parsippany, N.J., sponsored by TPF&C, a division of Towers Perrin, Forster & Crosby Inc.; no charge. **Also June 16** in Tarrytown, N.Y. Liz Guthridge, 212-309-3591.

JUNE 14. How to Comply With Section 89 seminar in New York City, sponsored by Kwasha Lipton; $25. Kwasha Lipton, P.O. Box 1400, Fort Lee, N.J. 07024; 201-592-1300.

JUNE 14-17. Mobile Cranes and Rigging Practices Safety Training in Orlando, Fla., sponsored by the Crane Institute of America; $445. Crane Institute of America, 455 Douglas Ave., Suite 2255A, Altamonte Springs, Fla. 32714; 407-682-0073.

JUNE 15-16. Health Care Cost Containment Workshop in Dallas, sponsored by Health Research Institute; $495. **Also June 21-22** in San Antonio, Texas. Workshop coordinator, Health Research Institute, 1600 S. Main Plaza, Suite 170, Walnut Creek, Calif. 94596; 415-676-2320.

JUNE 16. CAOHC Approved Recertification Course in Occupational Hearing Conservation in Kansas City, Mo., sponsored by Impact Hearing Conservation Inc.; $125. **Later conferences; $150: Aug. 2** in Milwaukee; **Aug. 16** in Nashville, Tenn.; **Sept. 20** in San Antonio, Texas; **Oct. 4** in Ogden, Utah; **Nov. 1** in Milwaukee; **Dec. 1.** in Kansas City, Mo. Impact Hearing Conservation Inc., 406 W. 34th St., Suite 400, Kansas City, Mo. 64111; 800-346-2139; 816-531-4848.

JUNE 16-17. Hazardous Waste Litigation: Current Problems and Practical Solutions seminar in New York City, sponsored by the Practising Law Institute; $425; $45 for coursebook only. Practising Law Institute, 810 Seventh Ave., New York, N.Y. 10019; 212-765-5700.

JUNE 16-17. AIDS: Confronting the Emerging Legal Challenges seminar in Chicago, sponsored by the Defense Research Institute Inc.; $345 for DRI members; $370 for non-members. Defense Research Institute, 750 N. Lake Shore Drive, Suite 500, Chicago, Ill. 60611; 312-944-0575.

JUNE 17. Communications/Education and Advanced Cost Containment Workshops in Dallas, sponsored by Health Research Institute; $250. **Also June 20** in San Antonio, Texas. Workshop coordinator, Health Research Institute, 1600 S. Main Plaza, Suite 170, Walnut Creek, Calif. 94596; 415-676-2320.

JUNE 19-22. American Society of Safety Engineers' 27th Annual Professional Development Conference and Exposition in Las Vegas, Nev.; $445 for ASSE members; $505 for non-members; $155 for ASSE students and members emeritus. ASSE Conference Registrar, 1800 E. Oakton St., Des Plaines, Ill. 60018-2187; 312-692-4121.

JUNE 20-24. 1988 Fundamentals of Employee Benefits Management course in Brookfield, Wis., sponsored by the International Foundation of Employee Benefit Plans; $900. **Also July 18-22, Aug. 15-19, Sept. 26-30, Oct. 17-21.** Registration Department, International Foundation of Employee Benefit Plans, P.O. Box 69, Brookfield, Wis. 53008-0069; 414-786-6700.

JUNE 22-24. CAOHC Approved Training Course in Hearing Conservation in Kansas City, Mo., sponsored by Impact Hearing Conservation Inc.; $295. **Later conferences; $325: July 20-22** in Chicago; **Aug. 3-5** in Milwaukee; **Aug. 17-19** in Nashville, Tenn.; **Sept. 21-23** in San Antonio, Texas; **Oct. 5-7** in Ogden, Utah; **Nov. 2-4.** in Milwaukee. Impact Hearing Conservation Inc., 406 W. 34th St., Suite 400, Kansas City, Mo. 64111; 800-346-2139; 816-531-4848.

