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update

Reinsurer cancels contracts with Dyna Span, ICA

NEW ORLEANS—New England International Surety Inc. said last week that it has canceled its reinsurance contracts with Dyna Span Corp. and Insurance Corp. of America effective May 31.

The Panama-based reinsurer concluded "that the dealings with these companies had become too controversial and has made New England unpopular at state levels

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California court levies tax on self-funded plan

By ROBERT A. FINLAYSON

SAN FRANCISCO—In a decision that could cost California employers hundreds of millions of dollars in back taxes, a federal appellate court upheld the right of states to impose a premium tax on benefit payments under a minimum premium health care plan.

Some attorneys believe the decision also permits the state to tax benefit payments made under self-insured group health plans covered by stop-loss insurance—either specific or aggregate.

If the decision stands, it could cost employers as much as $200 million to $300 million in back taxes, according to the California Insurance Department.

California tax law allows the state to collect back taxes for the four years prior to the current tax year. Most insurers pass state premium taxes onto the plan sponsor, so employers rather than the insurers are expected to pay these back taxes.

The premium tax in California is 2.35%.

A sustained decision also would increase future health care costs for many employers in California that purchase minimum premium plans and perhaps those that self-fund and buy stop-loss insurance.

Benefit experts also predict that other states are likely to impose the same type of tax on minimum premium plans.

"My guess is that other states will follow suit," says William J. Kilberg, a partner with Gibson, Dunn & Crutcher in Washington, D.C., which represented Gen-

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Newest bill escalates war over McCarran-Ferguson

By JERRY GEISEL

WASHINGTON—Insurers vow to fight revised legislation unveiled last week to amend the McCarran-Ferguson Act, contending the proposal would hurt both the insurance business and insurance buyers.

But, Senate support is building for amending the 1945 law, which gives insurers limited immunity from federal antitrust law and grants states primary regulation of the industry.

Sen. Metzenbaum says his bill 'would promote competition, lower prices and availability of coverage.'

Sen. Howard Metzenbaum, D-Ohio, for years the sole Senate crusader against McCarran-Ferguson, now is joined by two presidential candidates—Sens. Joseph Biden, D-Del., and Sen. Paul Simon, D-Ill.—as well as Sen. Edward Kennedy, D-Mass., in his bid to limit insurers' immunity from antitrust law.

Under Sen. Metzenbaum's latest proposal, S. 1299, insurers and advisory organizations would be permitted to jointly collect and exchange some historical data on paid claims and reserves.

In addition, the bill would allow insurers to engage in certain joint activities without violating federal antitrust law, such as banding together to provide coverage through industrywide pools.

Earlier proposals to amend McCarran-Ferguson introduced by Sen. Metzenbaum did not make clear that joint collection and exchange of historical loss data would be legal. There also were questions whether pool activities would be legal under antitrust laws.

While Sen. Metzenbaum modified his legislation, he says his intent remains the same: subjecting insurers to federal antitrust law, while preserving the power of the states to tax and regulate the industry.

"The bill I am introducing. . .would simply apply the same standards of free competition and fair play to insurance that apply to other industries, without in any way diminishing the power of the states to regulate insurance as they do now," Sen. Metzenbaum said last week when he introduced the bill.

"Requiring insurance companies to live by the rules of free competition would not disrupt state regulatory programs. It would not prevent insurance companies from sharing information. It would promote competition in the industry, promote lower prices and greater availability of coverage," he added.

But insurance industry spokesmen say the latest changes in Sen. Metzenbaum's bill are virtually meaningless and the measure, if enacted, could actually decrease the availability of insurance.

For example, while insurance advisory rating organizations like the Insurance Services Office still could collect and distribute historical data on paid claims and reserves, insur-

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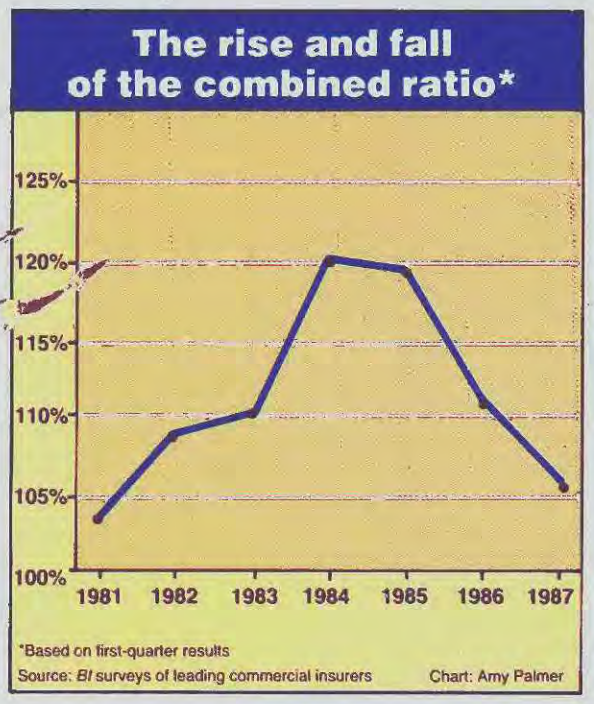
Insurers' recovery

Combined ratio falls to 6-year quarterly low



By JUDY GREENWALD

The property/casualty insurance market may be softening, but moderating rates are not yet reducing commercial insurers' earnings.

Following a relatively catastrophe-free first quarter, the 24 major insurers tracked by *Business Insurance* posted a 72.3% increase in aftertax operating income to $1.76 billion.

And, perhaps more significantly, five of the companies in the survey reported first-quarter combined ratios below 100%, while another four posted combined ratios of between 100% and 101%.

Overall, the insurers posted an aggregate combined ratio of 105.3% in the first quarter, down from 110.7% in last year's first quarter, and the lowest quarterly combined ratio since the first quarter of 1981 (see chart).

Insurers' first-quarter results were "pretty positive," said Sean Mooney, an economist with the Insurance Information Institute. "It shows the industry is defini-

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Boeing paying bulk of JAL loss

By STACY SHAPIRO and STEVE TARAVELLA

LONDON—Although the official accident report on the cause of the 1985 Japan Air Lines Boeing 747 crash will not be released until next week, Boeing Co. and its underwriters already have agreed to pay more than 80% of the liability losses.

Boeing and its aviation product liability underwriters in January agreed to pay 82.5% of the compensation to the four survivors of the crash and to relatives of the 520 people who died, *Business Insurance* has learned. JAL's liability underwriters agreed to pay the other 17.5%.

This agreement is not expected to be affected by the results of the JAL crash investigation by the Aviation Accident Investigation Commission of the Japanese Ministry of Transport, underwriters say.

The 82.5%-17.5% split "is supposed to be definite," said one of the underwriters involved.

Spokesmen at Boeing in Seattle and JAL in New York would not confirm or deny the breakdown.

Altogether, underwriters believe the final liability cost of the JAL crash, the worst single-aircraft aviation loss in history, could exceed $345 million, significantly more than the $160 million reserved by underwriters shortly after the Aug. 12, 1985, disaster.

"It is an expensive loss to the market," said one underwriter.

So far, Boeing aviation underwriters calculate they have paid or are reserving more than $295 million for liability losses from the crash, while JAL underwriters say they have paid or are reserving around $49 million in liability losses.

A Boeing spokeswoman says it is not possible to estimate what its ultimate liability will be, since it has not yet been determined whether damages to Japanese plaintiffs will be decided by U.S.

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Huge appliance store warehouse fire in Chicago estimated to cause $35 million in damages
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update

New England cancels contracts

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in light of the sincere efforts to establish New England as a serious insurance company," according to Joe Aguda, an official with New England International Surety of America Inc., the Louisiana-licensed subsidiary.

Dyna Span claimed to operate as a purchasing group under the federal Risk Retention Act, while ICA claims to be exempt from state regulation under two turn-of-the-century court decisions. Both have been hit with cease-and-desist orders or injunctions by several state insurance departments (*BI*, June 1; May 26, 1986).

A.R. Johnson, president of Dyna Span and ICA, said that Dyna Span no longer operates as a purchasing group, since recent amendments to the Risk Retention Act clearly require coverage to be placed with a licensed insurer.

The license of New England's Louisiana-based unit bars it from insuring risk retention or purchasing groups.

Dyna Span now functions as a "management service company" and has not yet found a licensed market to underwrite its business, Mr. Johnson said. He confirmed that ICA has replaced its New England contracts with coverage underwritten by Independence Insurance Co. Ltd. of Bermuda.

New England International is unrelated to New England Reinsurance Corp., while ICA, based in Boca Raton, Fla., is unrelated to a Texas-domiciled company of the same name.

Virginia MAP dissolved

RICHMOND, Va.—Virginia's statewide market assistance plan has been dissolved because it has served its purpose, said Insurance Commissioner Steven T. Foster. No new applications have been received since November 1986, he said.

Approximately 20 insurers participated in the program, which was designed to help state residents find liability insurance for: municipalities, day care centers, businesses with liquor law exposures and small businesses with product liability exposures. The program was dissolved April 16.

Since its inception in January 1986, the Virginia Market Assistance Plan received 76 applications. Of those, insurers quoted rates on 28 and wrote coverage for 14. Insurance was found elsewhere by 15 of the 76 applications. In addition, 19 applicants were declined and 10 were rejected as being ineligible.

Gunter fights Louisiana insurer

TALLAHASSEE, Fla.—Florida Insurance Commissioner Bill Gunter is trying to stop Baton Rouge, La.-based Physician's National Risk Retention Group Inc. from selling medical malpractice insurance to Florida doctors.

A hearing was scheduled last Friday in U.S. District Court for the Northern District of Florida in Tallahassee to discuss the request.

Mr. Gunter said the low-cost coverage—averaging 30% to 35% below other insurers with experience in the line—is appealing to Florida doctors who have been hit with soaring malpractice insurance premiums and few available markets. "But I would warn physicians that this group is in questionable financial shape and may not be around to make good on claims," he said.

A financial statement the insurer filed this year with the Florida Insurance Department indicated that Physician's National had $100,000 in capital and a $900,000 letter of credit.

As many as 750 Florida doctors have paid $5,000 each in "membership and capitalization fees" to Physicians National, and about 35 other doctors have paid premiums, an Insurance Department spokeswoman said. The insurer is offering claims-made and occurrence-based coverage with limits ranging from $250,000 to $1 million per claim with a $3 million annual aggregate.

There was no answer over two days at a telephone number listed for Physicians National in Baton Rouge.

Belvedere America pays fine

NEW YORK—The New York Insurance Department has fined Belvedere America Reinsurance Co. $61,000, charging that the reinsurer conducted business out of its New York office while its license application was still pending.

Robert Huggins, Belvedere America's president, said the reinsurer disagrees with the department's contentions but decided to pay the fine "in hopes of expediting the licensing process."

Belvedere America maintains a corporate office in New York and an underwriting office in New Jersey, where it is licensed as a reinsurer, Mr. Huggins noted.

Belvedere America is the U.S. reinsurance unit of Belvedere Corp., which went public last year, expanding from the operations of its Bermuda-based Belvedere Insurance Co. Ltd. Belvedere America applied for a license in New York in December 1986.

Court upholds severance pay

WASHINGTON—The U.S. Supreme Court last week upheld a Maine law requiring employers to pay a severance benefit to certain employees laid off because of plant closings.

A Maine company had contended that the state statute was preempted by the Employee Retirement Income Security Act of 1974

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errors & omissions

Correcting an earlier statement to *Business Insurance*, a Merrill Lynch & Co. spokesman says the firm is not insured for a $2.25 million punitive damage award in North Dakota, where a jury found the firm guilty of unauthorized trading (*BI*, May 11). The firm intends to pursue all remedies in fighting the award, he added.

Asbestos firms to gain $275 million from ruling

By STEPHEN TARNOFF

SAN FRANCISCO—Three of the asbestos producers involved in landmark litigation here stand to gain more than $275 million in insurance coverage to pay asbestos claims following San Francisco Superior Court Judge Ira A. Brown's long-awaited decision.

The May 29 decision also could persuade other judges to issue similar broad decisions in other asbestos coverage cases and in cases involving toxic substances, policyholders' attorneys contend.

Moreover, some producers believe that Judge Brown's decision will bolster policyholders' bad faith claims against insurers in the California asbestos litigation as well as their attempts to obtain coverage for asbestos property damage claims.

However, while the decision generally is being hailed as a major victory for policyholders currently involved in coverage disputes with insurers, not all asbestos producers see the decision as favorable.

At least one major producer with an asbestos coverage case says that Judge Brown's rulings on other issues in the case are detrimental to his client.

Attorneys for insurers, however, contend the decision likely will be limited to asbestos coverage cases—if it is used at all by other courts.

Some attorneys for insurers also contend that while the decision benefits producers in this particular litigation, it could hurt policyholders in general by leading to reduced availability and higher-priced liability insurance.

And, attorneys for insurers dispute policyholders' assessments of the decision's potential impact on bad-faith claims and asbestos property damage claims.

All attorneys generally agree that Judge Brown's decision gives the broadest insurance coverage possible to policyholders for bodily injury asbestos claims (*BI*, June 1).

Judge Brown ruled that producers are entitled to recover from all insurers that wrote liability insurance policies for them from the time a claimant was exposed to asbestos through the time the victim files a claim or until the victim's death. In many cases, this has been more than four decades.

Judge Brown also found that every policy triggered by an asbestos-related bodily injury claim must respond in full to a claim and that policyholders do not have to pay a proportionate share of defense and indemnification costs for periods when they were self-insured or uninsured.

But, in a part of the decision that favors insurers, Judge Brown held that under pre-1966 policies, insurers are not liable for defense costs after policy limits have been exhausted.

Judge Brown also ruled:

- Insurers bear the burden of proving that policyholders acted intentionally or maliciously in order to deny coverage on the basis that the policy only covers losses which are not expected or intended.
- The excess insurers of asbestos producer GAF Corp. of Wayne, N.J., do not have to drop down and pay the defense and indemnification costs for those primary insurers that either refused to defend or indemnify GAF or are insolvent.

However, insurers are expected to appeal Judge Brown's ruling.

The three policyholders that benefit directly from Judge Brown's wide-ranging ruling are GAF, Armstrong World Industries Inc. of Lancaster, Pa., and Fibreboard Corp., a unit of Portland, Ore.-based Louisiana-Pacific Corp.

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Deadline nears for RMIS listing

Business Insurance will publish its annual directory of risk management information systems in the July 13 issue, which will include a spotlight report on trends in the growing field of risk management automation.

There is no charge to be listed in the directory, but companies wishing to be included must fill out and return a questionnaire provided by *Business Insurance*.

If your company produces and supplies software to corporate risk management personnel and you have not yet received a questionnaire, please request one immediately by calling Marilou Jones at 312-649-5279.

The deadline for returning completed questionnaires to *Business Insurance* is June 15.

States query insurers on antitrust activity

By DOUGLAS McLEOD

NEW YORK—Investigations by five state attorneys general into possible insurance industry collusion during the recent liability insurance crisis could continue for several months, sources say.

The inquiries into possible antitrust violations and violations of unfair trade practice laws by insurers or reinsurers have been ongoing since last year.

Representatives from the offices of the California, Massachusetts, Texas, New York and Minnesota attorneys general traveled to London in March to interview industry officials, including reinsurance brokers.

Between 100 and 150 companies have been subpoenaed to provide information during the course of the investigations, sources say.

Officials in most of the states confirmed that they are conducting inquiries and are cooperating with one another in the investigations, but declined to provide further details for the record.

Insurers and reinsurers are taking the inquiries seriously. One source noted that some of the subpoenas—including those issued in connection with the California probe—cite possible violations of law that could carry criminal penalties.

Industry and regulatory officials say, however, they doubt the investigations will turn up any evidence of collusion or conspiracy, and

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departments

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Subject insurers to antitrust laws, NICO chief says

By LAURA MAZZUCA

SEA ISLAND, Ga.—While a consumer group advocates subjecting the insurance industry to antitrust regulations, proponents of the McCarran-Ferguson Act say regulation of the industry must stay in state hands.

"Everybody but the insurance companies and a few of their close friends" has pledged their support to repeal the McCarran-Ferguson Act, claimed J. Robert Hunter, president of the National Insurance Consumer Organization.

"What they support is not the abolition of state regulation, but a simple repeal of the antitrust exemption—because it is national policy, and because they haven't yet heard any reason for an overwhelming need for the insurance industry to be exempt," explained Mr. Hunter of NICO, a non-profit public interest group in Washington.

Mr. Hunter met two of his opponents during a heated panel discussion about the future of the McCarran-Ferguson Act at the 53rd annual meeting of the National Assn. of Insurance Brokers, held May 26-29 on Sea Island, Ga.

John E. Washburn, director of the Illinois Department of Insurance, countered Mr. Hunter by saying: "In its present form, state regulation won't survive the repeal of McCarran-Ferguson."

McCarran-Ferguson serves as a "beacon" in illuminating a state's regulatory responsibilities, allowing the states more flexibility and freedom to act, said Mr. Washburn. "When you take that away, you really start to get some very gray areas."

Sen. Donald M. Halperin, D-N.Y., concurred: "All change is not progress. . . . Simply moving something to the federal level doesn't mean you're going to solve the problem. By repealing McCarran-Ferguson, I don't believe we're helping the states."

"States have been regulating insurance for more than 120 years," continued Mr. Washburn, who is also president-elect of the National Assn. of Insurance Commissioners. "They have developed a system that doesn't depend on any one state."

States are responsible for regulating insurer solvency and the insurance marketplace in general, Mr. Washburn explained. Regulatory expertise and areas of specialization vary from state to state, based on the state's primary businesses.

Each state has its own test for determining a company's solvency. Over the years, many states develop specialties, such as an expertise in a given line of insurance. This individuality would be impossible under federal regulation, said Mr. Washburn.

"Each state is able to innovate, depending on how it looks at the marketplace," he said.

The repeal of McCarran-Ferguson would undermine the individual state's power, Mr. Washburn said, and "stifle the states' ability to innovate and their ability to be different."

However, "State regulation can and will survive, whether or not the McCarran-Ferguson Act is amended or changed, and that is the intention of those drafting the legislation," said Mr. Hunter of NICO.

Those favoring repeal of McCarran-Ferguson are less

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Tort reforms

States limit punitive awards, joint and several liability

The latest series of tort reforms passed by state legislatures make it tougher for plaintiffs to win punitive damage awards and limit the application of joint and several liability.

Governors in North Dakota, Montana, Kansas, Colorado and Utah have signed tort reforms recently passed in their states, most of which become effective July 1, while Texas Gov. Bill Clements is expected to sign the package of legislation passed by the Legislature last week.

The Colorado and Texas legislation also include some insurance reforms.

In addition, Minnesota Gov. Rudy Perpich has signed into law a package of insurance reform bills.

And, Maryland Gov. William Donald Schaefer last week signed three tort reform bills, as expected. The bills will cap damage awards against public entities and limit some medical malpractice awards (*BI*, April 20).

However, in Connecticut, Gov. William A. O'Neill has signed a law that liberalizes the doctrine of joint and several liability for economic damages in personal injury cases (*BI*, May 4). The new law, which weakens sweeping tort reform legislation enacted last year, becomes effective Oct. 1.

Graphic: Amy Palmer

Details of the tort and insurance reform legislation enacted in North Dakota, Montana, Texas, Kansas, Colorado, Utah and Minnesota follow:

North Dakota

Comprehensive tort reform legislation goes into effect July 1 in North Dakota, after being signed into law by Gov. George A. Sinner.

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Businesses to rally for product liability reforms

By JERRY GEISEL

WASHINGTON—Hundreds of business representatives are expected to swarm on Washington this week to persuade Congress to pass federal product liability reform legislation.

Tuesday's rally at the U.S. Chamber of Commerce—to demonstrate business support for reform legislation—comes at a time when the business community again is optimistic that Congress will give serious consideration to product liability legislation.

"Product liability is alive and kicking as an issue in Congress," says Jim Anderson, senior director of government relations at the National Assn. of Wholesaler-Distributors in Washington.

"There is a real feeling of optimism that reform legislation can be passed in the House of Representatives," added Sharon Spigelmyer, director of loss prevention and control at the National Assn. of Manufacturers in Washington.

This wave of optimism that reforms will be considered and perhaps passed this session by at least one branch of Congress is being fueled by a number of factors, including:

- Key House Democratic leaders agree that Congress should be considering product liability legislation.

For example, Rep. John Dingell, D-Mich., chairman of the House Energy and Commerce Committee, which has jurisdiction over product liability legislation, described the issue as "one of the most important before the committee . . . and it deserves careful, but expeditious consideration."

"Product liability insurance rates have skyrocketed in the

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College of Insurance refinances

By DOUGLAS McLEOD

NEW YORK—The College of Insurance expects to bring its $19.2 million debt under control with a refinancing plan announced last week.

The debt was incurred in the construction of the college's 10-story lower Manhattan headquarters, completed in 1984. The college had taken out a $15 million loan—backed by a letter of credit from the Bank of New York—in 1981, when construction of the building was approved. However, cost overruns and mounting interest saddled the college with larger-than-expected debt (*BI*, May 4).

The refinancing plan includes gifts and mortgage-backed financing from 23 companies in the industry, including property/casualty and life insurers, brokers and one individual, according to L. Patton Kline, chairman of the college's board of trustees and vice chairman of Marsh & McLennan Inc.