JUNE 24. The Future of Health Care: Public Policy and Trends seminar in Boston, cosponsored by The Boston Globe, Massachusetts Health Data Consortium Inc., WBUR Radio, WNEV-TV and the Challenge to Leadership Project; $75. Massachusetts Health Data Consortium Inc., 400-1 Totten Pond Road, Waltham, Mass. 02154.

AUG. 1-2. *Business Insurance* Employee Benefits Communication Conference in New York, sponsored by *Business Insurance*, $650 for first registrant, 10% discount for multiple registrants from same company. Registrar, *Business Insurance*, 220 E. 42nd St., New York, N.Y. 10017; 212-210-0780.

The Datebook is compiled from notices sent to Business Insurance. Notices should be sent at least eight weeks in advance to Datebook, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611-2590. Please include the price, if any, of the meeting and information on registration for interested readers. Business Insurance reserves the right to select meetings of most interest to its readers.

Medicare refunds

Continued from page 1

sponsor of the maintenance of effort provision.

Just as possible confusion over the period of time that savings will have to be extended to retirees was clarified, other issues were settled.

The news release says that employers will have a choice of using tables to be developed by the secretary of health and human services to determine the value of the duplicative benefits or using their own methods based on HHS guidelines.

In addition, the news release says that employers whose current retiree health care benefits pay less than 50% of the value of the expanded Medicare benefits will not have to return any savings to retirees.

However, most retiree health care plans offered by large employers will not qualify for exemption under this 50% test because the expanded Medicare program will duplicate much of the benefits currently offered by the plans, consultants said.

Under the Medicare expansion, the maximum out-of-pocket expense for hospital bills under Medicare Part A would be set in 1989 at about $580 per year. Currently, a retiree can be liable for tens of thousands of dollars in hospital bills. As a result, many employer-provided retiree health care plans are structured to pay these huge expenses.

In addition, in 1990, Medicare Part B will be expanded to limit retirees' physician expenses to about $1,400 per year. Currently, Part B—after a $75 deductible—pays 80% of physician bills with no annual stop-loss cap.

There still are issues that employers will have to resolve for themselves in complying with the maintenance of effort provision.

For example, the legislation says that employers have a choice of giving retirees cash or other benefits that are equivalent in value to the duplicative benefits.

For employers that require retirees to pay part of the premium for their retiree health care plans, it may be easier for the companies to pay more of the premium than to distribute thousands of checks to retirees, said Buck's Mr. Ferruggia.

Employers still are waiting for answers, possibly to be addressed through regulation, on other questions they have raised since October when Sen. Riegle attached the maintenance of effort provision to the Senate version of the Medicare bill.

Those questions include:

- At what point in the year will employers be required to rebate savings to retirees?
- Will employees who retire during the middle of 1989 and 1990 be entitled to the same amount of savings as those who were retired as of Jan. 1?
- Will the survivors of retirees be entitled to a portion or all of the savings if a retiree dies in 1989 or 1990?

Once the maintenance of effort provision expires, it is possible that unions will demand that employers expand other retiree health care benefits or pay a greater share of the Medicare Part B premium or the new supplemental Medicare premium established by the new law. That premium will be tied to the amount of retirees' tax liability.

"How hard unions will seek other benefit improvements for retirees will much depend on the health of a particular industry and what they are seeking for active employees," said John O'Donnell, a managing consultant with A. Foster Higgins Co. Inc. in New York.

It is doubtful, though, that employers on their own will look for new ways to add new retiree health care benefits.

"Employers already are frightened about retiree health care costs and liabilities. They are not in the market at all to expand benefits," said Janice Hand, a consultant with Hewitt Associates in Lincolnshire, Ill.

The Medicare legislation also calls for the establishment of a commission to study and recommend to Congress ways to finance comprehensive long-term care to the elderly and disabled.

The commission also would study ways of improving access to comprehensive health care for the non-elderly.

The report on long-term health care would be due six months after the Medicare legislation is enacted, while the report on comprehensive health care would be due a year after enactment of the legislation. ■

Product liability bill

Continued from page 1

And Rep. W.J. (Billy) Tauzin, D-La., agreed that "there is very little in this bill that will actually reduce insurance rates."