According to Mr. Kline, the plan includes:

- $2.3 million in gifts to the college.
- A 15-year, $9.2 million first mortgage, held by the Bank of New York and carrying interest of "slightly less" than 10%.
- A 15-year, $7.7 million second mortgage held by insurers, brokers and the individual contributor. The second mortgage, which carries an interest rate of 6%, is a shared appreciation mortgage, in which mortgage holders will share in any increase in the value of the college's physical plant over the 15-year term.

Under the terms of the refinancing, regular payments on the second mortgage will be made only when the college can afford them after making payments on the first mortgage, Mr. Kline said.

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Economist named top insurance woman


Photo: Arnie Adler

'Buyers have done a lot to bring about the change in the economics' of the insurance business, says Barbara D. Stewart, the APIW's Insurance Woman of the Year.

By MEG FLETCHER

NEW YORK—Barbara D. Stewart is the first economist to be named Insurance Woman of the Year by the APIW, a professional association of women within the insurance and reinsurance industry.

Analyzing the insurance industry from an economic perspective is increasingly important, says Ms. Stewart, who is president of Stewart Economics Inc., a New York-based consulting firm.

"Traditionally, the business hasn't had economic analysis," said Ms. Stewart, 44. Until recently, people in the insurance business have concentrated on technical aspects of operations like underwriting and risk management analysis, she says.

Now, with open competition in rating, insurers must be concerned with their market strategy, market position and developing an understanding of what constitutes a competitive advantage, she said.

"Participants can't assume they will do well or even survive," she said. "The business is overly crowded."

Insurers clearly are listening to Ms. Stewart, and her husband, Richard E. Stewart, who is chairman of the consulting firm. Both are in high demand to address meetings of insurance company executives and their 6-year-old consulting business is thriving.

While Mr. Stewart, a former New York Insurance Commissioner, was once more widely recognized, clients agree that the team is well balanced.

"Barbara Stewart is one of the brightest consultants in the country," says Joseph Fahys, president of the New York Insurance Exchange, which is a client of Stewart Economics.

Analyzing the economics of the insurance business, Ms. Stewart says that "buyers have done a lot to bring about the change in the economics of the business." Risk managers have become more sophisticated, she says, and, as a result, they have siphoned off the more predictable risks to self-insure. And, they have become more demanding of the industry services they need, she added.

The underwriting cycle is more severe and the current recovery period is much shorter compared with the last cycle than people would have predicted, Ms. Stewart said.

She predicts more of a shakeout among insurers that are competing to write the more predictable lines of coverage.

"There are just too many people chasing the easier risks," she explained.

Stewart Economics specializes in planning and problem solving primarily for insurers and brokers, both foreign and domestic, and

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Chicago blaze hits 2 insurers

By DONNA DiBLASE

MELROSE PARK, Ill.—A blaze that gutted a combination store and warehouse owned by retail chain Polk Bros. Inc. last week caused an estimated $35 million in damages, at least part of which is insured.

While the amount of the company's property insurance was not available, *Business Insurance* learned that the Chicago-based retailer of appliances and furniture is covered by a three-layer property insurance program.

Chicago-based Arthur J. Gallagher & Co. is the retail broker for Polk Bros. And, Atlanta-based Alexander Howden North America Inc. is the wholesale broker.

The bottom and top layers of the coverage were underwritten by the Atlanta-based London Agency Inc., a wholesale intermediary and an underwriting manager for Crum & Forster Insurance Cos. of Morristown, N.J., said Doug Winch, an underwriter with the agency.

Mr. Winch confirmed that Crum & Forster companies had written coverage for the primary and third layer of coverage, though he would not reveal the names of those insurers or the limits of coverage.

However, the primary layer is believed to be for $2.5 million and the top layer is believed to be $5.5 million to $6 million excess of $9.5 million.

A middle layer of $7 million excess of $2.5 million was written by a Transamerica Corp. unit, Transamerica confirmed.

Whether Polk Bros. has more insurance excess of $15.5 million was not known at press time.

The Crum & Forster policies were only a week old at the time of the fire.

Neither Gallagher nor Alexander Howden officials would comment. Officials at Polk Bros. did not return repeated telephone calls.

Last Monday's fire began in the carpeting department of the 40,000-square-foot building.

It took fire departments from about 12 area suburbs almost four hours to bring the blaze under control. The ruins of the building were still smoldering on Tuesday morning, fire department officials said.

The building included a store and a warehouse that employed 500 people and supplied merchandise to the 11 other stores in the Polk Bros. chain.

Officials of the Illinois Fire Marshal's Office conducted an investigation from Wednesday through Friday of last week. "The exact cause of the fire is as yet undetermined and the case is still open," said a spokeswoman.

"We do not believe the fire to be incendiary. The scene has now been released to the owners and their insurance company," she added.

Stockbrokers plan to form bond captive

By DEBORAH SHALOWITZ

WASHINGTON—The Securities Industry Assn. plans to form an industry-owned insurer to underwrite broker/dealer blanket bonds and related coverages for its members.

Edward I. O'Brien, president of the 500-member SIA, said surveys "have shown a great need for coverages of these types. In many cases, firms have found blanket bond insurance very expensive, and sometimes they haven't been able to obtain it at all."

New York-based SIA's brokerage and investment banking firms handle more than 90% of the securities business in North America.

The SIA's board of directors approved the concept of an industry-owned captive late last month and will give final approval after reviewing implementation plans, which are still to be developed.

The company will will be formed by year-end under the captive insurance laws of Vermont, said Robert Cope, director of insurance services.

The association plans for the captive to work in conjunction with the commercial insurance market, Mr. Cope said.

Doug Hoffman, a principal at the Tillinghast division of Towers, Perrin, Forster & Crosby Inc. in Darien, Conn., who worked with SIA in developing the proposal, said the "overriding objective of the company is to provide some additional stability to the (insurance) market for stockbrokers and investment bankers and that stability will come in the form of increased capacity."

He added that "this is a complementary strategy vs. a replacement strategy."

How the captive will dovetail with commercial insurers has not been decided yet, Mr. Cope said.

SIA's captive will be capitalized without plans for future assessments on its members, Mr. Cope said. The captive most likely will be organized as a stock company.

The new company should have at least $50 million in capitalization by the end of its first year, Mr. Cope said. The captive will write aggregate policy limits of approximately $5 million and eventually, it is hoped, $10 million.

The captive will be controlled and administered by a board of directors elected by the participants, although SIA will have a continuing oversight role, according to an association spokesman.

The blanket bond market has been in turmoil for several years.

Capacity today is less than half of what it was two years ago, said Mr. Cope, when $250 million in limits was available. And, from 1984 to 1986, premium costs increased 466%, he said, and deductibles now are five times what they were in 1984.

Blanket bond insurance covers employee theft or dishonesty; theft on the site of a securities firm; transit losses, including those involving armored cars and messenger services; and forgery or alteration of certificates and documents.

Some standard exclusions are time limitations on discovery of loss and losses resulting from unauthorized trading of customer's accounts. SIA is still deciding which exclusions will be added to the captive's policies.

It's "highly probable" that the captive also will underwrite directors and officers liability coverage and "possible" that it will offer errors and omissions coverage also, Mr. Cope noted. ■

They're lucky. Six million other retired Americans are in a different boat.

For many Americans, retirement is exactly what they hoped for.

But for others, retirement can be complicated by poor health. One out of four Americans will require long-term care in a nursing home with an average annual cost of $20,000 to $30,000. How that care is paid for has become a complex issue.

History has shown that personal savings and programs like Medicare and Medicaid can't cover all the costs of retirement health care. Companies with retirement health benefits also face the problem of unfunded future liabilities.

Additional solutions must be found to address this retirement health care cost issue that will eventually affect every person, company and institution in our country.

At NWNL Group, we're developing an employee benefit program called LifeScope* that would provide for a person's retirement years and working years. What makes the LifeScope Program unique is its comprehensive approach to providing benefits. It is more than life insurance and a nursing home policy.

By managing the delivery of health care and planning for future needs, the LifeScope Program can find alternatives that make health care more affordable, while allowing individuals to live independently. The program's benefits would be voluntary, flexible and portable.

Many elements of the LifeScope Program have already been put into place through current NWNL Group benefit programs. Using our resources as the nation's 10th largest group insurance company, we will soon be adding more elements.

To find out more about NWNL Group and the LifeScope Program, contact Ginny Patrick, NWNL Group, Box 20, Minneapolis, MN 55440 or call (612) 372-5784. Because now is the time to begin solving the problems of providing health care in the future.

NWNL GROUP

The right benefits for today.
The right ideas for the future.℠

Sources for statistics: Employee Benefit Research Institute, 1985; Benefits Research, Inc. 1986; National Underwriter, 1986

Architects, engineers forming new insurer

By MICHAEL BRADFORD

DES PLAINES, Ill.—Architects and engineers are banding together to form a risk retention group that initially will write $1 million in professional liability insurance limits.

Organizers hope to capitalize Architects & Engineers Insurance Co. at $10 million. While some 350 firms have shown interest in becoming investor/policyholders, it would take only 70 investors to get the insurer off the ground, the group's organizer says, adding that AEIC should be writing coverage on a claims-made form by Jan. 1.

Companies interested in participating in the risk retention group range from very small firms to those with gross receipts of $100 million, says C. Roy Vince, vp of Professional Liability Brokers & Consultants Inc. in Des Plaines, Ill.

In an organizational meeting held last month to discuss AEIC's proposed operation, Mr. Vince told prospective investors: "This initial $10 million capitalization is well in excess of any state requirement. It meets basic rules for conservative, safe operations and financial security for investors."

But, Mr. Vince noted that if all 350 firms decided to participate, AEIC would have $50 million in capital and be able to write limits of $5 million.

Mr. Vince, who has been involved in development of the company for the past eight months, said the insurer will be domiciled in either Delaware, Colorado or Illinois. Delaware and Colorado are "favorably disposed" to risk retention groups, he said, noting there is some concern as to whether Illinois will accept risk retention groups with open arms.

Mr. Vince said architects and engineers need a new market for professional liability coverage because "the commercial market has dwindled to a handful of carriers."

He pointed out that Design Professionals Insurance Co. in Monterey, Calif., and managing general agent Victor O. Schinnerer & Co. Inc. in Washington "are the only ones that write substantive amounts" of professional liability coverage for architects and engineers. Schinnerer writes on behalf of CNA Insurance Cos.

Those markets collect about 80% of the $406 million in annual written premiums for the line of coverage, Mr. Vince estimated.

And, architectural and engineering firms need more reasonably priced coverage, Mr. Vince said. They spend about 4.1% of gross receipts on insurance, according to Mr. Vince, making insurance the third-largest expense for most architectural and engineering firms behind salaries and the cost of the companies' facilities, he said.

Although organizers are continuing to finalize the structure of AEIC, they have outlined some basic operating concepts.

Under the proposal, principals of Professional Liability Brokers and two unnamed companies would form Architects & Engineers Risk Management Co. to manage the risk retention group. It is proposed that AEIC will have some ownership in the management company.

AEIC will write coverage on a primary or excess basis, depending on the needs of the policyholder.

In addition, AEIC will write at no more than a 3-1 net premium-to-surplus ratio and will probably write at closer to a 1-1 ratio.

Because of the high cost of reinsurance, AEIC will retain most of the risk it writes, Mr. Vince said. However, it will attempt to purchase stop-loss coverage if it can be found at a reasonable price.

He predicts the group will produce from $10 million to $15.4 million in premiums during its first full year of operation, depending on the number of policyholders and whether they purchase prior acts coverage

AEIC will charge an additional premium for prior acts coverage, which would cover any claims made after the inception date of the policy related to covered incidents that occurred before the policy was in force.

In addition, AEIC will offer "project insurance," or professional liability coverage for individual jobs, Mr. Vince explained. He said companies in some cases like to "put the direct overhead cost into the project."

A firm that applies to become a investor in AEIC is required to post a $5,000 deposit, or 10% of the minimum investment required of investors. That money will be used in part to fund a qualification study of the applicant. If the investor is accepted to participate, the remainder of the deposit will be used to defray start-up costs of the company. If the applicant is rejected, the remainder is refunded.

A participant's initial investment will be 2.5% of its gross annual receipts, or $50,000, whichever is greater. Twenty-five percent of the investment must be made in cash with a letter of credit acceptable for the balance.

An alternate capitalization plan suggests two contributions of 1.7% of a company's receipts or a minimum of $35,000.

Investors that join the company after it is operational will pay a higher capitalization fee than the total 3.4% of receipts charged in the initial plan, he explained.

While no specific penalties have been established for investors that want to withdraw from the group, Mr. Vince pointed out that the company's organizers are discussing a "redemption provision." He speculated there probably would not be "a specific penalty in terms of loss of funds, but the funds would be returned over time," rather than allowing an investor to immediately withdraw its capital.

Premiums would be based on gross receipts.

"Base premiums are projected to range from 0.75% to 1.75% of gross receipts," depending on the size of the firm, deductibles and the nature of the risk, he said. However, policyholders would be charged a minimum premium of $35,000.

There will be a minimum deductible that a policyholder can increase to reduce its premium. The minimum deductible will be based on a sliding scale starting at $25,000 for firms with $2 million in gross receipts, increasing to $300,000 for firms with receipts of $30 million or more. Companies with substantially higher receipts will be required to retain even larger deductibles.

In addition to the deductible, Mr. Vince said organizers may require a policyholder to assume some percentage of its losses.

Mr. Vince stressed that investors would own and control the company and will determine what to do with any profits.

AEIC's developers plan to provide loss control services. ■

Bicycling and golfing are favorite outdoor activities at The Cloister, the site of the 53rd annual meeting of the National Assn. of Insurance Brokers. The posh resort is located on Sea Island, Ga.

McCarran-Ferguson

Continued from page 3

concerned about state regulation and more concerned about the elimination of price fixing and the insurance industry's exemption from federal antitrust laws, Mr. Hunter explained.

NICO is supporting a bill introduced in Congress late last month by Sens. Howard Metzenbaum, D-Ohio; Paul Simon, D-Ill.; Joseph R. Biden, D-Del.; and Edward Kennedy, D-Mass.; called "The Insurance Competition and Improvement Act of 1987."

The bill would repeal the insurance industry's exemption from antitrust laws, although it would permit insurers to share certain data. And, it would not move regulation of insurers from the state to the federal level.

Joining NICO in support of the new bill are the Justice Department, the Federal Trade Commission, women's groups, environmentalists, small businesses, labor, banks and civil rights groups.

Mr. Hunter blamed the insurance industry's antitrust exemption for the commercial liability crunch of the recent past, as well as the destructive insurance industry cycles.

Price-fixing is another major target of McCarran-Ferguson reformers, Mr. Hunter said, pointing out that the Insurance Services Office's list of rates is available to any insurer that requests it, but not to the consumer.

"Those kinds of things are totally illegal in other areas," he said.

"Price-fixing is anti-competitive, particularly when it's unregulated, as was the case, in almost every state, for commercial liability insurance," he said.

"Insurance companies can compete deeper and be more predatory, knowing that they can recoup it" when the cycle swings the other way, Mr. Hunter said.

Rather than emasculating the state regulatory system, Mr. Hunter said that repeal of McCarran-Ferguson would "really be a vote of confidence to the states," giving each the power to either "regulate or deregulate."

"That's what seems to be the fear (within the insurance industry), that states would have to regulate those things that were anti-competitive," he said. "What's wrong with that?"

But Sen. Halperin expressed concern that total repeal or major modification of McCarran-Ferguson, and the resulting shift of regulatory power to the federal level, would put a double burden on the states: that of addressing industry problems, as well as having to demonstrate to the federal government their ability to regulate insurers.

Mr. Hunter

"Rather than trying to deal with the issues, I see the states having to wrestle with trying to meet that test," Sen. Halperin predicted.

He also was unconvinced that industry's cycles could be averted by repeal of McCarran-Ferguson, because most industry problems have arisen from bad underwriting decisions, he said.

And, the senator was skeptical that eliminating the antitrust exemption would improve insurance availability and affordability.

"We know that antitrust has really prevented a consolidation of power in the automobile industry, and saved that industry from foreign competition, so it's obviously a very good thing to have," he said sarcastically.

Sen. Halperin, an active member of the Senate Finance Committee and of the Insurance, Codes, Ethics, Higher Education and Rules Committees, also is concerned about passing federal legislation that could have a detrimental effect on a state's ability to govern itself.

"I, as a legislator from New York state, have seen how the federal government has hamstrung our ability to protect our constituencies" on a state level, Sen. Halperin said.

As an example, he cited New York's recent inability to pass legislation to bring down exorbitant interest rates levied by many major credit card companies. The New York Legislature was unable to circumvent the National Banking Act, which provides that the state in which the credit card company is domiciled is the only state with regulatory authority.

State insurance departments concentrate primarily on insolvency studies and consumer services, according to Sen. Halperin, and on that level, the states are doing their jobs well.

"I've heard very little questioning of the states' ability to do that at least as well as the federal government," he said.

And, he added, "anyone who has tried to deal with federal agencies—of which there are 2,061—knows that they don't always get the best responses in the world."

Although he admitted that state regulation of the industry is far from perfect, Sen. Halperin said that he would like to see the energy and funds now being devoted to repealing McCarran-Ferguson turned to help state insurance departments function more efficiently.

The panel was moderated by Robert L. Sanford, president of the New York brokerage Smyth, Sanford & Gerard Inc. ■

opinions

Talk to Kennedy

WE'RE ENCOURAGED by the revisions Senate Labor and Human Resources Chairman Edward Kennedy, D-Mass., has made in his latest proposal to require employers to offer group health insurance plans (*BI*, May 25; June 1).

For months, Sen. Kennedy had been saying that employers would not have to offer a "Cadillac" plan, but provide a bare-bones package to give employees protection from catastrophic health care expenses.

However, the initial minimum health care plan drafted by Sen. Kennedy's staff and circulated earlier this year was anything but bare-bones. With annual deductibles, for example, of $150 for individual coverage and $300 for family coverage, such a minimum mandated plan would have been more generous than plans currently offered by many employers.

Such low deductibles would force thousands of employers with well-designed, generous plans to needlessly overhaul their health care programs.

And, such unrealistically low deductibles also could exacerbate medical care inflation, because employees—who would be picking up few costs—would have little incentive to use health care services wisely.

But in legislation unveiled last month, Sen. Kennedy now is proposing much higher annual deductibles of $250 for individual and $500 for family coverage. Even with the recent trend toward more employee cost-sharing, most corporate health plan deductibles still are below the levels proposed by Sen. Kennedy.

The new package also raises the maximum annual out-of-pocket health care expenses that an employee would have to pay to $3,000 from $2,000.

Sen. Kennedy has made it clear that employers will be allowed to design their health care plans to meet the specialized needs of their employees so long as the overall value of the plan is not reduced. For example, a company could require higher deductibles than the proposed minimums if it enriched the plan in other ways.

Best of all, the Kennedy proposal would preempt state benefit mandate laws. Such laws have become an administrative nightmare for employers operating in multiple states and interfere with the right of employers and employees to decide on the specifics of a health care benefit package that best meets their needs.

With 37 million Americans lacking health insurance, Congress will do something to increase access to health care coverage—the political pressure is that intense.

Even with the recent changes, however, we're far from ready to endorse Sen. Kennedy's proposal, which carries a $25 billion price tag.

As we recently noted, there are other alternatives—including expanding health insurance programs for the poor, financed by general tax revenues—to consider and implement before Congress forces all employers to provide health care benefits.

But, we don't believe that employers can afford to blindly reject the Kennedy proposal on ideological grounds that benefits are voluntary and should not be mandated by the federal government.

While a federal benefit mandate may be distasteful, it is far less objectionable than other proposals Congress has been considering, including employer-subsidized health care pools for the uninsured.

The pool proposal, in effect, would make employers with health care plans pay twice—once for their own employees and once for individuals covered by the pools. The Kennedy approach avoids that inequity.

Employers have to recognize that Congress is not going to sit by while 37 million Americans lack health insurance. Congress will do something to increase access to health care coverage—the political pressure is that intense.

Sen. Kennedy's staffers have made a point to open their doors to listen to input from the business community before drafting legislation. That open-door policy, in sharp contrast to the closed doors behind which many benefit issues have been decided in Washington, clearly has produced a better proposal.

Employers, even those that oppose federally mandated health insurance, should take advantage of the open door Sen. Kennedy is offering. Such input can help produce a better legislative product. And that is in everyone's interest.

We would be the first to point out that the Kennedy proposal, as currently drafted, has a number of flaws that should be brought to the attention of Sen. Kennedy and his staff.

For example, Sen. Kennedy is proposing that employers generally would have to pick up 80% of the group premium for both individual and family coverage. Even at companies with generous health insurance plans, employees typically pay a greater percentage of the premium for family or dependent coverage than Sen. Kennedy is proposing.

Undoubtedly, many employers, especially smaller firms, would have difficulty paying such a high percentage of the premium.

But employers will find it difficult to recommend changes if they aren't part of the legislative debate. Employers should recognize that lobbying involves far more than simply opposing or supporting a bill.

The most effective and important lobbying often is convincing legislators to make an objectionable bill less objectionable.