While the legislation is expected to be approved this week, it is unlikely the full House will consider the bill this year primarily due to time constraints.

Under the Synar amendment, a plaintiff could sue a manufacturer for acting negligently or if its product was unreasonably dangerous.

The Richardson/Florio compromise bill permitted product liability suits only if a product was unreasonably dangerous—defined as containing a construction or design defect, a breach of express warranty or inadequate warnings.

The Synar amendment also defines a construction defect as any deviation whatsoever from a manufacturer's design specifications, formulations or performance standards.

The Richardson/Florio compromise had defined a construction defect as a deviation "in a material way" from a manufacturer's specifications.

The Synar amendment also establishes a state-of-the-art defense for manufacturers that could prove that a product's danger could not have been known at the time it was made or an alternative safer design was not feasible.

The Synar amendment also clarifies that a product, like a knife, that by its nature carries a risk of causing harm would not be considered defective.

Committee members on Thursday approved two amendments supported by manufacturers.

An amendment by Rep. Ralph M. Hall, D-Texas, allows a court to penalize a plaintiff or a defendant for frivolous actions in a product liability lawsuit.

The penalty could be dismissal of the lawsuit, dismissal of a party to the suit or making the party that acted frivolously pay for expenses incurred by the opposition in connection with the suit.

A frivolous pleading is defined as having no basis in fact and brought in bad faith or for harassment.

An amendment by Rep. Joe Barton, R-Texas, allows damage awards in a product liability lawsuit to be reduced by the amount attributable to misuse or alteration of a product.

The amendment, which prompted significant discussion, was approved by a 22-20 vote. It allows damages in a product liability lawsuit to be reduced if the product was misused or altered in a way contrary to the manufacturer's or product seller's warnings or instructions or in a way that an ordinary person should have known would bring a risk of harm.

Rep. Philip Sharp, D-Ind., in support of the amendment, noted that "a user should not be absolved of any responsibility for the safe use of a product."

Much to the relief of the insurance industry, the committee approved 25-17 an amendment by Rep. Al Swift, D-Wash., directing the Commerce Department to collect insurance information from state insurance departments and rejected 23-19 an amendment by Rep. Edward Markey, D-Mass., directing the federal government to collect information directly from insurers.

In a spirited discussion of the two amendments, legislators disagreed about whether allowing the federal government to collect information directly from insurers is the first step toward federal regulation of the industry.

These amendments are "the opening salvo" in an effort to engage the federal government in regulation of the insurance industry, declared Rep. William Dannemeyer, R-Calif.

Rep. Norman Lent, R-N.Y., pointed out that the state insurance departments already have information on product liability insurance rates, claims and losses, so the amendments are "completely unnecessary."

But Rep. Henry Waxman, D-Calif., opined that "the insurance industry ought not to be immune from the watchful eye of the federal government."

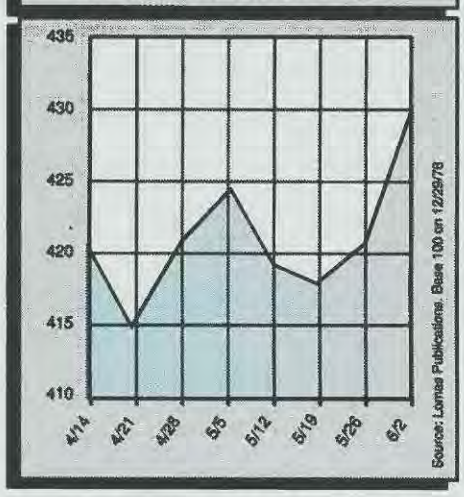
And Rep. Waxman warned the insurance industry that "this isn't going to be the end of the fight" to extend federal oversight of the insurance industry.

During markup on Wednesday and Thursday, the committee also voted down seven pro-consumer amendments offered by Rep. Waxman.