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Past RIMS chief offers tort reform essentials

By LAURA MAZZUCA

SEA ISLAND, Ga.—Declaring that "the American tort system is in need of change," a spokesman for the Risk & Insurance Management Society described risk managers' concerns about an American judicial system of "expanding liabilities and shrinking defenses."

Mr. Mather

"If our tort system is to regain its role as a true adjudicative mechanism, fault and culpability must be restored as the foundation of tort law," said William L. Mather, past president of RIMS, at the annual meeting of the National Assn. of Insurance Brokers held last month on Sea Island, Ga.

"It's a matter of equity, reasonableness and cost," he added. "When victims receive barely half of the total system costs, there is a serious problem. When a defendant is 10% at fault, but held 100% liable for damages, reform is needed."

Mr. Mather, who is administrator-risk management at The Gillette Co. in Boston, also commented on insurance regulation, the Risk Retention Act and the McCarran-Ferguson Act.

But, the focus of his talk was RIMS' proposed remedies for the tort system. These included:

- The replacement of joint and several liability by a pure comparative negligence system in which defendants pay only their percentage of fault.
- Revision of the present "inequitable" collateral source rule, which bans the introduction of evidence to a jury of compensation paid to a plaintiff by a source other than the defendant, he said.

RIMS favors a conditional system in which the injured party chooses from whom to collect.

- Altering punitive damage award rules so that the judge, rather than the jury, determines the amount of damages.
- Establishing a monetary cap for pain and suffering awards.
- Giving judges a role in setting caps on lawyers' contingency fees.

Other tort reform proposals supported by RIMS include: the continued experimental use of alternative dispute resolutions; structured settlements, in which a plaintiff receives an award over an extended period of time; and imposing penalties on plaintiffs who turn down "reasonable" settlement offers, he explained.

Another major area of concern to RIMS is insurance regulation.

"We would vastly prefer that the insurance industry exercise internal responsibility, rather than have imposed on it regulatory intrusions," Mr. Mather said, referring to mandated premium rollbacks, state rate setting, joint underwriting associations, assigned risk plans and policy form restrictions.

Mr. Mather said that RIMS continues to support the purpose of the Risk Retention Act revisions in freeing risk retention groups of "certain constraints and obligations placed on traditional insurers. . .and will oppose attempts by the NAIC (National Assn. of Insurance Commissioners) and others to thwart the goals of Congress in implementing this legislation."

RIMS also continues to encourage legislators to support the tax deductibility of self-insurance programs. This would "lessen society's reliance on an insurance mechanism prone to drastic fluctuations in availability and price by encouraging responsible self-insurance and alternative risk financing mechanisms," he said.

Risk managers are relatively unconcerned about repeal of or amendments to the McCarran-Ferguson Act, he added.

"I don't see RIMS becoming involved in the McCarran-Ferguson issue," he said, unless RIMS wanted to use it as a bargaining chip in negotiating with state regulators on other issues. ■

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John Trumbull: *The Declaration of Independence* (detail) ©Yale University Art Gallery

Regulations need complete review: Hueppi

By LINDA J. COLLINS

SEA ISLAND, Ga.—Legislators should focus on drafting regulations that address long-term insurance industry problems instead of acting to correct short-term worries, says an insurance company executive.

To be effective, insurance regulation "must look into the future of our dynamic, changing market. It's a challenge of anticipation," said Rolf F. Hueppi, chief operating officer of Zurich Insurance Group in Zurich, Switzerland, and chairman of its Schaumburg, Ill.-based Zurich-American Insurance Group unit.

Since insurance "plays a significant social role and fills a vital economic need," many legislators feel a "compelling urge" to regulate insurance, Mr. Hueppi said at the National Assn. of Insurance Brokers' annual meeting held last month on Sea Island, Ga.

The property/casualty industry must temper the severity of the underwriting cycle if it wants to avoid further government regulation, Mr. Hueppi stressed.

"For insurers, their challenge is to conduct business in a responsible manner" by foregoing opportunities for short-term profit that could jeopardize long-term opportunities and adversely affect insurance buyers, he explained.

Government regulation is "like an elephant—slow moving, thick-skinned and with a long memory," he warned. Once insurance regulations have been established, they are hard to change, he said.

But if insurers do not respond willingly to the needs of consumers by providing a more stable marketplace, legislators may retaliate by creating another regulatory "elephant," Mr. Hueppi stressed.

Property/casualty insurers have paid and will continue to pay the price for short-term management decisions during the last market cycle, both through record underwriting losses and loss of market share, he said.

But many regulators and legislators have inadequately responded to market problems by seeking industry "restrictions that perpetuate mainly the short-term approach to our problems," he suggested.

Rather than correcting problems, many of the restrictions sought by regulators would only "inhibit insurance industry adaptation, through coverage and pricing, to changes in society's behavior and expectations," he said.

"Our industry is now burdened with too much and generally static, history-oriented regulation," Mr. Hueppi complained.

Rather than adding regulation to regulation, Mr. Hueppi's solution is a "zero-based approach": When enacting future insurance regulations, regulators and legislators should first wipe the slate clean of existing insurance laws, then create new, more relevant laws, Mr. Hueppi stressed.

"Much as in zero-based budgeting, we should be forced, from time to time, to justify all (regulatory) actions as opposed to building on what has been used in the past. Nothing should be assumed as a given. All regulation should be questioned, should stand the test of the current and should be oriented toward the future," he stressed.

Four regulatory areas Mr. Hueppi emphasized included: solvency regulation; the guaranty fund system; rate and policy form regulation; and the surveillance of insurers' day-to-day business activities.

"Regulation for solvency is the most important responsibility of the state system," he said.

Some modifications have been made in "the fundamental tools" used to regulate insurer solvency, he conceded, naming statutory accounting, the annual financial statements and periodic financial examinations. But, he said, "their inherent limitations remain."

"A completely new system of regulatory accounting" is needed, he said. "The system should provide the regulator with enough information to determine whether the company can survive, rather than what its liquidated value would be."

Mr. Hueppi

And he criticized regulators' reliance on annual statements, because that information often is outdated by the time it reaches the regulators. Computerized reporting of quarterly statements would be much more meaningful, he said.

The guaranty fund system also requires a zero-based regulatory approach, he said. Minor modifications of the current system would be insufficient to address the mounting number of insurer insolvencies to which guaranty funds must respond, he said.

The guaranty fund system has deviated too far from its original purpose of providing protection to those policyholders who are the least able to assess the financial strength of their insurers and who are the most vulnerable when those insurers fail, said Mr. Hueppi.

The funds have been increasingly called upon in recent years to pay claims for large businesses—buyers he says should assume responsibility for their insurance-buying decisions.

In the area of rate and form regulation, Mr. Hueppi warned that the "flex rating" systems that many states have adopted would react too slowly to market changes and would reduce open competition significantly.

Regulators are quick to impose limits under flex rating when rates go up, but if rates begin to drop significantly, he said he hopes they will "have the political courage to hold rates within the permissible band at the bottom end of the flex rating system."

Mr. Hueppi also criticized policy form regulation. "Insurance companies should have the freedom to experiment with truly innovative forms of coverage and pricing, particularly in commercial lines."

His zero-based concept of rate and form regulation would not leave the industry without oversight, he stressed; it would simply call for individual examination of each regulation in this area to determine if that oversight is "desired or needed by the consumer."

Surveillance of day-to-day trade practices of insurers requires a full understanding of the insurance industry, an understanding that Mr. Hueppi said "many regulators and legislators" don't have. ■

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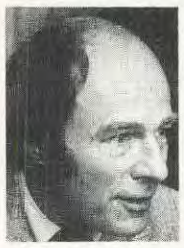
Sell service, not price, Clements tells industry

By LAURA MAZZUCA

SEA ISLAND, Ga.—Trouble lurks behind the insurance industry's prevalent attitude that it sells a commodity rather than a product, an insurance brokerage executive stresses.



Mr. Clements

This attitude may encourage shortsighted planning and slipshod client service, says Robert Clements, president of Marsh & McLennan Inc.

In their long-range plans and in their dealings with clients, brokers and insurers should focus on the total package of services provided, rather than only the cost of the product, Mr. Clements told brokers and insurance company executives at the annual meeting of the National Assn. of Insurance Brokers, held last month on Sea Island, Ga.

"The difference between a commodity and a product is that in the commodity business, the buyer can't tell one unit of production from another, so he buys only on the basis of price," Mr. Clements explained.

On the other hand, a product can be classified as something that can be differentiated from the products of all other producers because of an added value.

"This value is often an intangible—the cumulative positive impact of good service and reliability—that creates a perception of quality in the mind of the buyer," Mr. Clements said.

Especially in the face of a "great booming underwriting recovery," when competition from risk retention groups and other alternative markets is increasing, the industry must treat clients with respect and consideration, he said.

"All too often, claims are handled like an adversarial exercise with the policyholder. The claims departments of most insurers treat the policyholder like an enemy when he seeks fulfillment of the promise for which he paid the premium," he pointed out.

However, "quality service and sensitivity in the interest of the buyer are still the finest defenses against price competition," Mr. Clements said, adding, "The future of the business to a great extent depends on our credibility with our customers."

To illustrate his point, Mr. Clements said that Marsh & McLennan has developed an extensive data base to facilitate policy analysis, client consultation and claim processing.

The insurance industry is a "growth industry" that provides an "indispensable product" through a "unique distribution system," according to Mr. Clements.

However, he warned that in the last 20 years, "the cost and availability of insurance has fluctuated in an increasingly irresponsible manner."

These conditions are unacceptable to insurance buyers and detrimental to the industry, Mr. Clements said.

"The function of insurance is to substitute a known cost for an unknown cost, stability for instability. When the price and the terms of coverage fluctuate wildly from one year to the next, the product fails to accomplish its intended purpose," he warned.

"If we don't get our act together, if our marketplace continues to behave like some mindless commodity," the commercial insurance business will continue to lose market share to alternative risk financing mechanisms, Mr. Clements predicted.

But he does not believe that the insurance business' problems are insurmountable.

"Collectively we have the ability to make the analysts, the journalists and the consultants who are now busy discounting our future look pretty wrong. But it will take work and leadership," Mr. Clements stressed. ■

Pretty Good Marketing Reps Need Not Apply

There's a place for pretty good marketing reps. And pretty good claims people. And pretty good underwriters. But it isn't here. We're only interested in hiring the best.

You see, at Reliance, we've embarked on something really exciting. We intend to excel at everything we do. Our plan is simple: We intend to be the best insurance company in the business.

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Because we're getting better, we're getting bigger. In fact, our plans call for additional staff in almost all of our offices. In underwriting, claims, large accounts, marketing and data processing. We intend filling these jobs with people who won't be satisfied until they are working for the best company in the business—people who are themselves the best at what they do.

We've launched a nationwide search for the best underwriters, the best claims people, the best marketing people, the best data processing people.

If you're the best, we want you at Reliance, a company that really values outstanding people. And rewards them.

If you're the best, convince us. Write to our president, David Woodward, at Reliance Insurance Company, 4 Penn Center Plaza, Philadelphia, PA 19103. Of course, if you're only pretty good, you might want to save the stamp.

Reliance 1817

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An Equal Opportunity Employer

Employee Benefits Communications Conference

On August 3 & 4 an influential group of employee benefit executives will meet to explore issues critical to their professional responsibilities. The annual Business Insurance Conference provides an opportunity to gain valuable insight into communicating benefits to employees.

Speakers

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Manager, Compensation & Benefits
PEARL HEALTH SERVICES
Tax Reform and 401K

Catherine A. Corse
Employee Benefits Officer
BARNETT BANKS INC.
Communicating COBRA

Laura Fairman
Director, Product Research & Development
Group Insurance Marketing
METROPOLITAN LIFE INSURANCE COMPANY
PANELIST: *Triple Options*

Victoria George
Benefits Specialist
Benefit Planning Department
BANKAMERICA CORPORATION
PANELIST: *Utilization Review*

Sally Gottlieb
Flex Plan Coordinator
PACIFIC GAS & ELECTRIC COMPANY
CASE STUDY: *Total Benefit Programs*

Alfred Hayes
Director, Human Resources
SONY CORPORATION OF AMERICA
CASE STUDY: *Computer Communications*

Jeffrey Horn
Principal
TOWERS, PERRIN, FORSTER & CROSBY
CASE STUDY: *Total Benefit Programs*

Alfred Malecki
Publisher
BUSINESS INSURANCE
EBC AWARDS

H. L. Marchant
Principal
WILLIAM M.MERCER-MEIDINGER-HANSEN,INC
CASE STUDY: *Interactive Video*

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

Arnold Milstein, MD
President
NATIONAL MEDICAL AUDIT
PANELIST: *Utilization Review*

Agenda

Keynote Address ***Monday, August 3***
Influence — Elaina Zuker, President of Success Strategies, sets the tone for the 1987 EBC Conference. Effective communication possesses a powerful ability to influence. Communicators sometimes get lost in a maze of glitz and glitter, worrying too much about deadlines and production values. Employee benefits communicators may also get bogged down by legislative and health care cost control requirements. But no communicator should ever lose sight of the impact communication has ... its potential to influence attitudes, choices and responses. Ms. Zuker will walk you through six influence styles — discover an approach that can get you results.

Communicating COBRA
COBRA Simplified — Creative ways of communicating COBRA to employees and keeping paper work down to a minimum. Find out how one company took the sting out of COBRA.

Triple Options
The Challenge — Communicating indemnity plans, HMO and PPO options to employees. The challenge begins with devising a plan that keeps information overload to a minimum and ends with effective communication that still defines the parameters of employees' choices.

EBC Awards Luncheon
Achievement — Recognizing outstanding communications programs, Alfred Malecki, Publisher, Business Insurance, presents the 15th Annual EBC Awards. Also shown will be the first place a-v winner.

Research — Techniques
Inspiration — Developments in consumer research and statistical techniques inspire a new management strategy that identifies employee satisfaction with benefits and their direct relation to corporate benefit costs.

Case Studies
Informal workshops, presented as concurrents, give you the opportunity to attend all sessions.

Flexible Benefits — A Total Program
Innovative — Pacific Gas & Electric Company's benefits program, "Flex," is a 1986-award winning example of a total communications effort, effectively communicating flexible benefit options. They've taken the complexity out of choice. Their innovative approach incorporated input from their employees.

Interactive Videos
Creative Technology — When is it appropriate? This case study of the Ford Motor Company will cover the evaluation process that confirmed the use of interactive videos, the strategy for implementing this communication program, and examples of the technology used: touch screen, digital audio and video disc.

EBC
• conference •

John Parkington, PhD
Director, Organization Research
& Analysis Services
THE WYATT COMPANY
Research

Timothy Stentiford
Consultant
HEWITT ASSOCIATES
CASE STUDY: *Computer Communications*

I. B. Wallman
Employee Benefits department,
Employee Relations Staff
FORD MOTOR COMPANY
CASE STUDY: *Interactive Video*

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

Edward J. Zeman
Director, Employee Services
THE LONG ISLAND RAILROAD
PANELIST: *Triple Options*

Elaina Zuker
President
SUCCESS STRATEGIES
KEYNOTE: Influence In Communication

Computer Communication
The Cutting Edge — Why Sony Corporation opted for computer communication and how they combined market trends with technological innovations to implement state-of-the-art interactive computer communication vehicles. This case study walks you through personalized benefits and provides scenarios for combining benefit options.

Case Studies ***Tuesday, August 4***
All three case studies [illegible]ated.

You Be The Judge
A-V Excellence — Presented annually, this energetic session presents audio-visual programs submitted to the EBC Competition. You be the judge — see what other industry professionals are doing in this medium.

Luncheon
A final opportunity to gather with industry leaders and peers.

Utilization Review
Performance — The nature of utilization review demands peak performance. This session provides an examination of operations, key findings on performance levels and a look at how one benefits department performs this communications task.

Tax Reform & 401k
Issues and Ideas — Better marketing is essential to communicating tax reform and 401k, especially to lower paid employees. Find out how humor and a promotional contest got attention and boosted participation.

Adjournment
Until next year ...

Registration

The BI Conference opens Sunday, August 2, with registration check-in and a cocktail reception from 5-7pm. Sessions begin Monday, August 3 at 8:30am. The conference adjourns Tuesday, August 4 at 4:30pm.

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

Payment required with registration. All registrations will be confirmed.

Cancellations must be received in writing. A refund will be made on cancellations received prior to July 1. A **$100** service charge will apply to cancellations received after July 1. No refund will be made on cancellations received less than 5 business days prior to the conference. If your plans change, you may substitute the name of another person from your company without penalty.

To register, complete the form and send it with your payment to:

Business Insurance, Communication Services Department,
220 E. 42nd St., Suite 930, New York City, NY 10017
For information call: Barbara Dalton, Registrar, at (212)210-0780.

Hotel Accommodations

We have set aside a limited block of rooms at a special rate of **$130 single/$150 double**, at the Grand Hyatt Hotel in New York City. These rates are available to Conference Registrants only, and will be honored until July 13.

You must mention the *Business Insurance Benefits Conference* when making your reservations. Hotel cards will be included with your Conference Registration Confirmation. Or call the Grand Hyatt Hotel at (212)850-5900; or toll free at (800)228-9000.

Travel Arrangements

We have arranged for discounted airline tickets to New York City from almost every location in the U.S. Contact Travel Technology Group at 800/542-4442. You must mention the *Business Insurance Benefits Conference* to take advantage of these low rates with no restrictions.

Awards Luncheon

A luncheon ticket is included with your Conference registration. A limited number of additional seats are available for the EBC Awards Presentation Luncheon. Additional tickets are **$60** each, available on a first come-first serve-basis; **reservations required.** Contact Registrar.

Please register me for the 1987 BI Conference
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BI 6/8

Brokers must prove worth: NAIB president

By LINDA J. COLLINS

SEA ISLAND, Ga.—Brokers should emphasize their role as the client's representative and the value they add to the insurance transaction, says the new president of the National Assn. of Insurance Brokers.

"You might say we have to broker ourselves," quipped William S. Jennings, president of Johnson & Higgins of Connecticut. Mr. Jennings assumed the NAIB presidency at its 53rd annual meeting held May 26-29 on Sea Island, Ga.

"The tight market certainly gave us a chance to prove that we added value, but now that the market is showing signs of flexibility, perhaps our value-added will be less clear," Mr. Jennings explained.

Clients need to be reminded, as the market softens, that brokers "were there in the hard market, restructuring insurance programs, counseling clients on how to manage the risks they could retain and combing the marketplace worldwide to find coverage for the risks they could not" retain, Mr. Jennings stressed.

And not only did brokers help their clients find traditional insurance coverage, they also formed "significant alternative risk-transfer facilities to allow some buyers to avoid the hills and valleys of the underwriting cycle," Mr. Jennings added.

Congressional action 'will affect the way we do business for years to come,' says Mr. Jennings.

Those alternative facilities "were set up because the traditional market could not respond," said Mr. Jennings. "Our responsibility as brokers, to our clients and to the marketplace, is to build an insurance community that is able to respond to the risks of the day."

Captive insurance companies and risk retention groups will continue to serve an important and potentially expanding function for certain classes of risks, he predicted. He urged brokers not to relinquish their role in forming these groups to any "would-be competitors."

Mr. Jennings also encouraged brokers to become actively involved in lobbying efforts concerning any legislative "proposals that directly affect our competitive standing in the financial services community. . . and on issues relating to our clients and to the insurance industry."

"We have established a clear track record on our willingness to stand with buyers on insurance-related issues. . . . But we also owe it to our clients to watch out for the rights and interests of the insurance industry when those interests coincide with, rather than conflict with, the interests of insurance buyers," Mr. Jennings explained.

Insurance brokers believe in "the institution of insurance as a critical element in sophisticated risk management," he said, and a healthy insurance environment is crucial to both brokers and their clients.

Essential to maintaining a healthy insurance environment is tort reform, Mr. Jennings contended.

However, he warned brokers not to weaken their arguments for tort reform by "passing around examples of excesses as if they were spicy jokes. We must take care, if we are to champion this cause, that we have accurate statistics and authentic examples."

Mr. Jennings

He also cautioned brokers not to tie their arguments for tort reform to promises of improved insurance availability and affordability. "Some states are now re-examining their actions (on tort reform) because they are disappointed with" the lack of tangible response by insurers to those reforms, Mr. Jennings said.

This could backfire on insurers through an increase in insurance regulations.

In fact, increased insurance regulation is a very real threat to the industry, according to Mr. Jennings.

"Congress has recently learned a great deal about insurance. Now they want to fix it, and the changes they propose will affect the way we do business for years to come," he predicted.

Mr. Jennings said legislators are focusing on:

- Modification or repeal of the McCarran-Ferguson Act, which gives insurers limited exemption from federal antitrust laws and places insurer regulatory authority at the state level.
- Increasing insurer data reporting requirements.
- Strengthening methods of monitoring insurer solvency.
- Controlling insurance availability and affordability.

Brokers need to assess the potential long-term implications of these proposed changes on buyers and sellers of insurance, he emphasized.

Mr. Jennings also urged brokers and other industry representatives to encourage active public debate on these issues.

"Good policy will develop from open public debate—not from burying our heads in the sand. Self-scrutiny is painful, but it is essential" if brokers and the industry are to evolve and prosper, he stressed. ■

Blending cultures

Hong Kong may broaden China's insurance practices

By Jerome Karter

IF ALL GOES according to plan, the British flag will be lowered permanently over Hong Kong in 1997 and a fascinating period of history will come to a close as China and Hong Kong begin to blend their worlds.

The cross-breeding of these two cultures is expected to be felt in both the economic and political sectors.

Yet, the future fusion of the Chinese and Hong Kong insurance markets will have historic implications as well—because no two insurance markets are more diverse than China's monopolistic and Hong Kong's highly competitive, usually unregulated and sometimes overly aggressive underwriting practices.

Let's take a closer look at both insurance markets.

China's tradition holds that the Yangtze River traders practiced insurance more than 3,000 years ago by reapportioning their cargo to spread the risk of perilous river voyages. China also is credited with inventing the first national bureaucracy—a 2,400 year-old tradition that still exists in China today.

These two traditions dialectically met when the People's Insurance Company of China, the nation's current monopolistic insurer, was established shortly after the Chinese Communist Party gained control of the country in 1949. Despite many turbulent times, the PICC still retains a total monopoly on all insurance policies legally issued in China today.

In fact, the PICC's monopoly status was reinforced on April 1, 1985, through the enactment of regulations that authorize its exclusive right to provide:

- All compulsory coverages such as automobile insurance.
- All insurance on property in China, whether Chinese-owned or joint-venture property owned by the Chinese and a foreign partner.

international issues

The only exception to the PICC's monopoly position within China is Ming An Insurance Co., a Hong Kong subsidiary of the PICC. Besides writing all classes of business in Hong Kong and Macao, a Portuguese territory near Hong Kong, Ming An is authorized to issue admitted policies for joint-venture risks that are located in China's Special Economic Zones.

China's SEZs, established mainly in the border areas adjacent to Hong Kong and Macao, provide foreign investors with special tax and administrative benefits such as free entry and exit for foreign managers and technical personnel, and preferential treatment for imports and exports within the zones. SEZs also are permitted use of foreign currencies as well as limited repatriation of profits.

Most of China's existing SEZs are owned by Hong Kong-based companies that use labor from the People's Republic of China for re-export of finished products from Hong Kong. Undoubtedly, the SEZs have played an important role in China's recent economic expansion, but they are not the sole factor that has contributed to China's recent economic growth.

Foreign investment has recently traveled to China in the form of cooperative production projects and joint ventures that have been endorsed by the Chinese government.

In this fashion, some U.S. multinationals have tested China's economic waters and a growing number are expected to follow, despite uncertainties about the political situation.

While fostering foreign investment may be a relatively new direction for post-World War II China, the resulting influx of joint venture and development capital created a need for PICC to broaden its scope of operations. Today, PICC can provide more than 60 classes of admitted insurance, including "all-risk" policies for commercial property and construction projects.

PICC offers an admitted insurance policy that is written both in English and Chinese. More frequently, however, PICC underwrites many of the complex insurance needs of foreign joint ventures by means of a manuscript policy that must be carefully negotiated by bilingual professionals. Working with local underwriters often requires lengthy bargaining sessions between PICC and the foreign investor, but the results are well worth the effort.

Why? Unless manuscript policy wording is negotiated with PICC, a foreign investor could receive a local policy that is more tailored to Chinese than to Western concepts.

Sample local policy wordings include the following:

- PICC policies provide that all disputes shall be settled by "friendly negotiation."
- A PICC contractors' "all-risk" policy will specify coverage only for the most common named perils.

An additional clause must be endorsed onto the policy to provide coverage for "all other accidental or unexpected events," unless excluded elsewhere in the policy.

- A PICC motor insurance policy will include coverage for accidents to ferryboats.
- An "all-risk" property policy issued by PICC will cover "natural calamities and/or sudden and unforeseen *accidents*," but will specifically exclude losses arising from the policyholder's gross negligence (which is not defined precisely and is, therefore, subject to "friendly negotiation").

Fortunately, PICC's management has recognized that a monopoly insurer must try to satisfy the reasonable needs of foreign joint venture investors who have no other recourse. With patience and mutual goodwill, PICC underwriting problems usually can be circumvented.

For example, upon request, PICC will issue an insurance policy with limits denominated in foreign currency, as long as the premium is paid in the same foreign currency. Almost all PICC foreign currency policies, however, are denominated in the U.S. dollar or Hong Kong dollar.

Under some very limited circumstances, non-admitted insurance is legally permitted in China.

The situations arise largely in the case of wholly foreign-owned property, such as machinery loaned to a joint venture by a foreign parent that will be, in effect, sold to the joint venture over a period of years.

Today, the initial euphoria over the "opening up" of China has been replaced by greater sophistication and greater caution.

Today, U.S. multinationals rely on experienced Asian hands to help facilitate investment decisions. In the meantime, all eyes are focusing on Hong Kong as an impetus for expanding the insurance industry in China.

Unlike China, Hong Kong is a large regional insurance market with expertise in both direct insurance and reinsurance placement. At year-end 1986, Hong Kong had 282 insurance companies or branches that met the minimum capital requirements set forth by the Hong Kong government.

These insurers represent many nationalities, but the majority are small local companies that frequently provide a second-tier market for the big players.

In addition to a multitude of insurance companies, every major international broker is based in Hong Kong, as are several prominent insurance consulting firms.

The resulting depth of industry talent has made Hong Kong an important regional insurance center in Asia.

Hong Kong places no restriction on non-admitted insurance, except for the compulsory lines of employee compensation/employers liability and automobile liability.

In the past, there were tariff committees that ostensibly set rates for both lines. Today, the automobile liability insurance tariff is used mostly as a guideline, with prevailing discounts and/or surcharges.

But, nobody pays any serious attention to the tariff rating for employee compensation/employers liability insurance, a single policy that affords coverage for all employees including expatriates.

Tariff rates for other lines of coverage and policy wordings are highly flexible. All-risk property insurance and sizable deductibles are common. Similarly, an insurance contract in Hong Kong can be denominated in many currencies, although U.S. dollars and Hong Kong dollars are used most frequently.

The highly unregulated nature of the Hong Kong market diminishes the demand for non-admitted insurance since virtually any type of exposure can be insured locally at extremely competitive rates and conditions.

In its role as the biggest foreign investor in China, Hong Kong has continued a tradition that is rooted in the trading houses of the early 19th century. In fact, Hong Kong's role as an entrepot for China business has been increasing dramatically in recent years.

Barring a worldwide recession, Hong Kong's role should continue to increase up to and after 1997—the year that Hong Kong will shed its colonial ties with Britain and assume the status of a "Special Autonomous Region operating under the sovereignty of the Peoples Republic of China."

Yet despite a common tie, the questions still remain: Will the commonality of heritage and language help the two cultures to merge successfully? And will Hong Kong's influence in the insurance sector broaden the acceptance of international insurance practices in China?

All bets are on China rising to the challenge—but a more authoritative prognosis will have to await the opening of additional fortune cookies.

Jerome Karter is vp and manager of the New York International Department of Johnson & Higgins.

ASK A RISK MANAGER

Risk managers to focus on loss control in future

Q **Looking ahead from last year's frustrating renewal period to the next three- to five-year period, what are the most important opportunities you see facing risk managers?**

A I can only answer this question from the perspective of a company with large self-insured retentions, principally in the workers compensation and liability areas, where claim volumes are large.

While large property deductible losses also can be a part of the answer, their low frequency may not lend itself to the same degree of opportunity as may be found on the casualty side of your program.

In any effort to run an effective risk management department, one must continue to recognize that the job involves addressing the day-to-day problems found in:

- Accurately identifying and analyzing profit center risks.
- Insurance contract negotiations and servicing.
- Financial and systems control.

Gaining visibility for your risk management efforts over time, however, may be achieved through effective claims administration and, eventually, loss and risk control.

I see the most important problem or, better still, opportunity to be found in the risk and loss control area. And, the only practical way to develop an effective, supportive and measurable program is through effective claims administration.

Some of the reasons for this include:

- The apparent continued increase in large retentions required by insurers. There is a need, therefore, to assume more risk and address the problem of controlling it.
- An increase seen by insurance industry analysts in the use of alternative financing mechanisms for commercial insurance. This need is driven by form restrictions, price, ability of large policyholders to assume more risk and the fear of price and coverage swings in the marketplace.
- Concern about how to reduce the cyclical effect of the insurance marketplace on the expense of your risk management program.
- State insurance department rules and limitations on the size of self-insured workers compensation retentions. This, of course, translates into forcing you to seek alternative ways to satisfy the insurance department of your ability to manage claims, control losses and guarantee your financial ability to pay claims.
- Guarantees required by those insurance companies that are not willing to write coverage over non-fronted self-insured programs. The question I ask here is why can't you develop a more responsive program of claims administration—together with loss and risk control and financial guarantees—than others?
- The possibility, however remote at this point in time, of securing a dedicated line of credit with banking relationships to fund the peak losses of a bona fide, comprehensive self-funded program.

Stop for a moment and divide your insurance and risk management expense dollars into insured program expenses, self-insured claims expenses and service charges (for claims handling, taxes, assessments, bonds and other departmental expenses). Where are all of your dollars going?

In my case, 65% of the total dollars go to self-insured claim reimbursements, with 10% of that amount for service expense. Only 35% of my total goes to insurance policy premium expense.

This division of expense should bring the focus directly to the claim expense, an item that seems to recur annually and grows with inflation and the skyrocketing medical and hospital inflation indexes. Given the numbers of articles we see addressing health care costs, this expense seems uncontrollable. You may have to point out to senior executives the direct relationship between medical/hospital expense and workers compensation expense.

Your starting position in addressing the *cause* of this large claim expense seems to me to be in gaining attention (and recognition) for your work through the efficient and controlled administration of these claims and losses. You focus on this problem because of its visibility and measurability. The effectiveness of your efforts can be shown and understood by others.

At some point in time, the sleepy profit center decides it must do something about the cause of this expense and begins to act seriously in making a commitment to risk control. It is impossible to accomplish anything in the loss and risk control area without a commitment and desire to do something by the profit center senior management. You waste your own time and effort without this commitment.

Your goal, throughout this problem-solving exercise, is to create a risk/loss control program through your daily efforts in managing a claims administration program.

Claims administration service costs are on the rise. Levels of service vary by administrator, company and claim office. The need to measure value received from your third-party administrator or insurance company claims department is mandatory.

A comprehensive claims administration audit, addressing not only the internal (risk management department) management of the program but also the administrator, could be the best place to start.

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

Mr. Perry

This month's column, on risk management issues, is written by Ralph F. Perry Jr., vp and director of risk management at Amfac Inc. in San Francisco. Joseph W. Duva, director of employee benefits at Allied-Signal Inc. in Morristown, N.J., answers benefits management questions. William J. Miner, an actuary with The Wyatt Co. in Chicago, answers actuarial questions on benefits issues. And, Richard E. Sherman, a principal with Coopers & Lybrand in San Francisco, answers actuarial questions in the casualty field.

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

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

Building policy does not cover stolen cash

legal briefs

A special building form policy—providing for coverage of buildings or structures and attached additions and extensions, materials and supplies intended for use in the construction or repair of a building and personal property of the policyholder used for building maintenance and service—did not provide coverage for the theft of money from the business premises, the Supreme Court of North Dakota ruled.

Kelly Inc. was insured by Federated Mutual Insurance Co. under a special multiperil policy including a special building form and an implement dealers stock floater endorsement. During the policy period nearly $8,000 was stolen from Kelly's business premises. Kelly sought reimbursement for the lost cash under the policy. Federated denied coverage.

Kelly then sued Federated. The trial court ruled for Federated.

The appellate court said that the language of the policy was clear and explicit. "Coverage is afforded for buildings," the court said, "and money is not included within that coverage. In order to impose liability under that provision, we would have to strain the clear language of the policy." *Link vs. Federated Mutual Insurance Co.*, Supreme Court of North Dakota, May 13, 1986 (*BI*/01/M—$10).

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.*

Business interruption

A business interruption policy covering a restaurant damaged in a storm could be construed to allow for coverage after the restaurant had reopened but before the previous level of operation had been re-established, a Texas appellate court ruled.

Island Recreational Development Corp. operated Alexis, a restaurant in Texas. An insurance policy with a business interruption endorsement was issued by Lexington Insurance Co. on April 23, 1982. Alexis opened in August 1982; but in September 1982, a wind and rain storm caused severe damage. The restaurant was actually closed from Sept. 11, 1982, until Dec. 3, 1982. The restaurant did not regain its previous level of operation until June 1983.

Island filed suit to recover under the business interruption endorsement. The trial court awarded Island a total of $55,109.38 in damages. The award included $20,000 for lost profits between the reopening in December 1982 through June 30, 1983. Also, the court awarded Island $328,000 for the same period for fixed expenses of $65,000 a month less a total credit of $126,890.62.

On appeal, the insurer argued that it was an error to allow recovery for any loss after the restaurant reopened. The appellate court said that, unfortunately, the policy here was not drafted in terms that specifically related to the restaurant business. Thus, the court said that the uncertain language was to be interpreted to avoid forfeiture or diminution of the policy. The court said that the lower court's decision that the policy did allow for recovery for the period the restaurant was rebuilding its business was not inconsistent with a business interruption endorsement. The trial court decision was upheld. *Lexington Insurance Co. vs. Island Recreational Development Corp.*, Court of Appeals of Texas, March 6, 1986, *rehearing denied*, April 9, 1986 (*BI*/05/F—$10).

Insurers share liability for cycles: Experts

By LINDA J. COLLINS

SEA ISLAND, Ga.—Insurance company top management will be held accountable for future severe swings in the property/casualty underwriting cycle, predicts one insurance company executive.

Most large insurers now have very sophisticated monitoring systems that track insurance pricing patterns, reports William E. Thiele, executive vp of New York-based Continental Corp. and president of its brokerage and special operations group.

With this information available to them, "management won't be able to duck responsibility" for the severity of market cycles, Mr. Thiele says.

"Front-line pricing is very much a product of the will and direction of senior managers. It's up to them how they behave over the next two years," Mr. Thiele told industry representatives attending the annual meeting of the National Assn. of Insurance Brokers held last month on Sea Island, Ga.

Mr. Thiele and three other insurance company representatives discussed the key issues currently facing casualty underwriters, including the emergence of competition among insurers, the role of reinsurance, long-term relationships with clients, court interpretation of insurance policies and the future of risk retention groups.

While new pricing control mechanisms are in place now, insurers need to give them time to work before changing their pricing strategy, advised panelist William E. Buckley, chairman and chief executive officer of Crum & Forster Commercial Insurance in Morristown, N.J.

William H. Boornazian, senior vp-national accounts for Aetna Life & Casualty Co. in Hartford, Conn., agreed. Insurers will have to set up the "necessary monitoring vehicles within their own organizations to be able to monitor their written premium price adequacy on a current basis," he stressed.

While current insurer results indicate that the financial condition of insurers improved significantly in 1986 compared with the past several years, insurers should curb their exuberance and avoid engaging in wide-scale competition, Mr. Boornazian warned.

"We have to acknowledge that the calendar year price adequacy, or published results, always lag the written premium adequacy," he said.

A careful examination of the current property/casualty insurance market will reveal that these "adequate prices are now beginning to fall. If those players who left the market in difficult times are now hungry to come back into the market and get their market share, the adequate and falling prices are going to become inadequate and falling prices in a year or so," Mr. Boornazian warned.

Photo: Linda J. Collins

Participating on the NAIB panel are from left: Moderator Martin J. McFadden Jr. of Marsh & McLennan; William H. Boornazian of Aetna Life & Casualty; William E. Buckley of Crum & Forster Commercial Insurance; Charles J. Clarke of Travelers Insurance Co.; and William H. Thiele of Continental Corp.

Yet, he added, "1987 results will still show excellent numbers."

Reinsurance soon may play a more important role in insurance companies, panelists said.

Insurers that assumed larger net retentions when faced with reinsurance availability and recovery problems once again may cede larger portions of each risk to reinsurers, but only to pre-approved reinsurers and only when the price is right.

Insurers learned to operate more independently of reinsurers during the last hard market, Mr. Thiele pointed out.

And, if insurers need reminders of why they began taking larger net retentions, "we'll keep getting them in the form of unrecoverables. . . that loom ever larger on company balance sheets," he said.

According to Mr. Thiele, insurers should assume some of the blame for the reinsurance crisis, because most were eager to pay premiums for reinsurance that often could have been predicted as inadequate.

Many reinsurers that went bankrupt from these practices are now "having their revenge from the grave," as ceding insurers are unable to recover their losses, he pointed out.

A more careful examination of the financial stability of reinsurers is necessary in the future, Mr. Thiele stressed. "Until several years ago, we had several hundred approved reinsurers. One of my goals is that I hope, before I retire, to have all of our reinsurers on one postcard," he quipped.

During the most recent tight market, "we increased our net retention as high as we ever will. If the price stays high, I have a huge appetite for net retention," said Charles J. Clarke, senior vp of Travelers Insurance Co. in Hartford, Conn.

Mr. Buckley agreed that a careful examination of reinsurers is crucial. Crum & Forster's list of approved reinsurers "is a lot shorter than it ever was before and the security committees we have in place go through a very vigorous analysis of reinsurers before they are approved. . .It's a greatly reduced list."

One key to stabilizing market swings and improving the insurance climate is forging long-term relationships between insurers and insurance buyers, panelists agreed.

Mr. Boornazian of Aetna said brokers should encourage their clients to stick with the insurers that provided them with coverage during the last hard market.

Mr. Clarke said that loyalty between insurers and their clients is essential to the insurance industry. The ability to build long-term relationships requires cooperation and understanding between both parties, he added.

And the best way for insurers to emphasize commitment to their clients is through superior claims service, Mr. Clarke said.

Improvements to insurance company claims departments will pay off down the road in lower settlement costs, he stressed. However, he conceded that insurers may have a hard time convincing their boards of directors that these up-front costs are justified.

Insurers need to recognize that their strengths and weaknesses are more apparent to their clients "in their delivery of service rather than in the products they provide. It is imbedded in the claims function," Mr. Thiele agreed.

While the panelists agreed that they would be happy to step into the marketplace and provide coverage to their clients for such difficult lines as pollution insurance, they pointed out that court interpretations of policy contracts have held insurers responsible for claims they never intended to pay.

"What's holding all of us back is concern over whether or not we can write a contract that will be respected in court. We have no confidence that our agreements will stand the test of time," Mr. Thiele stressed.

"I'd love to write pollution liability coverage, but I need regulatory control to do it," Mr. Clarke agreed.

While many regulators infer that insurance rate regulation would solve availability problems, Mr. Clarke said: "We need loss cost regulation, not price regulation. Judicial predictability is the best chance we have to stabilize cycles."

Mr. Thiele said there will be one significant change in the insurance marketplace of the future.

"Companies are pursuing divergent strategies. . .and have abandoned the effort to be all things to all people," he said.

Insurers have begun to recognize that they cannot be experts in all fields, keep up with changes in every industry and compete in all markets, Mr. Thiele explained.

The panelists also predicted that their greatest competition in the next few years will come from other insurers as opposed to risk retention groups.

Mr. Boornazian does not expect the formation of risk retention groups under the 1986 amendments to the Risk Retention Act of 1981 to lure a significant number of potential insurance buyers away from the traditional marketplace.

He views risk retention groups as primarily a byproduct of the last hard market. "I don't see them right now. . .as having a major impact on the marketplace."

There will always be those entities "who think they can come into an industry with hundreds of years of experience" and do a better job, Mr. Buckley agreed.

The panel was moderated by Martin J. McFadden Jr., a managing director and account executive in the Chicago office of Marsh & McLennan Inc. ■

NAIB meeting sets record

SEA ISLAND, Ga.—Insurance company executives turned out in record numbers for the 53rd annual meeting of the National Assn. of Insurance Brokers held at the Cloister, a posh resort on Sea Island.

The NAIB annual meeting, held May 26-29, drew 65 NAIB members and 39 non-members, who were primarily insurance company executives, as well as 79 guests.

Brokers said the large attendance by insurance company executives was indicative of more competitive conditions in the property/casualty insurance business.

However, notably missing this year from the roster were representatives of the London market. While that could reflect diminished interest in London for U.S. risks at lower rates, NAIB representatives said that an annual spring meeting between NAIB executives and London market leaders was postponed until summer. This spring meeting usually generates London interest in the NAIB annual meeting, they explained.

Members of the Washington-based NAIB include most of the national insurance brokerage companies, as well as regional and local brokerages.

Risk groups create worries: Regulator

By LAURA MAZZUCA

SEA ISLAND, Ga.—The 1986 amendments to the Risk Retention Act of 1981 were "passed too quickly, without adequate study and knowledge on its potential impact," according to one state insurance regulator.

Addressing the 53rd annual meeting of the National Assn. of Insurance Brokers last month in Sea Island, S. David Childers, director of the Arizona Department of Insurance, praised the motives behind the act.

But, Mr. Childers expressed concern about its eventual impact on state legislators, who may be unable to move quickly enough to prevent potential solvency problems for risk retention or purchasing groups.

And, because of the potential glut of alternative markets in the future, Mr. Childers said the act could exacerbate a return to the "unhealthy" competitive market of 1981-1984.

The purpose of the 1986 amendments to the Risk Retention Act, Mr. Childers explained, was to enhance the availability of liability insurance by expanding the permissible scope of operation of risk retention and risk purchasing groups, and by freeing them from multiple-state regulation.