The bill, as currently crafted, also would:

- Prohibit punitive damages in cases involving drugs and medical devices that were approved by the federal Food and Drug Administration.
- Allow damages to be reduced if a plaintiff was under the influence of drugs or alcohol and that was determined to be more than 50% responsible for the harm.
- Establish a 25-year time limit on bringing lawsuits for capital goods used in the workplace.
- Prohibit plaintiffs from suing product sellers unless the product seller was negligent.
- Require manufacturers to provide warnings to consumers about dangers discovered after a product has been sold.
- Require a plaintiff to file a lawsuit against a manufacturer within two years of discovering the harm and its cause. ■

BI Insurance Index



Insurance industry stocks rose last week as the *Business Insurance Index* jumped 8.8 points to 430.1 on June 6, from 421.3 on May 27. Advancing issues were led by Frank B. Hall & Co., up 9.5%; Transamerica Corp., up 8.9%; Belvedere Corp., up 8.4%; Zenith National Insurance Corp., up 8.4%; CNA Financial Corp., up 7.9%; Nobel Insurance Ltd., up 7.6%; and American Indemnity Financial Corp., up 7%. Declining issues were led by Tokio Marine & Fire Insurance Co. Ltd., down 4.7%; Lawrence Insurance Group, down 3.3%; Baldwin & Lyons Inc., down 3.2%; Liberty Corp., down 3%; Durham Corp., down 2.8%; Poe & Associates Inc., down 2.7%; and Hilb, Rogal & Hamilton, down 2.1%. Issues showing the most activity were: Sears, Roebuck & Co. (Allstate), 2.9 million shares traded; ITT Corp. (Hartford Group), 1.8 million shares traded; and American International Group Inc., 1.4 million shares traded. The *Business Insurance Index* gained 2.1% for the period, lagging behind the leading market indicators: The Dow Jones 30 Industrials gained 4.4%; the Standard & Poor's 500 gained 4.2%; and the New York Stock Exchange Composite saw a 3.8% rise.

Insurers pay bulk of Savitch settlement

By MARK A. HOFMANN

PHILADELPHIA—Insurers of The New York Post paid the bulk of an $8 million settlement reached with the estate of television newscaster Jessica Savitch.

Ms. Savitch died in 1983 while a passenger in a car driven by Post Vp Martin Fischbein.

The settlement was reached in January after a Philadelphia Common Pleas Court judge had rejected the Post's contention that it should not be held liable because Mr. Fischbein and Ms. Savitch were together socially rather than professionally.

Also contributing to the settlement were the Commonwealth of Pennsylvania, the estate of Mr. Fischbein and the restaurant at which Ms. Savitch and Mr. Fischbein had dined on the evening of their deaths.

The Post's $7.1 million share of the award was covered by primary and excess liability insurance, according to Angelo Scaricamazza with the Philadelphia law firm of Naulte, Scaricamazza & McDevitt.

The Post was covered by a $1 million primary occurrence liability insurance policy issued to News America Publishing Inc., the Post's New York-based parent company, by Atlantic Mutual Insurance Cos. of New York. The Post also was covered by a $99 million excess liability policy written by Lloyd's of London underwriters, said Mr. Scaricamazza, who represented the Post.

The Commonwealth of Pennsylvania contributed $250,000 to the settlement. That is the most the state is allowed by law to pay from its Tort Claims General Fund, which was established under a sovereign immunity statute in 1978.

The restaurant, Chez Odette in New Hope, Pa., contributed $650,000 to the settlement, all of which was covered by its liability insurance, according to James Hilley of the Philadelphia law firm of LaBrum & Doak, which represented the restaurant. However, he declined to discuss details of the coverage.

Mr. Fischbein and Ms. Savitch died on Oct. 23, 1983, when the car Mr. Fischbein was driving plunged into a canal in New Hope, Pa.

The fatal accident occurred as Mr. Fischbein attempted to leave the fog-shrouded restaurant parking lot and accidentally pulled onto an old tow path running next to the canal. The car flipped into the water and overturned, trapping both passengers, who drowned.