Under the amendments to the law, risk retention groups can be formed by businesses and professionals in similar businesses to self-fund all liability risks except workers compensation; purchasing groups permit businesses and professionals to buy liability insurance as a group.

"Perhaps the most important reason for the federal law's passage was the political need for Congress to act, and act rapidly, to deal with the mounting problems associated with the pricing and availability of casualty insurance," he explained.

But the liberalization of risk retention group requirements ultimately may spawn real headaches for the state regulators, Mr. Childers said, because regulators have less authority to monitor their activity.

The National Assn. of Insurance Commissioners adopted a model regulatory act in December 1986 to address some of its concerns about the revamped Risk Retention Act and is now considering additional amendments (*BI*, Dec. 15, 1986; April 27).

"We all anticipated that there would be a number of purchasing groups and risk retention groups formed with which we'd have to deal in the upcoming year," Mr. Childers explained.

"We also wanted to try our best to provide a relatively consistent framework for state regulators to use when dealing with risk retention groups," Mr. Childers continued.

He added: "It was not our idea to regulate where the federal law has precluded or pre-empted regulation. But it was our desire, if we could, to regulate where they were not pre-empted."

Mr. Childers

One of the major problems that state regulators face is an inability to move quickly to stop the operation of a risk retention group that they believe to be in "hazardous financial condition."

Under the law, state regulators first must carry out a full examination of the risk retention group, then must file a petition with a state or federal court, which must issue an injunction to halt the group's activity.

Meanwhile, a group that has been established for fraudulent purposes can continue to operate unhindered, said Mr. Childers.

When founders have formed these groups "for the purpose of getting a lot of money very quickly and getting out of town, those are the people we really can't get hold of under the law, and that's our concern," he said.

While most entities forming risk retention or purchasing groups are legitimate, "there are the ones that go into the business knowing that in all likelihood they're not going to pay claims. They're the ones we have the problems with and the ones we try to gear the law around," Mr. Childers pointed out.

He predicted an insolvency boom in three to five years if states aren't given more authority to crack down on financially unstable groups, since it may take that long for their abuses to surface.

Through its model act, the NAIC also has attempted to more clearly define some of the terms used in the 1986 amendments to the Risk Retention Act, Mr. Childers pointed out.

In particular, Mr. Childers cites the vagueness of the term "located," used to determine the state in which the group must file.

Currently, the term could refer to:

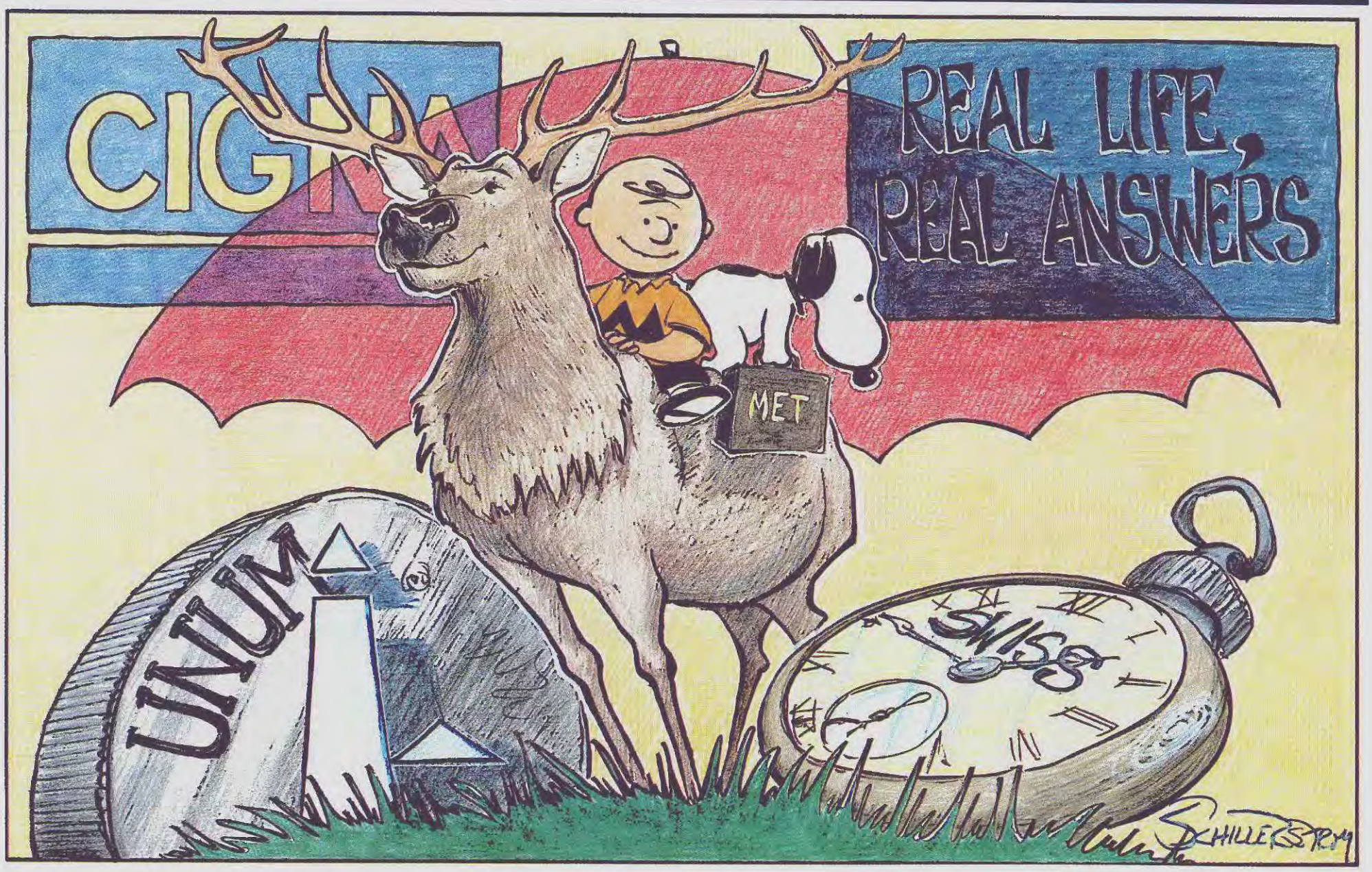
- The state where the risk or exposure exists.
- The state of domicile.
- The state with the highest aggregate premium.
- The state where most group members reside.

The NAIC is attempting to clarify this term, Mr. Childers explained.

According to Mr. Childers, the NAIC will continue to amend its model risk retention act as new problems and questions develop. ■

insurer topics

A special editorial section
sent exclusively
to insurers and reinsurers



A NEW LOOK

Insurance companies craft identities to project modern image

By AVRA WING

Insurance companies are investing a significant amount of time, effort and money to polish their images.

And, for many of the companies, the goal is often the same: They want to retain their traditional hallmarks of security and stability, but they also want to project the image of being modern, aggressive and innovative companies.

This is especially true for the growing numbers of insurers that are branching out into the broader financial services marketplace. Their goal is to transfer the reputation they've built up over the years in the insurance industry to their new lines of business, while shedding any negative associations potential customers might harbor about insurance companies.

And, in some cases, while a company may have a strong reputation within the insurance industry, consumer awareness of the company is low, making it difficult for the insurer to break into the competitive financial services arena.

The message that insurers are sending out is that "we are more than we were before," says George Trapp, vp of corporate communications at New York Life Insurance Co.

For example, Hartford Insurance Group's new ad campaign is aimed at portraying the insurer as "a modern, innovative company that still retains all the traditional values that consumers expect of an insurance company—stability, dependability and integrity," comments Roger Dove, senior vp-corporate relations for the Hartford, Conn.-based insurer (see story, page 24B).

Insurers like Travelers Corp. and New York Life each are spending about $20 million a year to convey new corporate images to a national audience (see story, page 24D).

There is an "increasing need" for insurers to portray a corporate image "consonant with strategic directions," says William Potvin, a partner with Touche Ross & Co. in New York, discussing the importance of "building market image" in the newly competitive financial services industry.

In a field such as financial services "where you are dealing with an intangible product, there's not much of a gap between corporate communications and marketing communications," notes Stephanie Brown, an account supervisor with Lefkowith Inc, a New York-based marketing, communications planning and design firm.

Arkwright Mutual Insurance Co. in Waltham, Mass. —formerly Arkwright-Boston Manufacturers Mutual Insurance Co.—changed its name to reflect its nationwide presence and to update its image, notes Sherril Brown, vp of marketing (see story, page 24E).

"Companies in any industry in flux—subject to change faster than usual—have an imperative to communicate that they can handle change and are prospering in the environment of change," comments Clive Chajet, chairman and chief executive officer of Lippincott & Margulies, a New York-based corporate communications firm specializing in corporate identity programs.

Lippincott, a unit of Marsh & McLennan Cos. Inc., has worked with Arkwright, New York Life and UNUM Corp. of Portland, Maine, among others, on major corporate identity programs.

Without a renewed emphasis on corporate identity, Mr. Chajet says, companies communicate "the way they were, rather than what they've become."

"There's a major gap between where (insurers) really are and how they communicate about themselves," says Ms. Brown of Lefkowith, who formerly worked in corporate communications at American International Group Inc.

"There's a perception on the part of the general public that insurance is a conservative industry back in the Dark Ages. That's not true anymore," Ms. Brown adds.

But some insurers are not helping themselves, Ms. Brown notes: Much of the external communications produced by insurers is "schlocky stuff—it looks like

Continued on next page

New York Life ads reflect diversification

By AVRA WING

NEW YORK—New York Life Insurance Co. is bringing its message of diversification to the general public.

The insurer launched in September 1986 a print and television advertising campaign, which will cost between $50 million and $100 million over the next five years, according to George Trapp, vp-public relations.

On the way to launching the new ad campaign—designed by Saatchi & Saatchi Compton in New York—the insurer also found itself developing a new name to identify its securities-based product offerings: NYLIFE.

The ads and new name, Mr. Trapp said, are designed to convey that New York Life, which the company felt was "well recognized as an old-line, traditional life insurance company, had gotten into other kinds of insurance and financial services products."

"Did the name New York Life Insurance define the company now and what it would be in the future?" was one of the first questions management asked itself in late 1985 before beginning to develop the new ad campaign, which would put New York Life commercials on TV for the first time in two years.

Although there wasn't much sympathy in-house for changing the name, Mr. Trapp recalled, the insurer called in New York corporate communications firm Lippincott & Margulies for help. The insurer wanted to find out what "barriers the name New York Life put up to positioning ourselves as a broader financial services organization."

The consultant, which had developed New York Life's current logo approximately 20 years ago, set up survey groups of potential customers, talked with senior management, field personnel and competitors, and reviewed the company's printed materials. Lippincott concluded that there was still a good deal of "integrity" to the New York Life name, Mr. Trapp reported.

However, the company was perceived as primarily offering individual life insurance, noted Jim Johnson, senior vp at Lippincott. The insurer, he said, needed a name to identify its new risk-based products, the "more aggressive" part of its business.

The decision was made to divide the company into two areas, Mr. Johnson explained. Under the heading of New York Life Insurance would fall the company's traditional insurance products. The company's risk-based products would be identified by the newly developed name NYLIFE, which was launched in September 1986, at the same time as the new advertising campaign.

The new designation "signalled a change," Mr. Johnson noted, while still "keeping a bridge to the old New York Life" and its strengths.

The company had "achieved a reputation and level of awareness over the years that was very, very valuable," commented Clive Chajet, chairman and chief executive officer of Lippincott. "Why abandon all history?"

"The NYLIFE name will become whatever (the company and market) make it," he added. "By association and performance, it will begin to develop an identity separate from New York Life."

To facilitate that, it is very important to "adhere strictly" to the separate use of the two names, Mr. Chajet warned.

Lippincott developed guidelines for the company to use in advertising, promotion materials, employee literature, signs and even on vehicles, Mr. Johnson noted.

All printed materials coming out of New York Life are being redesigned, Mr. Trapp explained, not only to reflect the two names for the company's services, but also to give them a "more contemporary" look.

Although it's been "very complicated" to rework stationery and forms for the home offices, branches and agents, "it's important to get all procedures done upfront," Mr. Trapp commented. "Otherwise you have a mishmash for a system."

The advertising campaign itself grew directly out of the findings from the focus groups set up by Lippincott and by Saatchi & Saatchi to test reactions to the New York Life name, Mr. Trapp noted. These focus groups consisted of the company's target market for its securities products: upscale, college-educated professionals earning more than $40,000 annually.

"What we would hear," Mr. Trapp said, is "I'm great at what I do—I'm a great writer and I also play a mean game of tennis, but when it comes to finances. . . ."

What people need, the focus groups revealed, is a professional to lead them through financial decisions. New York Life took this information and tied it together with what it perceived to be one of its strengths, its agency force, and "Voila, you have a campaign," Mr. Trapp remarked.

Through the image of a door opening onto a huge, modern office filled with busy professionals and electronic equipment, the insurer is aiming to suggest that it is an "up-to-date company that can serve financial needs," Mr. Trapp explained.

The company, in studying the competition, perceived that "No one else was talking about the delivery system. The commercials never told (people) where they could go (for financial advice)," he noted.

New York Life plans to use its ad campaign at least through the end of the year, Mr. Trapp said. The first-year budget for print and electronic advertising was $18 million. Mr. Trapp said the company will monitor the impact of the ads and "assess the competition" before deciding what to spend in the future.

The insurer will continue conducting market research on the effectiveness of its advertising campaign.

Although companies usually wait a year before looking at advertising impact, Mr. Trapp commissioned a study after six months, he said, because "I got antsy."

The initial results show "We're beginning to move into the public's perception as a broader financial services company," Mr. Trapp said. ■

'Arkwright' moniker shows updated image

By AVRA WING

The insurer dropped 'Boston,' because the regional connotation was too 'limiting,' Ms. Brown explains.

WALTHAM, Mass.—Arkwright-Boston Manufacturers Mutual Insurance Co. was not the right name to reflect the up-to-date image the insurance company wanted to convey, says Sherril Brown, vp-marketing.

So, in March the Waltham-based member of the Factory Mutual System changed its legal name to Arkwright Mutual Insurance Co. and its "communicative" name—the one it uses in advertising and promotion materials—from Arkwright-Boston Insurance to simply Arkwright.

The company wanted to keep the Arkwright name because it had "a lot of history," Ms. Brown said. It dropped "Boston," however, because the regional connotation was too "limiting." It also eliminated the word "Insurance" because "this company is much more than an insurance company," she added.

And, referring to the old legal name, she said the term "Manufacturing" had become "a total misnomer."

The name change was the product of a 10-year review of the insurer's operations, Ms. Brown explained.

ARKWRIGHT

"As a rule of thumb, most companies go through changes every decade," she commented.

Arkwright started two years ago to take "a long, hard look at what it's become and what it wants to be," Ms. Brown said, and decided that the time was right to take a major step.

"What compelled us was that we had become a much more marketing-oriented company, especially coming out of the last insurance cycle. We had expanded products and services and truly customized our work," Ms. Brown noted.

Arkwright, a recognized leader in writing all-risk property insurance, initiated its corporate identity program to help "define (Arkwright) and where we want to go," Ms. Brown explained.

It wasn't a case of "just designing a new logo" so people would say "that's nice." Arkwright wanted to "bring all facets of the company into clear focus in order to have a clear presentation to the public."

Before deciding on any changes, the company called in New York-based communications consultant Lippincott & Margulies to help it analyze the insurer's strengths and how it was perceived in the marketplace.

Some of the questions the company wanted answered by Lippincott's research, according to Ms. Brown, included: "What do we need to do that is appropriate? What is the appropriate positioning strategy? Do we need to do things differently? Do we need to clarify things?"

The insurer found that "the public's perceptions (of the company) were the same as ours," Ms. Brown recalled.

"It was nice to find out."

She said that the "direct service approach to business" that Arkwright fosters was found to be "quite valued by customers." While that "jibed" with what the company's management and employees in the field perceived, the corporate identity program helped the company to bring that knowledge "to the fore" and "improve the leverage in communications."

Arkwright is now developing an advertising campaign that will incorporate the new name, Ms. Brown pointed out. But, she downplayed the significance of an advertising campaign, saying that "personal contact" is a "more critical way" of communication for Arkwright. ■

Road to UNUM was long, arduous

By AVRA WING

PORTLAND, Maine—Union Mutual Life Insurance Co. found itself in an unusual situation after deciding to go public: Legally, once it "demutualized," it could not use its name anymore.

Last November, the company officially became UNUM Life Insurance Co.

And, while it seems to be only a short leap from Union Mutual to UNUM, the road between the two names was actually a long and arduous one, according to Susie Gribbel, project manager for public relations at UNUM.

The Portland, Maine-based company decided to go public in 1983, and began its search for a new name early in 1985, around the time it filed its demutualization plan with Maine's superintendent of insurance, Ms. Gribbel said.

The insurer first contacted a number of consultants, including Lippincott & Margulies, a New York-based corporate communications firm, and the one UNUM eventually chose to direct its identity program.

Lippincott worked closely with the company's senior management to develop criteria for what the new name should be, Ms. Gribbel continued.

These criteria included:

- No limitation on the range of products and services offered.
- Distinctiveness.
- Ability to bridge with the past.
- Clarity.

From an original list of 500 names (which, interestingly, included Allegis), the company narrowed the field to 20, from which UNUM emerged as the final victor.

The name serves the bridge function, Ms. Gribbel said, and also raises associations with the motto "E Pluribus Unum" found on U.S. coins and dollar bills. The meaning—one out of many—suggests "we stand out from the crowd; we are unique," Ms. Gribbel explained.

UNUM is a "totally unique construction," said Clive Chajet, chairman and chief executive officer of Lippincott.

"It can be made to mean anything. It's not an English word, but is very familiar to any one who ever carried a coin in their pockets," Mr. Chajet said.

He emphasized the obstacles to a name change: "Most names have been taken, and it is very time consuming," he added, referring to the testing required to find a suitable name without negative connotations in any language.

Along with the new name, Lippincott designed a new logo for the company, retaining the lighthouse symbol that research showed holds a good deal of equity.

The letters UNUM in the logo were "tilted," Ms. Gribbel explained, to give the impression of movement.

The idea was to convey that the company "is not standing still, it is going somewhere."

Dark gray was chosen for the letters, blue for the symbol. While gray was considered "not as stodgy as black," she said, the company wanted something that was low-key.

"Obviously, when you're an insurer you can't be too out of line," Ms. Gribbel commented.

Once the name was picked, the company embarked, in the fall of 1985, on an advertising campaign "focused on policyholders and people in the community" to "roll out" the name, she continued.

In November 1986, the campaign to increase name recognition was brought to national publications, such as the Wall Street Journal and Time.

It was the first time the company had advertised to a public audience, noted Kathryn Davis, manager of corporate advertising. Before that, the insurer had advertised only to the insurance brokerage community, she said.

Meanwhile, along with registering the name, the company began using the tag line, "the UNUM commitment to excellence," in advertising and sales promotion materials to establish ownership of the name through usage, Ms. Gribbel explained.

It also was necessary to refile documents notifying the Maine superintendent of insurance of the company's new name, to change the name of all of its subsidiaries, and then to refile both the corporate and subsidiary names in all 50 states, Canada and Mexico, Ms. Gribbel said. Each state and country had different regulations concerning name changes, he noted.

The UNUM name serves the bridge function, Ms. Gribbel says, and also raises associations with the motto 'E Pluribus Unum' found on U.S. coins and dollar bills.

Everything with the company's name on it—from signs to forms to cars to stationery—had to be changed.

The company felt it was important to consistently use the new name and logo, Ms. Gribbel said.

To this end, brochures were created explaining the name change to employees and those doing business with the company.

In addition, the company newsletter published numerous articles explaining the changes, and a slide show was developed to show employees how the new name and logo were to be used.

A graphics standards manual was produced to provide guidelines for using the new name and logo, as well as official formats for business forms and letters.

Printing also has been centralized, and all new materials must meet the established standards.

Although Ms. Gribbel termed employee compliance with the changes and new standards "pretty successful," she admitted, "we have met with some resistance. People like to do things their own way."

In February, UNUM started a new corporate image advertising campaign aimed at a national audience and, more specifically, at the financial community, according to Ms. Gribbel.

That campaign, on which UNUM will spend $2.5 million this year for print advertising, emphasizes the company's special niche—long-term disability insurance, Ms. Gribbel added.

The second campaign links the new name with the company's "business mission of relieving financial risk by protecting income," Ms. Davis said.

"We are clearly directed," she added, pointing out that the advertising is "unified" to convey a total message about the company rather than highlight one specific product.

This "faces" campaign, which features close-up photographs of people who have had accidents that threatened their earnings, evolved from discussions with senior managers who described the company's primary business as "income protection," Ms. Davis explained.

After that message tested positively on focus groups, the company asked Brouillard Communications in New York to develop the campaign, Ms. Davis said.

The ads are designed for "stopping power" she noted—large close-ups of "startling" faces used in conjunction with bold headlines and "lots of white space" in a spread format.

The campaign will be used for 18 to 24 months, Ms. Davis said.

Although it is too early to judge its impact on customers, she noted, reaction from the field sales force has been very positive: "It's great you're getting your name out," they've told the home office. ■

Hancock adopts label to depict services

By AVRA WING

BOSTON—John Hancock Mutual Life Insurance Co. is using an attention-grabbing "Real life, real answers" advertising campaign to promote the company's expanding services.

John Hancock Mutual Life which began diversifying in 1968, adopted the label John Hancock Financial Services at the end of 1985. At the same time, the insurer launched the new advertising campaign, which features vignettes of Hancock representatives helping solve real-life financial problems, explained Frank King, general director of advertising.

At the time, Hancock management had begun to realize that the legal name of the company did not sufficiently convey the image of a broad-based provider of such financial services as mutual funds, municipal bonds and other securities, as well as a wide range of life, health and property and casualty insurance, according to Richard Bevilacqua, director of corporate public relations for the insurer.

"We took a look at the name," he recalled, and decided "change was necessary."

The "clear financial services label was the best way to portray to the public" what the company had to offer, Mr. King added.

Market research conducted following adoption of the financial services logo showed that seven out of 10 people surveyed "preferred a company that offered diversified financial services" rather than just life and health insurance, Mr. Bevilacqua commented. Respondents perceived the company "to offer more options and choices," he added.

The study, which was conducted by SRI Research Center Inc. of Lincoln, Neb., sampled 1,000 heads of households nationwide chosen at random from neighborhoods where the average household income was more than $30,000 annually.

The research also indicated that 57% of those responding thought the new name showed diversification; 17% said the new name showed exactly what the company is; 10% said the new name sounded better than the legal name of the insurer; while the remainder gave a variety of responses, noted Charles Tarbox, general director of communications planning and programs.

Hancock is using its financial services logo to convey the same message in both its print and television advertising, explains Frank King, general director of advertising.

What these market research results revealed, Mr. Tarbox continued, was the significance of "branding" the company's various businesses with the financial services identification.

As a result, John Hancock Financial Services became the "umbrella for the entire company," he said. It was a label that could "unify, yet talk to the diversity of the company."

The insurer showed its commitment to the new logo with a $20 million national advertising campaign and with "heavy documentation," both in print and video, to its field offices, Mr. Tarbox said.

The John Hancock signature, however, was retained. "We haven't walked into that trap," Mr. Tarbox said, referring to the danger of throwing out a company's established reputation and recognition factor when making a change.

"The signature is the one constant. It has the attributes of stability and longevity we want to maintain," he stressed.

The logo change "had to be executed with great care," Mr. Tarbox recalled. All levels of management were involved in developing it. The most difficult part of adopting the new logo, Mr. Tarbox remarked, was "getting people to agree on what it would look like."

"You're walking on eggshells when dealing with business cards and personal stationery," Mr. King added.

It was difficult at first to persuade some Hancock staff members to cooperate on the change, Mr. Tarbox commented. "People are rooted in the past, in sameness," he said.

Now, however, the internal response has become "overwhelmingly positive."

To ensure consistency in the use of the new logo, a corporate identity manual outlining how it is to be used in printed materials and advertising has been developed, Mr. Tarbox said.

Uniformity has begun to take hold in the "volumes of printed matter" that the company and its 17 subsidiaries have distributed to consumers, Mr. Tarbox noted. "We're beginning to speak with one voice."

Hancock is using its financial services logo to convey the same message in both its print and television advertising: That no matter what the individual's economic situation is, Hancock can help with its wide array of products, Mr. King explained.

The company wanted the advertising campaign, created by Hill, Holliday, Connors, Cosmopulos, Ingalls Associates Inc. in Boston, to "cut through the clutter" of existing financial services advertising, Mr. King explained, and be "creative, different, memorable. The common thread running through our rivals' advertising was talking about their companies, rather than about consumers."

The insurer also wanted the advertising campaign to address the changing demographics of American society, which it discovered in its own market research. Not only was the population aging, the research showed, but the number of working women and single parents also had skyrocketed.

The advertising campaign, consisting of 60-second and 30-second television spots, was positioned to run during nationally televised sporting events. The print advertisements appeared in magazines such as Time, Newsweek, Money, Working Woman, People and Sports Illustrated.

Sales representatives' reactions to the advertising campaign, now in its second year, has been "outstanding," Mr. King said. In addition, the advertisements have made a "marked difference in how we are perceived" by consumers, he noted, declining to quantify his statement.

Pleased with the results, the company will continue the "Real life, real answers" campaign throughout this year and almost definitely through 1988, Mr. Tarbox said.

"We couldn't be happier with the campaign. We see using it for some years to come. It fits whatever product, whatever target group" the company wishes to promote or reach, he said.

"The more consumers see the campaign, the more they understand it. We'll get tired of it before the consumers do."

Zurich-American to promote U.S. ties

By AVRA WING

SCHAUMBURG, Ill.—After promoting its Swiss ownership for many years, Zurich-American Insurance Group soon is going to emphasize its American presence.

Zurich-American promotes itself in corporate image advertising as "American creativity, Swiss dependability."

The corporate image campaign began about five years ago, said Robb McPherson, senior vp and management supervisor at BBDO Chicago Inc., Zurich-American's advertising agency. The concept then was to show the company having the "best of both worlds—a sugar daddy for a parent in Switzerland, but also American creativity and fast turnaround."

The decision was made to use "instantly recognizable Swiss symbols," i.e., a Swiss army knife, watch and chocolate bar, to emphasize the "strength of the Swiss parent."

The campaign was launched in Forbes magazine, which was seen as "delivering the quality corporate top executive. We wanted to use one top quality publication real well." This has proved to be a "very, very effective strategy," Mr. McPherson said, according to research BBDO conducts every two years. Name recognition is "certainly on an uptick," he said, while declining to quantify the results.

The new corporate ad campaign now being developed is intended to run this fall in Forbes and other national publications. Mr. McPherson dubbed it "Son of Corporate Campaign."

Because the company is perceived as "growing well," the management has decided to "stress more strongly the American aspects of the insurer," he noted.

But, the company's connection to an international organization still will be stressed, says President and Chief Operating Officer William Bolinder, noting that the world has become a "global village."

In addition to its corporate ads, the company began a campaign one year ago aimed at agents and producers.

"We wanted to add independent producers," said Fred Dabney, vp-corporate communications. The ads were designed to convey the idea that producers would be "associated with a quality organization with commitment to its customers," he explained.

Appearing in trade publications, the ads are designed to "build rapid name recognition" and are more "product-oriented and deal with issues important to producers," Mr. McPherson said.

"The need to 'brand' is very, very important," he stressed, noting that without the "marketing horsepower" of some other companies, Zurich-American had to "do what it could with the money available" to make itself known.

BBDO came up with the "silhouette" campaign, which features business people encountering situations in which another insurer is unable to provide sufficient service. The ads "invite people to stop and look." The use of white space allows the "logo and name to come up very big."

The ads are "efficient" to produce, and can be updated quickly, if necessary. They have an art deco look, which lends them a "trendy" aspect as well, he added.

All Zurich-American's advertising is in print. The company considered electronic advertising, Mr. McPherson noted, but decided it would not be "cost-effective."

Zurich-American once had a problem with what its name was, notes Mr. Dabney. Legally it is Zurich Insurance Co. U.S. Branch, but up until 1985, it billed itself as Zurich-American Insurance Cos. Customers and people in the business tended to refer to it in the singular, as Zurich-American Insurance Co. "No such thing existed," Mr. Dabney said.

But even after the company started using Zuich-American Insurance Group in advertising and promotion, confusion persisted about the umbrella name.

On the side of the Schaumburg, Ill., headquarters building facing an interstate, a huge sign displayed the name Zurich-American Insurance Group. But over the entrance to the home office, there still hung "Zurich-American Insurance Cos."

This lack of coordinated communications prompted the company to undertake a corporate identity program that included such basic elements as standardizing signs, stationery and other printed materials, as well as a modification and augmented use of its logo.

The stylized "ZA" shown by itself to test groups was neither widely recognized nor read correctly, Mr. Dabney said. "There was some confusion, basically, among customers. Those not familiar with the logo saw it as '7A.' We had to hang the name Zurich-American immediately under the logo."

While the company was generally satisfied with the logo in the early 1970s, it did some "fine-tuning" of it, in Mr. Dabney's words, to make it more recognizable.

"The most important thing a company has to offer (in communications) is its name and its logo," he said. These two things create "that first, quick visual" impression.

A logo is also important for the impression it creates internally, as well as externally, he noted: "That's the flag we all salute."

Mr. Bolinder stressed the importance of the logo as a vehicle for "building the culture" of the company. He has introduced lapel pins for employees and items emblazoned with the Zurich-American logo. Everything from coffee cups to jackets to golf putters are available from the "Z-A Collection."

The logo is the "capstone" of the "whole style" of the company—"what we want to get from our employees"—Mr. Bolinder remarked.

That is, Mr. Dabney summed up, "quality, service and a sense of responsibility." ■

Grade our efforts

Dear *Insurer Topics* reader:

You have received eight editions of *Insurer Topics,* this special demographic section now included six times a year in *Business Insurance* solely for our insurance company readers.

We created this section to report on the special concerns of our insurance company readers and we want to know what you think of our efforts.

Please take a few minutes to fill out the following questionnaire, tear it out of the magazine and mail it to me at the address below.

Your comments will help *Insurer Topics* Associate Editor Avra Wing and I plan future issues of *Insurer Topics* to make it more useful to you.

Thank you for sharing your time with us.

Sincerely,

Kathryn J. McIntyre
Editor
Business Insurance

1. The following topics have been addressed in *Insurer Topics.* For each issue, please note if you read the section and then rate the articles in that section, with 5 being the most interesting and useful and 1 being dull and useless.

	Did you read?			Rating
"A new look: Insurance companies craft identities to project modern image" (included articles on how property/casualty and life/health insurers have developed and promoted their corporate identities) June 8, 1987.	☐ Yes	☐ No	☐ Don't recall	1 2 3 4 5
"United front: Insurance trade associations strive for cooperation" (included profiles of the major property/casualty and life/health trade associations) April 27, 1987.	☐ Yes	☐ No	☐ Don't recall	1 2 3 4 5
"Attracting talent: Financial inroads pit insurers vs. Wall Street for high-caliber workers" (included articles on how insurers are attempting to upgrade the talent of people joining their companies) Feb. 9, 1987.	☐ Yes	☐ No	☐ Don't recall	1 2 3 4 5
"What's ahead? Property casualty insurers still unsure of effects of tax reform" (included articles on the provisions of the Tax Reform Act of 1986 affecting insurers) Dec. 8, 1986.	☐ Yes	☐ No	☐ Don't recall	1 2 3 4 5
"Game plans: Consultants coach insurers to plot winning strategies" (included articles on strategic planning, what it is and how it is implemented in several property/casualty and multiline insurance companies) Sept. 8, 1986.	☐ Yes	☐ No	☐ Don't recall	1 2 3 4 5
"On-line investing: Portfolio managers agree computers help answer 'what if?' " (included articles on computer software for investment activities and insurers' investment strategies, for both property/casualty and life/health insurers) June 16, 1986.	☐ Yes	☐ No	☐ Don't recall	1 2 3 4 5
"Snuffing out swindlers" (included articles on arson prevention, health care fraud prevention and auto claim fraud prevention) March 10, 1986.	☐ Yes	☐ No	☐ Don't recall	1 2 3 4 5
"Underwriters learning their lessons as market tightens" (included articles on how property/casualty insurance companies were revamping their underwriting practices, brokers' complaints about underwriting practices and software used in underwriting) Nov. 25, 1985.	☐ Yes	☐ No	☐ Don't recall	1 2 3 4 5

2. Do you want to read more sections based on one theme, as in the past, or would you prefer a section with stories that cover a variety of topics? Please check one of the following:

☐ Stick with a theme and cover it in detail.
☐ Give me more variety in the topics covered and less detail.

3. Do you want a new column that reports brief descriptions of new products and services offered to insurance companies? ☐ Yes ☐ No

4. Do you want to read speeches on insurance topics delivered by insurance company executives and industry observers? ☐ Yes ☐ No

5. Do you want to read personality profiles of insurance company executives? ☐ Yes ☐ No

6. Is publication every other month ☐ too infrequent; ☐ too frequent; ☐ just right.

7. Please tell us of any subjects you would like to see in *Insurer Topics* or make additional comments about the section:

_____

_____

Please mail this completed questionnaire to:

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Business Insurance
740 N. Rush St.
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Pollution case rulings differ on duty to defend

By STEPHEN TARNOFF

Two recent court decisions give differing views on whether policyholders are entitled to a defense from their insurers in pollution cases.

In *Fireman's Fund Insurance Cos. vs. Ex-Cell-O Corp.*, U.S. District Court Judge John Feikens in Detroit ruled that Troy, Mich.-based Ex-Cell-O was entitled to a defense from its liability insurers for environmental contamination alleged at 22 locations, even though it had not formally been served with a lawsuit.

But in *Witco Corp. vs. Travelers Indemnity Co.*, U.S. District Court Judge John W. Bissell in Newark, N.J., ruled the insurer did not owe Witco a defense in an environmental case in which the underlying complaint against Witco did not allege that the pollution occurred during Travelers' policy periods.

In addition, Judge Feikens ruled in the Ex-Cell-O case that coverage was not barred by either the pollution exclusion clause in general liability policies or an exclusion that bars coverage for damage to property owned by the policyholder.

He further ruled that coverage was triggered by the exposure of the pollutant to the environment and not its manifestation.

Both cases are examples of numerous conflicting decisions nationwide on whether insurers must defend and indemnify policyholders facing pollution or hazardous waste suits.

The May 18 Ex-Cell-O decision involved Ex-Cell-O, subsidiary McCord Gasket Corp., and McCord subsidiary Davidson Rubber Co., all which sought defense coverage from their primary insurers: Fireman's Fund, Wausau Insurance Cos. and Zurich Insurance Co.

According to the Ex-Cell-O decision, the policyholders received notice from a government agency or owners or operators at various sites informing them that they were potentially responsible for contamination at various sites.

The insurers covered Ex-Cell-O and the subsidiaries at various times from 1965 to 1985, under comprehensive general liability policies.

In a wide-ranging opinion, the court addressed:

- Whether Ex-Cell-O's insurers were required to provide defense coverage even though no lawsuits seeking legal damages had actually been filed against the policyholder.
- Whether an exclusion in the policies for damages to property owned by the policyholder prohibited coverage.
- Whether coverage was barred by the pollution exclusion clause in the policies.
- The time of the "occurrence" that triggered coverage under the policies.

The court first ruled that the insurers must defend the environmental claims even if Ex-Cell-O was not yet named as a defendant in a traditional lawsuit for monetary damages.

At issue was language that defined the insurers' duty to "defend any such suit against the insured seeking damages" on account of bodily injury or property damage.

"The insurers construe their policies too narrowly: Coverage does not hinge on form of action taken or the nature of relief sought, but on an actual or threatened use of legal process to coerce payment or conduct by a policyholder," Judge Feikens said.

"I hold that a 'suit' includes any effort to impose on the policyholders a liability ultimately enforceable by a court, and that 'damages' includes money spent to clean up environmental contamination."

Judge Feikens next ruled that the exclusion for damages to property owned by the policyholder did not preclude coverage "because the claims at sites owned by the policyholders include property damage to adjoining landowners and to the public."

Next, Judge Feikens held that the pollution exclusion clause did not bar coverage for the policyholders. This clause provides that insurance does not apply to bodily injury or property damage arising out of the discharge or release of various pollutants unless the discharge is "sudden and accidental."

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 1987		Consolidated revenues 1987	Aftertax[1] operating income 1987	Percent increase (decline) 1986-1987	Combined[1] ratio 1987	Combined[1] ratio 1986	Net premiums written 1987	Percent increase (decrease) 1986-1987	Pretax underwriting income (loss) 1987	Percent increase (decline) 1986-1987	Pretax investment income 1987	Percent increase (decrease) 1986-1987	Policyholders surplus 1987	Percent increase (decrease) 1986-1987
1	The Home Group Inc.	596,300	31,400	6,180.0	111.9	117.1	537,600	13.5	(58,300)	19.7	99,400	9.0	837,600	3.9
2	Reliance Ins. Co. & subs.	801,740	37,089	1,631.5	104.7[2]	114.3[2]	357,944	(17.6)	(16,058)	65.5	46,929	28.0	N/A	N/A
3	Crum & Forster Inc.	897,700	42,300	284.6	108.2	114.3	775,100	16.1	(74,700)	28.4	120,700	14.6	1,276,900	30.0
4	The St. Paul Cos. Inc.	838,471	70,042	186.7	106.8[2]	117.2[2]	650,794	10.2	(40,337)	59.9	119,578	14.0	1,084,955	27.6
5	Sentry Insurance Cos.[2]	161,199	2,666	169.0	103.3	109.3	270,602	31.3	(16,017)	27.5	29,072	32.5	400,823	75.7
6	Continental Corp.	1,562,300	87,000	150.0	99.8[2]	107.9[2]	925,500[2]	13.0	19,000	131.5	87,975	4.3	1,563,000	40.4
7	Fireman's Fund Ins. Cos.	1,008,427	66,637	121.8	107.7	111.7	955,310	11.9	(68,524)	19.1	112,095	(1.2)	1,598,098	31.3
8	Kemper Corp.	920,544	55,770	100.1	99.1	108.0	195,505	1.9	(2,905)	84.2	18,814	0.2	401,064	13.9
9	General Re Corp.	883,524	111,926	98.6	100.9[2]	106.0[2]	597,614	(0.5)	(4,034)	90.9	113,306	29.6	2,097,464	39.5
10	USF&G Corp.	1,140,026	94,829	87.6	104.5[2]	111.2[2]	938,058[2]	5.9	(30,277)	61.9	146,575	10.8	1,328,500	33.4
11	CIGNA Corp.	4,229,200	126,900	77.0	108.0	114.0	1,473,300	8.4	(111,400)	33.9	190,600	11.0	1,840,000	30.6
12	Ohio Casualty Corp.	388,972	26,010	76.6	100.5[2]	104.8[2]	353,173[2]	16.7	(3,976)	79.3	37,217	9.3	520,578	46.4
13	Chubb Corp.	876,300	78,700	74.5	97.9	101.2	638,900	10.8	11,900	174.8	62,700	15.7	1,126,200	14.7
14	American International Group	2,545,700	207,408	67.4	100.6	103.2	1,894,623	33.2	(22,022)	80.1	154,038	34.0	5,214,786	23.6
15	Hartford Insurance Group	2,285,858	69,329	67.0	103.6	107.2	1,644,625	21.5	(82,095)	23.9	148,232	6.3	2,251,843	4.1
16	Royal Group (U.S. subs.)[2]	N/A	34,800	53.3	100.4	107.4	535,600	12.7	(600)	98.6	67,700	13.8	1,041,868	65.6
17	SAFECO Corp.	693,837	54,167	49.1	98.8	107.0	353,741	10.6	4,095	119.5	41,799	19.7	836,310	22.8
18	Fremont General Corp.	N/A	6,154	48.0	105.3	115.8	65,799	(26.7)	(3,292)	72.2	9,203	(33.0)	N/A	N/A
19	CNA Financial Corp.	1,689,000	79,600	47.7	112.3[2]	116.4[2]	1,194,000[2]	9.5	(161,600)[2]	16.1	177,900[2]	10.0	1,908,000	37.6
20	Old Republic Int'l (incl. life)[3]	271,000	23,000	45.6	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
21	Travelers Corp.	5,190,000	108,800	37.7	103.0	107.8	1,388,900	7.9	(41,700)	62.2	131,800	18.4	1,846,100	18.3
22	Hartford Steam Boiler	101,057	13,072	35.2	85.3	86.6	70,479	4.6	10,284	21.6	7,487	16.3	220,242	17.3
23	Aetna Life & Casualty Co.	5,126,700	182,000	29.4	108.7	112.2	1,611,500	13.1	(127,500)	21.4	195,600	8.8	1,977,127	37.0
24	American General Corp.	1,650,000	148,000	16.5	104.2[2]	107.9[2]	390,000	16.4	(11,000)	45.0	41,000	10.8	962,000	24.1
—	Commercial Union Ins. (U.S.)[2]	N/A	N/A	N/A	107.9	116.6	285,500	0.9	(32,100)	40.1	42,200	5.4	514,400	23.6
—	Liberty Mutual Ins. Co.[2]	N/A	N/A	N/A	111.7	113.2	1,793,587	30.0	(161,445)	18.3	183,861	11.5	N/A	N/A
—	Nationwide Mutual Ins. Co.[2]	N/A	N/A	N/A	104.8	115.6	1,402,699	0.8	(51,023)	75.5	136,882	1.3	2,399,880	21.3
	Cumulative	33,857,855	1,757,599	72.3	105.3	110.7	21,300,453	12.8	(1,075,626)	44.9	2,522,663	11.9	33,247,738	26.7

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

Insurer results

Continued from previous page

This could be seen as a sign insurers are willing to lose some business rather than cut prices, said Gloria Vogel, noting the number of policies written by some major insurers is down. She added that softening rates for some lines of property/casualty insurance "really didn't affect the first-quarter numbers as far as I could tell."

But Barbara Stewart, president of Stewart Economics in New York, believes it is likely the decline in premium growth reflects the leveling or lowering of rates.

Chubb is experiencing slower premium growth because while rates are still going up, they are rising at a much slower pace than last year, said a spokesman. Chubb reported a 10.8% increase in net premiums written, to $638.9 million, compared with a 32.4% increase in all of 1986.