According to Mr. Hilley, a similar incident occurred at the same place four years earlier, resulting in the death of one man. Despite that, the state Department of Environmental Resources did not erect barriers at the entrance to the tow path, for which the state has maintenance responsibility. ■

British Issues

June 2 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence	pence
Comml Union	370	14.0	21.9	5.8	370—359	
Genl Accident	883	10.2	47.9	5.3	886—883	
Gdn Royal Exch	874	13.0	55.2	6.3	877—874	
Royal	400	10.6	26.4	6.4	400—391	
Sun Alliance	913	14.9	43.1	4.5	920—913	
Brokers						
Bradstock	222	12.5	6.8	3.0	225—222	
CE Heath	409	15.1	34.5	8.1	410—404	
Hogg Robinson	148	11.8	9.6	6.3	152—148	
Lloyd Thompson	155	13.5	6.8	4.3	155—155	
PWS Holdings	188	7.9	14.4	7.4	188—187	
Sedgwick Grp	225	14.0	16.4	7.1	229—225	
Steel Birl Jones	194	12.0	13.7	6.9	195—194	
Willis Faber	251	13.1	15.4	6.1	254—251	

Source: Philip Olsen/Alan Clifton, Insurance Industry Specialists Kitcat & Aitken Stockbrokers, London