Net written premiums declined 17.6% in the first-quarter to $357.9 million at Reliance Insurance Cos. The company is underwriting more selectively and issuing fewer policies, a spokesman said.

Fremont General Corp. posted a 26.7% decline in net premiums written to $65.8 million as a result of discontinuing certain operations, including treaty reinsurance and all primary property/casualty business other than workers compensation and a small amount of medical malpractice coverage, said David L. McIntyre, president and chief executive officer of Fremont Insurance Group.

Rates for some lines already are coming down, while prices for other lines, like workers compensation, will continue to rise, said Mr. Stradtner, adding he does not expect to see a decline in premium volume until next year.

Along with slower premium growth, the industry is recording decreased investment income growth as well, noted Ms. Stewart. "Most of the bang in investment income comes from the cash flow in underwriting," she explained.

The relatively modest increase in insurers' cash flow, however, did offset lower interest rates, noted David Seifer, vp at the First Boston Corp. in New York.

In terms of investment strategy, most insurers are continuing to invest more heavily in tax-exempt instruments, while they also are moving a "little bit more" into equities because of stock market gains, said Mr. Wells.

"I think they've invested more in equities than they had in a number of years," said Mr. Seifer, though investments remain mainly in the fixed-income market.

Chubb has been investing in tax-exempt securities, because under the new tax law, the insurer is subject to being taxed much more quickly, said the company spokesman, noting it has invested a "bit more money" in equities as well.

Some observers say they do not anticipate dramatic growth in investment income this year.

"I don't think we'll see very strong results in that area this year," said III's Mr. Mooney, noting the industry reported $1.8 billion in capital gains during the first quarter, up 12.5%, compared with $1.6 billion during the comparable period a year ago.

"I don't see any big push this year in investment income," said Robert Branche of the Branche Research Group in Morrisville, Pa., noting that the industry still has a lot of money invested at low interest rates.

Interest rates are up "quite a bit" since the beginning of the year, and they will grow at a faster pace, but insurers' bond portfolios will be hurt by the rise in rates, said Shearson Lehman's Mr. Weinhoff.

The higher interest rates will help insurers, however, by enabling them to put new funds into higher-yielding securities, noted Ms. Vogel.

Insurers are continuing to boost reserves, observers say. Most companies took a percentage of their fresh start benefit and put it into loss reserves, which made these insurers' combined ratios a bit larger than anticipated, said First Boston's Mr. Seifer.

Additions to reserves in the first quarter were more modest, however, than fourth-quarter 1986 additions, said Mr. Stradtner.

Companies did seem to add to their reserves in the first quarter, Shearson's Mr. Weinhoff agreed, though he noted that the rise in inflation partially offsets any increase in reserves.

Ms. Stewart also said last month's California Superior Court decision in asbestos coverage litigation raises questions about the adequacy of insurer reserves. The decision said all insurers that wrote liability insurance policies for asbestos producers from the time a person was exposed to asbestos through the time the victim files a claim or dies were liable for asbestos injury claims (*BI*, June 1).

"I still believe the industry as a whole is underreserved," said III's Mr. Mooney. ■

Product liability

Continued from page 3

past five years, and it is time that the problem be addressed," he added.

• Congressional support for product liability legislation is winning bipartisan support.

For example, the drive to pass product liability legislation in the Energy and Commerce Committee is being led by Rep. Bill Richardson, D-N.M. Rep. Richardson, who introduced H.R. 1115 earlier this year (*BI*, March 2), is considered a liberal Democrat.

By contrast, the previous unsuccessful battles for federal product liability legislation, which were in the Senate, have been exclusively led by Republicans.

"The Democrats now are leading the charge," said NAM's Ms. Spigelmyer. "That makes me much more optimistic," she said, noting that the Democrats control both the House and the Senate.

• The business community, which in previous years spent almost as much time squabbling among itself as it did lobbying, now is much more united.

For example, the American Tort Reform Assn., the Business Roundtable, the National Assn. of Manufacturers, the National Federation of Independent Business, the Coalition for Uniform Product Liability Law, the Product Liability Alliance and the U.S. Chamber of Commerce all have banded together to form) a new oganization —the Product Liability Coordinating Committee—to ensure more business unanimity.

• The business community's greater realism about the scope of product liability legislation.

While previous proposals considered by the Senate Commerce Committee and embraced by business totaled dozens of pages, the reform menu now is much shorter.

Lobbying groups now are concentrating on four major reforms: elimination of joint and several liability; reduction of product liability awards by collateral sources; establishing a fault-based standard of liability; and establishing clear and stringent standards for awarding punitive damages.

In addition, business groups endorse so-called "non-controversial" items—such as making it more difficult to sue wholesalers and retailers that do not manufacture products—that were part of product liability legislation passed by the Senate Commerce Committee last year (*BI*, June 30, 1986).

"A shorter bill is easier for Congress to consider, but still can be meaningful," said Victor Schwartz, counsel for the Product Liability Alliance and a partner with the Washington law firm of Crowell & Moring.

"The business community realized it could not seek everything and still get a bill passed. You can't have 99 different defenses," NAM's Ms. Spigelmyer said.

The new optimism that product liability reform legislation is a congressional priority is in sharp contrast to the gloom and doom that swept the business community following last November's congressional elections, when Democrats regained control of the Senate.

Democratic control of the Senate catapulted Sen. Ernest Hollings, D-S.C.—widely considered Congress' most outspoken opponent of federal product liability legislation —to the chairmanship of the Senate Commerce Committee.

The Commerce Committee has jurisdiction over product liability legislation in the Senate and, as committee chairman, Sen. Hollings has the power to delay, and perhaps kill, legislation he opposes.

With Sen. Hollings at the helm, the decision of business groups—ever since the drive to enact a federal product liability statute began in 1981—to cultivate support from Republican members of the Commerce Committee suddenly seemed to be a wasted effort.

But the despair began to wear off after a December "phone-in" day organized by the TPLA resulted in more than 5,000 calls to House members urging support of federal product liability legislation.

" 'Phone-in day' put product liability back on the radar screen of members of the 100th Congress," said Mr. Anderson of the wholesalers association.

At the same time, business lobbyists began seeking House Democrats' leadership in backing product liability legislation. That effort was successful when Rep. Richardson, an Energy and Commerce Committee member, agreed to introduce and press for enactment of product liability legislation.

Indeed, while there is a perception that little has happened in Congress on product liability legislation since the elections, the reality is quite different, lobbyists say.

"Everything has been positive," notes Liberty Mahshigian, co-counsel for the TPLA and an associate with Crowell & Moring. "Hearings on the legislation have been proceeding," and the debate has not become partisan.

Still, there are plenty of roadblocks ahead for federal product liability legislation, which manufacturers and insurers say would make the legal system fairer and more predictable.

Even if the House were to pass a federal product liability bill this session—still considered a longshot—Sen. Hollings could bottle up the legislation in the Senate.

In fact, Sen. Hollings, using his power as committee chairman, recently turned back a request from Sen. Robert Kasten, R-Wis., to have the committee vote on product liability legislation. Instead, Sen. Hollings indicated that the committee could hold hearings, a move considered by some to be a standard delaying tactic.

But some observers say that even a determined foe like Sen. Hollings can't stop a bill if it receives strong support early in the session.

"If a bill has substantial support, no one senator, except in the dying days of the session, can stop it," said Ms. Spigelmyer, referring to the relative ease of filibustering.

Despite this new-found optimism, lobbyists caution that enactment of federal product liability legislation still may take years.

"From the very beginning, we have said this will be a multiyear effort," observed Mr. Anderson. ■

College of Insurance

Continued from page 3

The term of both mortgages extends to the year 2002, when a covenant in the deed to the college's land is set to expire, he added, noting the covenant restricts use of the land to institutional purposes, and the value of the land is expected to increase as the covenant's expiration date draws closer.

If the college has not repaid the second mortgage by 2002, it could either refinance again—possibly with the help of additional gifts—or sell the property and lease back space or move to a new location, Mr. Kline said.

College officials would not identify the companies or the individual that provided gifts or the second mortgage.

However, Mr. Kline said that M&M and "every other major insurance broker" contributed, along with insurers based in Hartford, Conn., Philadelphia, Massachusetts and California.

The college, Mr. Kline said, is now focusing on four goals:

- Making itself "first class in every way as a leading insurance and financial education institution." One step in this direction is the "executive in residence" program, designed to bring students into contact with industry executives.
- Making an "all-out" effort to recruit top-quality faculty and staff.
- Continuing efforts to attract support from property/casualty insurers, while broadening the college's base of support among life insurers and financial services companies.

The college may be able to soften the impact of the next insurance market cycle on its own revenues by diversifying its curriculum to include a broader range of financial services, said Linda H. Lamel, the college's president.

- Reviewing the structure of the college, including its board of trustees.

Eight of the college's 30 trustees will retire on June 18. Retiring are Jack R. Manning, chairman and chief executive of Columbian Mutual Life Insurance Co.; John B. Ricker Jr., counselor with International Insurance Counselors; Robert F. Froehlke, chairman of the Equitable Life Assurance Society of the United States; Edwin L. Knetzger Jr., former president of Johnson & Higgins; Richard I. Purnell, former J&H chairman; John R. Cox, chairman of A.C.E. Insurance Co. Ltd.; Jacob B. Underhill, president and chief administrative officer of New York Life Insurance Co.; and Melvin B. Bradshaw, chairman and CEO of Liberty Mutual Insurance Cos.

It is unclear how many members will be on the college's board following the annual meeting.

Nominations for new trustees include Thomas A. Cook, chairman and CEO of Cook & Miller International Ltd.; Robert Sanford, president of Smyth, Sanford & Gerard Inc.; Richard H. Blum, president and CEO of Guy Carpenter & Co.; Richard E. Meyer, executive vp of J&H; and Joseph Fahys, president and CEO of the New York Insurance Exchange.

Incumbent members nominated for re-election include Kenneth C. Nichols, president and CEO of Home Life Insurance Co.; Maurice R. Greenberg, president and CEO of American International Group Inc.; Robert F. Corroon, chairman and CEO of Corroon & Black Corp.; Philip Briggs, vice chairman of Metropolitan Life Insurance Co.; and Edith F. Lichota, senior vp of Irving Trust Co. ■

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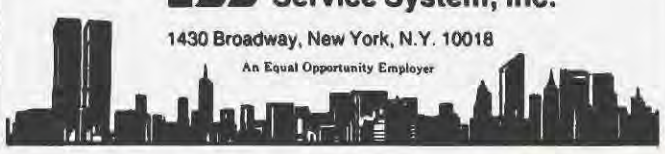

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Commercial Consumers

Administrative:

CEO's Presidents and Owners 2,426
Vice-presidents, General Managers and Other Administrative Personnel 3,136

Financial:

Chief Financial Officers and Vice-presidents of Finance 2,683
Secretaries, Treasurers, controllers and other Financial Personnel 4,888

Risk/Employee Benefits:

Vice-presidents, directors, managers, and other related department personnel of: insurance, risk, employee benefits, personnel, compensation, pension, safety, security, industrial relations, human resources and employee/labor relations 8,144

Sub-total 21,277

Associations 506
Government, Unions and Educational Institutions 1,400

Commercial Consumers

Sub-total 23,183

Insurance Agents and Brokers 11,009
Insurance Companies 7,111
Financial Institutions 989
Actuaries, Attorneys, Adjusters, Appraisers and Consultants 5,560
Others Allied to the Field 1,442
TOTAL 49,294

* Source Business/Occupational breakdown of qualified circulation, November 24, 1986 issue, as submitted to BPA for December 1986 BPA Publisher's Statement.

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Tort reform bills

Continued from page 3

Although the legislation includes a June 30, 1993, sunset provision, Bradley L. Kading, regional manager for the Alliance of American Insurers in Schaumburg, Ill., said the law "emerges as a more significant piece of legislation than many states have been able to pass in 1986-87."

The major provisions of the new law:

- Require that plaintiffs provide clear and convincing evidence that shows a defendant is guilty of "oppression, fraud and malice, actual or presumed" before a court can award punitive damages.
- Abolish joint and several liability for both economic and non-economic damages, unless defendants acted in concert.

Previously, a defendant that was unrelated to other defendants could have been forced to pay all of a judgment for which it was only partially liable if the co-defendants could not pay their share.

- Prohibit plaintiffs' attorneys seeking more than $50,000 in non-economic damages from specifying a specific amount.
- Allow economic damage awards to be reduced by payments from collateral sources.
- Require juries awarding damages to specify the amount of damages awarded in each of three categories: non-economic damages, past economic damages and future economic damages.
- Codify existing case law by clarifying that pure comparative negligence standards apply only to product liability and other actions for which persons and companies are strictly liable.

In all other cases, modified comparative negligence standards apply, so plaintiffs more than 50% liable for damages cannot collect damages.

- Prohibits an adult passenger in a car driven by an intoxicated person from suing under the state's new dramshop law, unless the passenger was intoxicated or incompetent at that time.

Montana

Montana's tort reform legislation, which, among other things, significantly limits punitive damages and joint and several liability, is "a very good package of reforms," said Blair Childs, executive director of the American Tort Reform Assn. in Washington, D.C.

The reforms have been signed into law by Gov. Ted Schwinden.

Under H.B. 442, punitive damages in tort cases are limited to only those cases in which defendants acted with "actual fraud or actual malice."

A provision in the bill requiring a judge to review every punitive damage award set by a jury against a set of objective standards should "increase the rationality of awards," said Denis Lopach, chairman of the tort reform committee of the Montana Liability Coalition.

Under S.B. 51, any defendant whose negligence is determined to be 50% or less of the combined negligence of all parties in a suit will be liable only for its percentage of the damages.

Defendants determined to be more than 50% liable can be held jointly and severally liable.

The Legislature also passed several other tort reform measures:

- Under H.B. 567, courts may consider collateral sources of monetary awards, such as workers compensation or health insurance, to reduce compensatory awards in actions arising from bodily injury or death.
- S.B. 49 exempts officers, directors, employees and volunteers of non-profit corporations from liability in civil cases except when the court finds that they acted to intentionally commit a tort or an illegal action.
- H.B. 167, which applies to only parties in a contract, eliminates non-economic damages for items such as emotional and mental distress.
- Periodic payments for damages of $50,000 or more in actions for personal injury, property damage or wrongful death are allowed under S.B. 48.
- Under S.B. 375, only one personal representative of a deceased in a wrongful death case can file a suit.
- A bill modifying the statute of limitations for minors in medical malpractice suits, H.B. 344, allows malpractice suits to be filed any time after the injury of a child 4 years old or younger.

Previously, the statute of limitations in the state required that parents or guardians of those children wait until the child was at least 8 years old before filing suit for an injury.

- In product liability cases, S.B. 380 allows manufacturers, wholesalers and sellers two defenses based on the contributory negligence of the user. One defense is that the user discovered or should have discovered the defect and used the product anyway. The other defense is that the user misused the product, which caused the injury.

However, there may be constitutional challenges to the reforms passed in Montana, said Mr. Lopach, pointing to an article in the Montana Constitution stating that every person is entitled to "full legal redress" in tort cases.

In addition, an amendment to the constitution passed earlier this year allowing the Legislature to enact tort reforms was struck down by the state Supreme Court in late May, after the legislative session ended April 15.

Mr. Lopach added that a Supreme Court ruling on the tort reforms is expected sometime this summer.

Texas

In a special session last week called by Gov. Clements, the Texas Legislature passed a package of insurance and tort reform measures that include changes in the doctrine of joint and several liability and authorize the creation of an insurance exchange in Texas.

Gov. Clements is expected to sign the reforms.

While the new law includes some of the more than 50 recommendations made by the House-Senate Joint Committee earlier this year, several were killed during months of haggling among legislators. The committee had been charged by the state's lieutenant governor and house speaker in 1986 to study the impact of the "tort recovery process on the insurance industry" (*BI*, Feb. 9).

There may be constitutional challenges to the reforms passed in Montana, said Denis Lopach, chairman of the tort reform committee of the Montana Liability Coalition, pointing to an article in the Montana Constitution stating that every person is entitled to 'full legal redress' in tort cases.

Like lawmakers in North Dakota and Colorado, the Texas Legislature passed tort reform that would require claimants to prove fraud, malice or gross negligence to collect punitive damages.

The new law also would cap punitive damage awards at four times the amount of actual damage awards or $200,000, whichever is greater.

The law says that punitive damages will not be assessed against drug manufacturers or sellers in cases that involve a product that was manufactured and labeled according to federal standards.

Legislators somewhat limited joint and several liability so that a defendant can be liable for payment of an entire award only if its percentage of responsibility is greater than 20% of the total damages and is greater than the responsibility of the plaintiff. A defendant also may be ordered to pay an entire award if the plaintiff has no responsibility for the damages and the defendant is more than 10% responsible.

In addition, defendants can be held responsible for entire awards if co-defendants are unable to pay their share of damages in cases involving personal injury, property damage or death caused by hazardous substances.

The legislation also recodified Texas law that allows a plaintiff to collect damages when negligence is proved in cases of personal injury, property damage or death only if the plaintiff's responsibility is less than or equal to 50%. The measure also would apply to cases involving negligence by providers of professional services, like architects, attorneys and accountants, in cases other than personal injury, property damage or death.

In strict tort liability, strict product liability or breach of warranty cases, the claimant could recover only if he is less than 60% responsible for damages.

In addition, plaintiffs that file frivolous suits would be required to pay "reasonable costs" incurred by defendants.

But Texas legislators failed to agree on a limit on non-economic damage awards and did not act to limit plaintiffs' attorneys' fees.

Texas lawmakers also passed several insurance-related proposals. One of these permits creation of an insurance exchange in Texas.

A spokeswoman for the State Board of Insurance explained that the exchange would be structured similar to exchanges established in New York, Illinois and Florida.

She said the facility, if created, would write primarily reinsurance but would allow underwriters to eventually accept other kinds of business. The legislation does not establish any timetable for the creation of such an exchange.

Other insurance measures contained in the legislation:

- Call for liability insurers to provide a 60-day notice before cancellation or non-renewal of coverage.
- Subject insurers to increased disclosure of financial data, including information on claims and reserves.
- Allow non-profit organizations to create pools to insure liability risks.
- Create a public counsel office to represent policyholders in disputes and rate hearings before the State Board of Insurance.

Kansas

Kansas Gov. Mike Hayden has signed into law several tort reform measures that, among other things, cap punitive damages and pain and suffering awards and offer certain groups or individuals immunity from liability.

The major bills, which go into effect July 1, include:

- H.B. 2025, under which a plaintiff seeking punitive damages must prove by clear and convincing evidence in the initial phase of the trial that the defendant acted with willful or wanton conduct, or with fraud or malice.

A separate proceeding must be held to determine the amount of the punitive award.

Punitive damage awards cannot exceed the lesser of $5 million or the defendant's annual gross income, based upon the highest annual gross income during any one of the five years immediately preceding the action.

But, the court can award up to 1½ times the cap if it finds that the profitability of the defendant's misconduct exceeds the cap.

- H.B. 2472, which caps pain and suffering awards at $250,000 from all defendants except for medical malpractice claims, which are addressed under existing law.

Kansas already caps non-economic damage awards in wrongful death cases at $100,000.

- H.B. 2021, which requires itemized jury verdicts for personal injury and wrongful death awards.

The bill also requires periodic payment of damage awards for future economic losses—such as lost wages or future medical care—in medical malpractice actions.

- H.B. 2023, which provides immunity from liability for members of governing bodies of municipalities and members of appointed municipal boards, commissions and committees who act without fraud or malice.

The bill grants immunity from any claim that arises out of performance of community service other than damages resulting from operation of a motor vehicle.

The bill also authorizes municipalities to reimburse employees for attorneys' fees and other costs of defending punitive damage claims, if the employee's action was in the scope of employment, if the employee acted in good faith and without actual fraud or malice.

- H.B. 2024, which clarifies that the state's comparative negligence law applies to economic losses as well as death, personal injury or property damage.
- S.B. 25, which provides conditional immunity from civil damages for certified public accountants because of acts, omissions, decisions or other conduct in the rendering of professional services.

Colorado

Gov. Roy Romer has signed nearly a dozen tort and insurance reform bills into law—and vetoed one—passed during the ongoing legislative session.

Most of the bills go into effect July 1. A few of the bills are designed to modify or otherwise correct perceived errors in more comprehensive tort and insurance reform measures enacted last year (*BI*, Aug. 18, 1986).

The bills signed would:

- Restore joint and several liability for defendants that acted in concert.
- Require that civil actions seeking $50,000 or less in damages be assigned by the court for mandatory arbitration as long as they are not brought in county courts, small claims courts or involve indigent parties.
- Require that plaintiffs' attorneys suing professionals submit an expert's certificate of review that the claim is justified.
- Permit judges to award attorneys' fees to defendants when wrongful death or injury cases are dismissed before trial.
- Allow shareholders or members to limit the liability of directors and officers of for profit companies, not-for-profit organizations and state banks, unless their actions are willful and wanton.

The Colorado Legislature also passed several insurance reform measures. Those reforms:

- Shorten from 90 days to 45 days the notice an insurer must give a commercial policyholder if the insurer intends to cancel or not renew the policy.
- Allow an insurer, subject to the commissioner of insurance's approval, to charge a claims-made policyholder seeking an extended reporting period more than 200% of the expiring policy premium. The insurer must submit a qualified actuary's opinion supporting a larger premium.
- Exempt surplus lines insurers from provisions adopted last year that require insurers to submit claims-made policy forms to the commissioner of insurance for prior approval.
- Allow a judge to inform a jury that an insurer's duty to deal fairly and in good faith with claimants is breached if payment is delayed without reason.