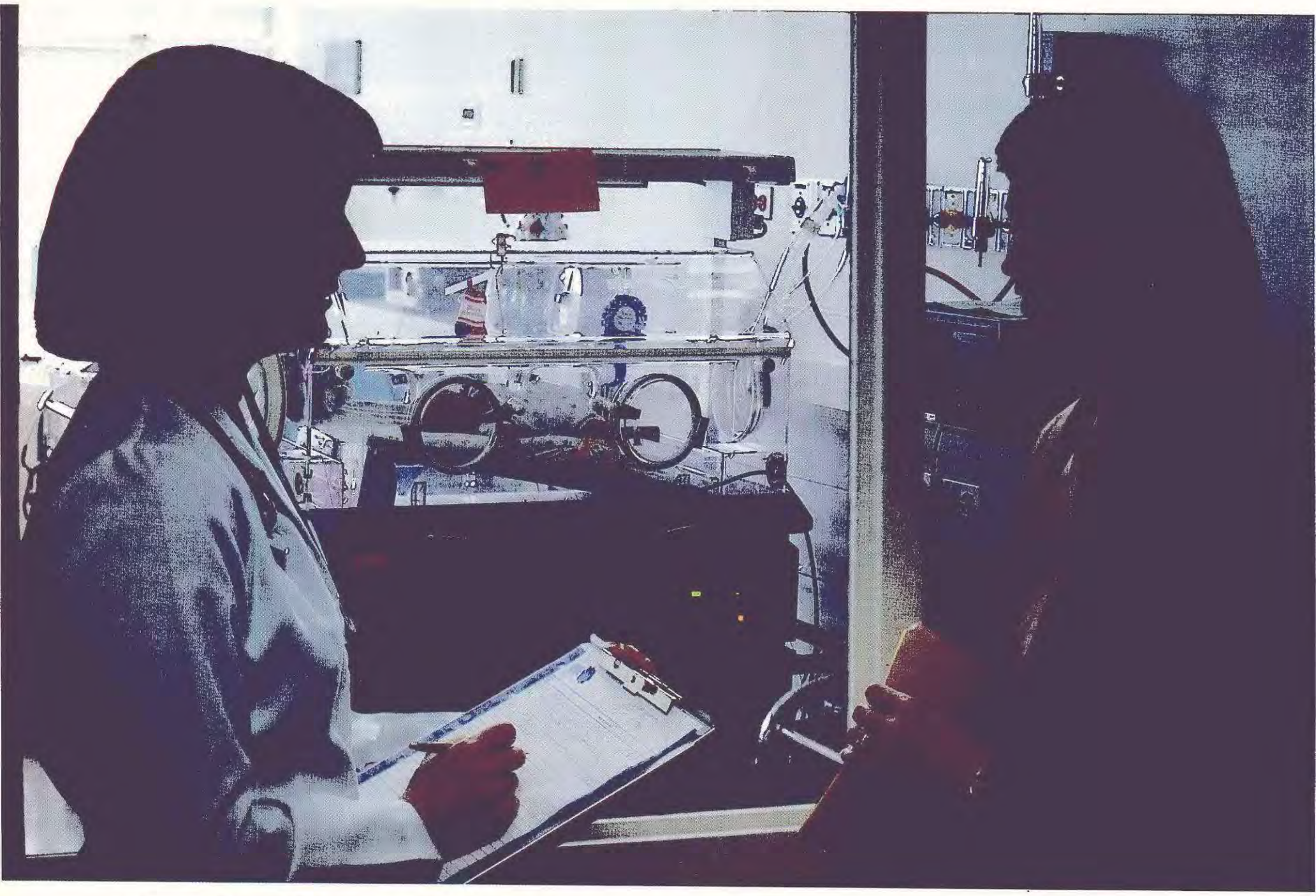
BI Industry Stock Report

JUNE 2, 1988 **5/27/88 THRU 6/2/88**

Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
BROKERS										
Alexander & Alexander Svcs	NYSE	22.13	1.1	24.7	24.50	17.75	292	1.00	4.5	14.0	3.40	6.51
Baldwin & Lyons Inc.	OTC	15.00	-3.2	25.0	15.50	12.00	0	0.20	1.3	5.8	18.31	0.82
Corroon & Black Corp.	NYSE	31.00	0.8	9.7	34.75	28.00	356	1.08	3.5	4.7	5.43	5.71
Gallagher Arthur J. & Co.	NYSE	16.88	5.5	5.5	18.00	13.88	35	0.48	2.8	11.2	5.16	3.27
Hall Frank B. & Co.	NYSE	4.25	9.5	47.6	5.50	2.88	93	0.00	0.0	11.2	0.00	N/A
Hilb, Rogal & Hamilton	OTC	11.75	-2.1	20.5	12.75	9.75	1	0.00	0.0	11.2	0.00	N/A
Marsh & McLennan Cos. Inc.	NYSE	53.25	-0.5	7.6	55.63	45.25	420	2.40	4.5	13.0	6.74	7.90
Poe & Assoc. In.c	OTC	9.00	-2.7	28.6	9.25	6.75	0	0.40	4.4	8.7	0.57	15.79
BROKERS	AVERAGE		1.1	21.2					2.6	9.5		
CONGLOMERATES & HOLDING COMPANIES												
Berkley W.R. Corp.	OTC	25.25	0.0	5.2	29.00	23.50	44	0.36	1.4	6.2	17.63	1.43
Berkshire Hathaway Inc.	OTC	4025.00	5.2	36.4	4050.00	2755.00	142	0.00	0.0	19.6	69.38	10.90
CIGNA Corp.	NYSE	47.75	7.0	8.8	51.88	42.75	569	2.96	6.2	6.5	49.19	0.97
CNA Fin'l Corp.	NYSE	58.38	7.9	4.9	64.25	51.00	206	0.00	0.0	8.4	46.40	1.26
General Re Corp.	NYSE	54.88	5.3	-1.8	56.38	45.50	1350	1.20	2.2	10.9	26.21	2.09
ITT (Hartford Group)	NYSE	48.00	2.1	6.7	49.25	43.25	1827	1.25	2.6	6.1	52.23	0.92
Sears, Roebuck & Co. (Allstate)	NYSE	35.13	2.6	4.5	39.88	32.25	2941	2.00	5.7	8.6	34.74	1.01
Transamerica Corp.	NYSE	33.75	8.9	13.4	36.75	29.75	528	1.84	5.5	6.7	24.94	1.35
CONGLOMERATES	AVERAGE		4.9	9.8					3.0	9.1		
INSURERS												
Aetna Life & Cas Co.	NYSE	44.50	5.6	-1.7	49.88	39.50	1013	2.76	6.2	6.3	53.56	0.83
American General Corp.	NYSE	30.13	4.8	-5.1	36.38	27.50	792	1.40	4.6	8.2	27.99	1.08
Amer Heritage Life Invt	NYSE	24.75	-0.5	2.1	26.00	24.00	2	1.08	4.4	11.2	20.98	1.18
Amer Indty Fin'l Corp.	OTC	11.50	7.0	27.8	11.75	8.25	4	0.56	4.9	17.7	15.26	0.75
American Int'l Group	NYSE	56.63	5.1	-5.6	65.38	49.00	1386	0.40	0.7	9.3	33.56	1.69
Aneco Reins Ltd.	OTC	3.13	0.0	-7.4	4.00	3.13	3	0.00	0.0	4.3	2.51	1.25
Aon Corp.	NYSE	24.88	2.6	8.7	27.00	21.88	121	1.28	5.1	8.7	15.13	1.64
Argonaut Group	OTC	44.25	-1.1	48.7	49.00	29.50	100	0.00	0.0	7.2	29.19	1.52
AVEMCO Corp.	NYSE	24.13	1.0	22.9	25.25	17.88	4	0.34	1.4	11.7	7.74	3.12
Belvedere Corp.	AMEX	4.88	8.4	11.4	6.00	4.38	7	0.04	0.8	7.1	7.87	0.62
Business Mens Assum Co.	OTC	35.25	1.4	31.8	36.00	25.50	69	1.20	3.4	64.1	27.39	1.29
Chubb Corp.	NYSE	57.25	2.2	2.5	63.38	51.25	371	2.16	3.8	6.6	46.13	1.24
Continental Corp.	NYSE	37.63	1.7	-2.9	41.63	34.75	90	2.60	6.9	7.2	42.10	0.89
Durham Corp.	OTC	26.25	-2.8	22.1	28.00	21.50	3	0.92	3.5	27.1	26.00	1.01
Farmers Group Inc.	OTC	61.13	2.9	51.9	65.75	40.50	1337	1.44	2.4	14.9	22.02	2.78
Fireman's Fund Corp.	NYSE	28.25	2.2	8.7	31.00	25.75	316	0.50	1.8	470.8	26.17	1.08
Fremont Gen Corp.	OTC	10.00	5.3	3.8	13.50	8.75	35	0.60	6.0	470.8	16.75	0.60
Home Group Inc.	NYSE	11.88	3.3	0.0	14.38	11.50	160	0.20	1.7	2.5	17.65	0.67
Hanover Ins Co.	OTC	23.00	2.2	-1.1	26.25	20.50	44	0.36	1.6	5.1	25.10	0.92
Harleysville Group Inc.	OTC	15.13	-0.8	15.3	16.38	13.38	6	0.40	2.6	6.7	16.65	0.91
Hartford Steam Boiler	OTC	26.00	3.0	13.0	29.25	22.50	85	1.20	4.6	9.7	10.65	2.44
Kans City Life	OTC	30.50	0.0	16.2	30.75	25.25	0	0.00	0.0	9.7	0.00	N/A
Kemper Corp.	OTC	24.00	2.1	17.1	25.25	20.75	303	0.72	3.0	7.5	26.50	0.91
Lawrence Ins. Group	AMEX	14.88	-3.3	120.4	15.88	6.88	2	0.32	2.2	15.3	4.35	3.42
Liberty Corp. S.C.	NYSE	40.00	-3.0	12.7	47.25	34.50	5	0.80	2.0	14.8	17.40	2.30
Lincoln Nat'l Corp.	NYSE	45.50	4.6	13.4	48.75	40.25	121	2.36	5.2	8.8	36.62	1.24
NAC Re Corp.	OTC	23.75	5.6	33.8	24.50	18.50	28	0.00	0.0	13.8	19.92	1.19
Nobel Ins Ltd.	OTC	5.25	7.6	-40.0	9.50	4.50	32	0.44	8.4	25.0	9.37	0.56
Northwestern Nat'l Life	OTC	27.00	1.9	18.0	29.25	22.63	30	1.12	4.1	6.9	35.05	0.77
Ohio Cas Corp.	OTC	33.75	1.5	-6.9	38.25	32.25	201	1.88	5.6	8.0	27.86	1.21
Old Rep Int'l Corp.	OTC	22.88	4.0	14.4	24.63	19.13	241	0.74	3.2	5.3	27.82	0.82
Orion Cap Corp.	NYSE	16.50	1.5	22.2	17.25	13.13	5	0.76	4.6	5.8	9.34	1.77
Phoenix Re Corp.	OTC	8.25	0.0	26.9	8.75	6.75	92	0.00	0.0	5.9	11.08	0.74
Protective Life Corp.	OTC	12.88	3.0	5.1	15.13	12.25	16	0.70	5.4	12.3	17.25	0.75
Provident Life & Acc Ins Co.	OTC	20.25	4.5	29.6	21.88	15.63	125	0.84	4.1	155.8	27.45	0.74
St. Paul Cos. Inc.	OTC	42.75	3.0	-7.1	51.00	38.25	914	2.00	4.7	6.1	35.83	1.19
SAFECO Corp.	OTC	24.75	5.3	-10.8	30.00	22.75	461	1.08	4.4	7.9	21.39	1.16
SCOR US Corp.	OTC	9.25	0.0	0.0	9.50	7.25	106	0.00	0.0	6.7	9.20	1.01
Seibels Bruce Group Inc.	OTC	13.00	0.0	15.6	14.25	11.00	31	0.80	6.2	8.4	12.51	1.04
Selective Ins Group Inc.	OTC	23.75	1.1	25.0	23.75	19.25	208	1.24	5.2	5.4	19.52	1.22
Statesman Group Inc.	OTC	3.94	1.5	-16.0	2.75	1.81	17	0.05	1.3	5.4	3.48	1.13
Tokio Marine & Fire Ins	OTC	76.25	-4.7	15.7	85.88	63.25	45	0.19	0.2	68.1	0.00	N/A
Torchmark Corp.	NYSE	30.88	0.4	26.0	31.25	24.50	240	1.00	3.2	9.9	12.24	2.52
Travelers Corp.	NYSE	35.38	3.3	0.7	40.00	33.00	547	2.40	6.8	9.1	45.28	0.78
Trenwick Group Inc.	OTC	12.00	0.0	17.1	12.50	9.75	11	0.16	1.3	10.3	15.41	0.78
United Fire & Cas Co.	OTC	25.50	0.0	-1.9	27.00	24.00	0	1.08	4.2	4.8	22.56	1.13
United States Fid & Gty	NYSE	32.25	2.8	13.2	34.38	28.88	732	2.64	8.2	7.2	19.53	1.65
UNUM Corp.	NYSE	21.75	6.1	17.6	22.75	17.88	337	0.48	2.2	10.8	28.53	0.76
USLIFE Corp.	NYSE	35.50	4.4	24.6	39.00	28.00	94	1.28	3.6	9.2	46.77	0.76
Washington Nat'l Corp.	NYSE	27.63	0.9	15.7	28.63	24.00	12	1.08	3.9	21.8	32.33	0.85
Zenith Nat'l Ins Corp.	NYSE	22.50	8.4	50.0	23.88	15.00	67	0.88	3.9	10.0	12.26	1.84
INSURERS	AVERAGE		2.3	14.0					3.4	24.7		
ALL COMPANIES	AVERAGE		2.4	14.4					3.3	21.3		

System design: Lomas Publications

Is your medical case management program on site or out of sight?



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See if you agree.

A baby is born late one night at a rural hospital. He weighs 2 pounds, 11 ounces and is three months premature.

The next morning, an Intracorp RN specializing in neonatology arrives at the hospital. She assesses the baby's condition and meets with the primary physician and parents. Her recommendation: move the baby to an urban neonatal care unit a hundred miles away. All agree and she arranges for an air ambulance staffed by a neonatal flight team to transfer the baby that morning.

That afternoon, Intracorp's RN locates housing for the baby's mother convenient to the hospital so that she can be in continual contact with the medical treatment team.

Over the next few weeks, with complications always a threat, the baby's care must be continually monitored.

By the end of week six, the baby is stabilized and allowed to go home. Anticipating this step, Intracorp's RN has already arranged for home care and seen that the mother is instructed in all necessary care techniques.

Result: The family is once again reunited at home—two months earlier than expected.

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BI-H

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