For a plaintiff to prove bad faith against a third party's liability insurer, he need only prove that the insurer was negligent. In litigation between a plaintiff and its insurer, the plaintiff must prove that the delay or denial of the payment was unreasonable and that the insurer was reckless.

Utah

Utah now limits the liability of corporate directors and, officers at non-profit organizations.

The law, which took effect last month, is patterned after Delaware's much-touted directors' liability statute. It applies only to shareholder actions, not third-party lawsuits.

Directors are immune from liability except in cases of fraud, illegal activity or activities "not in the best interests in the corporation," explained Sen. K.S. Cornaby, R-Salt Lake City, who sponsored the bill.

Minnesota

An omnibus insurance bill that will increase regulation of insurers and mandate certain employee benefit coverages was signed by Gov. Perpich last week.

The bill included 132 sections of new legislation and clarifications of existing legislation (*BI*, April 20). The effective dates vary.

Among the major provisions in the bill is a use-and-file insurance rating system, which requires insurers to file rate increases of 25% or more with the commissioner of commerce, who oversees insurance matters. However, insurers can charge the increased rate unless the commissioner determines within 60 days it is excessive.

The bill also requires: that group health insurance plans cover treatments for disorders of the jaw; employers with self-insured health plans that purchase stop-loss insurance to annually file a surety bond or securities with the commissioner; the state property/casualty guaranty fund to provide claims-made tail coverage if it was not issued to policyholders before an insurer becomes insolvent; commercial property and homeowners replacement value property policies cover replacement or repairs up to state minimum code requirements at the time of loss.

Two controversial provisions were deleted in the final bill. One would have given the commissioner discretionary authority over surplus lines rates and forms, and the other would have required all benefit plans covering Minnesota residents to meet all of Minnesota's minimum benefit requirements.

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Contributing to this report were Associate Editors Donna DiBlase, Michael Bradford, Meg Fletcher, Deborah Shalowitz and Steve Taravella.

Premium tax

Continued from page 1

eral Motors Corp. in the case. "It's a pot of gold for them."

A petition for a rehearing of the case, *General Motors Corp. vs. the California State Board of Equalization,* is now before the 9th U.S. Circuit Court of Appeals. But attorneys familiar with the case say such petitions seldom are granted, and that they expect an appeal to the U.S. Supreme Court.

Meanwhile, the California Board of Equalization is taking an aggressive stance following the decision. Board officials say that by late summer they will begin action to collect the past due taxes from both employers with minimum premium plans and self-funding employers that buy any stop-loss insurance.

The board's authority to tax health care benefit payments made under a minimum premium plan was first upheld by a 1982 decision of the California Supreme Court in *Metropolitan Life Insurance Co. vs. the State Board of Equalization,* which is referred to as the Minimet case.

California's highest court held in that case that under a minimum premium plan, the benefit payments made by a plan sponsor were actually premiums for the purpose of taxation.

(Minimum premium plans vary widely but generally require the employer to pay a fixed minimum premium to the insurer to cover the insurer's administration of the plan and profit. Generally, this premium is 10% of the employer's expected claims under the plan. Above that minimum premium the employer is responsible for paying claims until those claims in the aggregate reach a trigger point. Beyond that point, the insurer is responsible for all claims.

In comparison, under a self-funded plan with stop-loss insurance, the employer is responsible for claims payments until losses exceed a trigger, either per claim under specific stop-loss insurance or in total under aggregate stop-loss insurance.)

Following the California Supreme Court's 1982 decision, attorneys warned that the court had looked beyond the label applied to the plan, in this case a "minimum premium plan," and reached its decision based upon the actual facts and characteristics of the plan.

These attorneys predicted that the State Board of Equalization would take a broad view of the decision and begin seeking premium taxes on a wide range of plans.

Indeed, the Board immediately began sending tax bills to insurers offering minimum premium and stop-loss insurance benefit plans in California.

Most insurers declined to pay the tax and filed petitions for re-determination with the board, saying that their plans did not come under the purview of the Minimet decision and asking for a hearing before the board.

These petitions were held in abeyance pending the outcome of the General Motors case, in which GM and the American National Red Cross were fighting the state's authority to tax their minimum premium plans through their insurers. Their case began Oct. 20, 1983.

GM and Red Cross alleged that the Employee Retirement Income Security Act pre-empts all state laws that regulate or tax self-funded employee benefit plans.

The 9th Circuit disagreed.

Attorneys and benefit experts disagree on the impact of the appellate court's decision, but most say the opinion fails to resolve the key question of exactly what types of health benefit plans fall under the California tax law.

The plan at issue in the General Motors lawsuit was a minimum premium plan, but officials with the Board of Equalization say they see the decision as applying to most self-funded health benefit plans involving any insurance policy.

"From my reading of the case, it looks pretty far-reaching. Based on my experience, it would probably apply to just about all the (plans) I've seen," says E.L. Sorensen Jr., senior staff counsel to the California State Board of Equalization.

Those plans that are totally self-funded cannot be taxed, Mr. Sorensen says.

But, Mr. Sorensen adds, the board will consider every petition for re-determination on a case-by-case basis.

Such a broad interpretation, attorneys say, likely will result in more litigation as insurers resist state efforts to impose the premium tax on various plan funding mechanisms that involve an insurance policy.

Larry J. Tucker, a consultant with Hewitt Associates in Santa Ana, says the suit "clearly applies to minimum premium plans. I don't think it applies to fully self-insured plans because there isn't any (insurance) premium involved.

"The ones in between are in a gray area," Mr. Tucker continues, referring to "those that are self-funded but have (stop-loss coverage). I wouldn't be surprised, frankly, if that would take a whole new lawsuit."

In reaching its decision, the 9th Circuit reversed the decision of the U.S. District Court for the Central District of California. The lower court had ruled that the ERISA pre-emption clause prevents states from regulating or taxing self-funded employee benefit plans, which fall under the purview of the federal law.

The appellate court agreed with the district court that because the tax at issue is based on benefit payments under ERISA-covered benefit plans, the ERISA pre-emption clause applies. But, the appellate court said the insurance savings clause of the act preserves the state's right to impose the tax because it is levied on insurers offering these plans, not on the plans themselves. The tax is "intimately associated with the business of insurance," the court said.

"The Supreme Court has repeatedly emphasized the broad scope of the (ERISA) pre-emption clause," the appellate court wrote. "The Court's broad reading of the pre-emption clause leads us to conclude that the tax at issue 'relate(s) to' benefit plans," the court added.

However, the court said, the second step in the pre-emption analysis involves the insurance savings clause of ERISA, which must be construed broadly and with due regard for the states' powers in the field of insurance.

"Such a construction will undoubtedly return to the states much of the authority the pre-emption clause has taken away," the appellate court wrote.

The court said the insurance savings clause must be construed to cover taxation of insurance, "for the tax is intimately associated with the business of insurance."

Turning to the issue of how the tax is calculated, the court said that while the tax is based on the benefits paid under the plan, "this reference, which is used to measure the cost of insurance provided accurately, does not deprive the tax of the protection of the saving clause for the incidence of the tax remains on the insurer, not the plans."

'We believe there is a distinction between regulation of insurance on the one hand and taxation on the other,' says attorney Benjamin Boley.

Finally, the court said that the deemer clause of ERISA, which provides that benefit plans shall not be deemed to be an insurance company, does not affect the tax.

The court said the tax at issue in the case "is imposed on insurance companies, not benefit plans. It may affect benefit plans, but effects are not determinative," the court concluded.

The court said that the U.S. Supreme Court's decision in *Metropolitan Life Insurance Co. vs. Massachusetts* "left intact a mandated benefit law that had significant effects on Massachusetts plans. In doing so, it indicated that state laws affecting benefit plans may escape pre-emption if they fall directly on insurance companies, as the tax at issue does," the appellate court concluded.

Attorneys for General Motors contend the court misread key provisions of ERISA, misinterpreted several previous ERISA cases decided by the 9th Circuit and ignored a recent related decision by the U.S. Supreme Court.

Mr. Kilberg says the appellate court decision is in conflict with *Moore vs. Provident Life & Accident Insurance Co.* and *United Foods and Commercial Workers vs. Pacyga,* two ERISA cases decided by the 9th Circuit in 1986.

Mr. Kilberg says that while the court in the GM case referenced *Moore* and *Pacyga,* it drew the wrong conclusions.

Both cases hold that when a benefit plan purchases insurance triggered only when a specified aggregate amount of claims has been paid by the plan, the plan must be treated as a self-insured employee benefit plan and may not be regulated either directly or indirectly by the state since these plans are regulated exclusively by ERISA, according to Mr. Kilberg.

The 9th Circuit's ruling in the GM case "points to no factual distinction between the insurance relationships in the three cases," Mr. Kilberg says in GM's petition for rehearing, "yet the panel finds that 'the benefits paid by the plans' can be used 'to measure the cost of insurance provided accurately.' "

"But how can uninsured benefits reflect the cost of insurance?" Mr. Kilburg asks in the petition. "Either the panel is finding that GMC and the Red Cross plans are fully insured, in direct contradiction of *Moore* and *Pacyga,* or it is deeming the uninsured benefits to be insured benefits, in direct contradiction of the 'deemer clause' and *Pacyga,*" he concludes.

Further, Mr. Kilberg says, the appellate court ignored a recent U.S. Supreme Court decision in *Pilot Life Insurance Co. vs. Dedeaux* that he says indicates that the insurance savings clause of ERISA is to be construed as a narrow exception to the pre-emption language of the law.

Benjamin W. Boley, a partner with Shea & Gardner in Washington, which filed an amicus curiae brief on behalf of National Railway Labor Conference in the GM case, agrees that the appellate court misinterpreted ERISA.

"We believe there is a distinction between regulation of insurance on the one hand and taxation on the other," Mr. Boley says. "Both of these terms are used in the McCarran-Ferguson Act, and only one is used in ERISA. Taxation of insurance was not saved by the savings clause in ERISA," Mr. Boley contends.

"So far as the deemer clause is concerned, I don't believe the court fairly addressed that question," he says. "I think the court's conclusion is erroneous and is unsupported by any analysis in the opinion. I would certainly hope the court grants General Motors' petition for rehearing."

Attorneys and benefit experts disagree over whether the court was referring to only minimum premium-type benefit plans or whether its ruling is to apply to all benefit plans that include any type of insurance coverage.

Laird M. Post, a consultant with The Wyatt Co. and an expert on flexible benefits, says he believes the decision only affects minimum premium plans, "which look a lot like self-funded arrangements but are really fully insured arrangements."

"I don't see any argument put forth in this decision that it could arguably include self-funded plans," Mr. Post says.

"If it's going to be construed to include all self-funded plans, that would be saying a self-funded plan is an insurance company," Mr. Post says, adding that ERISA specifically prohibits states from deeming ERISA benefit plans to be insurance companies.

But most of the attorneys involved with the GM case say that for the purposes of this litigation, they see little difference between a minimum premium plan and a self-funded plan that involves the purchase of stop-loss coverage to pay claims that in the aggregate or individually exceed a given trigger point.

Mr. Kilberg says that he has always assumed the case applied to both minimum premium and self-funding plans with stop-loss insurance.

Mr. Kilberg notes that the court cited both the *Moore* and *Pacyga* cases, which involved self-funded plans that purchase stop-loss coverage.

Mr. Boley says that while there are many variations on minimum premium plans and stop-loss policies, "In practical effect they are the same thing: self-insurance up to a trigger point, and the insurance company pays claims above that point."

However, Mr. Boley says that because the decision is not explicit about which types of plans fall under the tax, he expects that if the California Board of Equalization applies the tax to self-funded plans that buy stop-loss insurance, "In my view the matter will be litigated."

"If there is no insurance affecting the benefit plan and no right of a covered individual to go against the insurer and we're talking about aggregate losses, not individual losses, if that's the arrangement, I would like to think that is substantially different" from the plan at issue in the GM case, says Jack B. Helitzer, vp of government affairs for Metropolitan Life Insurance Co.

"But when you start getting things that bear a resemblance to minimum premium plans, it's not all that clear which way it (the decision) goes," he adds.

Mr. Helitzer says Metropolitan is satisfied that the decision does not apply to totally self-funded plans where the insurer is providing pure administrative services.

But he says that with other types of arrangements, "You've got to be careful not to be confused by a label. Calling a minimum premium plan stop-loss isn't going to help," he says.

If the decision applies to self-funded plans that buy stop-loss insurance, "It will have a substantial effect upon the way in which ERISA-covered plans will be funded," says Mr. Boley. He and Mr. Kilberg maintain that employers that can afford to likely will shift to fully self-funded plans with no insurance to avoid the premium tax.

Mr. Post, who sees the decision as only applying to minimum premium plans, says he expects the GM case to have "no major impact" on the way benefit plans are funded.

If the decision applies only to minimum premium plans, the impact on future costs could be minimal, observers point out.

Most large employers already have switched to self-funded plans with stop-loss coverage, while the 2.35% premium tax imposed on smaller employers that buy minimum premium plans will not increase the cost of the plans. ■

Asbestos decision

Continued from page 2

GAF officials and attorneys would not disclose how much coverage the company would obtain from its insurers under the decision. However, the company has at least $65 million to $75 million in coverage from its insurers.

Under the decision, Armstrong will be able to recover in excess of $165 million, said attorney John Heintz with the Washington, D.C., firm of Popham, Haik, Schnobrick & Kaufman.

Fibreboard, in addition to being able to recover $45 million in excess insurance, also can take advantage of policies written in the 1950s that had no aggregates. The insurers that wrote these policies—Pacific Indemnity Co. and Continental Casualty Co., a CNA Financial Corp. unit—are on the hook forever if claims fall within the coverage period, said Tom Freeman, a Fibreboard attorney with the San Francisco firm of Brobeck, Phleger & Harrison.

Another producer involved in the litigation, Nicolet Inc., settled prior to the litigation with all of its insurers. Nicolet also has announced it now has no more insurance to pay asbestos claims.

In addition, Manville Corp., the largest asbestos producer in the litigation, previously settled with more than two dozen of its insurers and with its former broker, Marsh & McLennan Inc. (*BI*, Nov. 3, 1986).

The insurers directly affected by the decision are several American International Group Inc. and CNA Financial Corp. units; Commercial Union Insurance Co.; Prudential Reinsurance Co.; Employers Reinsurance Corp.; Great American Insurance Co.; Travelers Corp.; and Pacific Indemnity Co. of Los Angeles, which is part of the Chubb Group.

Mission Insurance Co. and St. Helen's Insurance Co. Ltd. also are involved, but both are insolvent.

None of these insurers are members of the Asbestos Claims Facility established under the Wellington Agreement, which settled insurance coverage disputes between member insurers and asbestos producers. GAF, Fibreboard and Armstrong are members of the facility.

However, many insurers that have settled coverage disputes with policyholders remain in the litigation because they are bringing or face cross-claims with other insurance companies that are not members of the facility.

'It reaffirms the position policyholders have been advocating around the country,' says Mr. Oshinsky.

Last week, attorneys for policyholders said the decision was extremely significant for policyholders involved in other asbestos litigation and other toxic tort litigation.

"I think it is a major decision," said David Steuber, who represents GAF and Nicolet.

Mr. Steuber of the Los Angeles firm of Paul, Hastings, Janofsky & Walker said that the ruling is very important because the insurers had set the stage and sought a major decision that could be applied industrywide.

In addition, Mr. Steuber and others pointed out that the decision stems from the most extensive record ever developed in a coverage dispute case, which they say will affect decisions returned by other courts even though it is not binding on other courts.

The record developed for the trial includes extensive medical evidence on the nature of asbestos-related diseases, testimony and documents concerning the history of the drafting of the comprehensive general liability policy, and investigation into past conduct and practices of insurers and policyholders.

"It is a wonderful decision," said Jerold Oshinsky, who represented Keene Corp. in the landmark *Keene Corp. vs. Insurance Corp. of North America* case in 1981 before the District of Columbia Circuit Court of Appeals. The Keene decision was the first to grant broad coverage for asbestos producers.

"It reaffirms the position policyholders have been advocating around the country and is based upon the most exhaustive analysis any judge has undertaken on the issue," said Mr. Oshinsky, who is with the firm of Anderson, Baker, Kill & Olick in Washington, D.C.

Policyholders' attorneys also believe that the decision will be of great value in other asbestos and toxic tort insurance coverage cases.

"A lot of the opinion is transferable," said Robert Sayler, who represents Armstrong and is with the firm of Covington & Burling in Washington, D.C. "It is our belief that this decision has enormous significance for pollution cases."

While Judge Brown relied in part on the medical aspects of asbestos for his decision, his broad interpretations on the meaning of the comprehensive general liability policy will assist policyholders in other disputes with insurers, Mr. Sayler predicted.

"The industry's defenses to coverage have been heard completely," he added. "They advanced every defense that they had. For these reasons, it will have very considerable teaching force to the industry and enormous teaching force for other courts."

Mr. Sayler said the decision also supports policyholders' arguments for broad coverage to pay school districts and local governments that have sued to recover the cost of removing asbestos found in buildings.

"I think it opens the door to very broad coverage in the building cases," said Mr. Steuber.

However, attorneys for insurers do not agree with these analyses, contending that the decision will be largely confined to asbestos.

An attorney for AIG believes that Judge Brown sought to limit the decision to facts concerning asbestos-related diseases. "That's important," said Jeffrey Carlisle, with the Los Angeles firm of Lynberg & Watkins. "I don't think it is transferable."

"We don't view this as a sweeping decision," noted David M. Cain, associate counsel for Travelers, which is litigating with Armstrong.

Mr. Cain also claims that Judge Brown's reasoning that coverage is triggered upon "injury" favors the insurance industry's position in certain coverage disputes involving asbestos and other toxic substances.

"It leaves open that courts won't find any injuries or damages for hazardous waste or asbestos property damage," Mr. Cain said. "I don't see any negative in this decision for other insurance coverage disputes."

Mr. Cain added that Travelers considered the duty to defend under pre-1966 policies the potentially most costly issue.

"Travelers generally feels that it is a favorable decision on those issues that impact on Travelers coverage," he said. "In our view, it has a limited financial impact."

"Policyholders will still have to prove in a given toxic tort case precisely when the injury occurs," said Robert Muhlbach, an attorney for CNA with the firm of Kirtland & Packard in Los Angeles.

Policyholders also believe that the decision will support their bad-faith claims against some of the insurers in the litigation because Judge Brown relied on the "plain meaning" of the policies and found that the policies were unambiguous and because he explicitly rejected the exposure and manifestation theories of coverage.

"This gives the industry enormous punitive damage vulnerability," Mr. Sayler says.

"I think it might well be helpful," Mr. Steuber agreed.

However, insurers also disagree on this point.

"I don't think his decision alters or affects the merit of any punitive damage claim against Travelers," Mr. Cain said. "I don't believe there is any merit to any punitive damage claim."

Another attorney for insurers said that if the decision is upheld, it would hurt policyholders in the long run.

Evidence was introduced that a broad decision would be "economically irrational" and would lead to choking off underwriting capacity and an escalation of premiums for occurrence policies, said Fred Gregory, who represents Aetna Casualty & Surety Co. and certain Lloyd's of London underwriters and other London insurers in the litigation.

The ruling also will discourage insurers from using occurrence policies, unless they have many exclusions, hastening the move toward use of the claims-made policy, added Mr. Gregory, who is with the Los Angeles firm of Gibson, Dunn & Crutcher.

"I don't think too many people should be dancing in the streets over this one," he said.

However, Mr. Gregory added that he thinks the decision "will serve to support the asbestos claims facility." Because it is similar to the terms of the Wellington agreement, it should help resolve disputes between insurers and reinsurers over payment of reinsurance claims for asbestos injuries that are settled by the facility, Mr. Gregory said.

While some reinsurers have contended that payments by the facility under the broad coverage it provides were overly generous, "this decision will show them it was not," he said.

Another lawyer said that while the decision benefits Wellington insurers on the trigger of coverage issue, it does not benefit them on the duty to defend issue, which is broader under Wellington than under Judge Brown's decision.

While many policyholders praise the decision, not all think it is entirely favorable.

"I probably will not be using it," says Frank Heap, who represents Raymark Corp. in its battle with its insurers over coverage for asbestos claims.

Mr. Heap, who is with the Chicago firm of Bell, Boyd & Lloyd, said that the decision is favorable to policyholders on the trigger of coverage issue.

But he labeled as unfavorable Judge Brown's rulings that insurers have no duty to defend policyholders of pre-1966 policies that have exhausted their policy limits and that excess insurers do not have to drop down and provide coverage when the primary insurer is insolvent or refuses to pay.

"It has some good aspects," Mr. Heap said of the decision. "But it has some very serious drawbacks."

Raymark is awaiting a coverage decision from the Illinois Supreme Court, which could come this month.

But, Peter J. Kalis, an attorney representing policyholders with coverage disputes over asbestos and other toxic substance claims with the Pittsburgh firm of Kirkpatrick & Lockhart, said of Judge Brown's decision: "I think it will be of profound significance."

A spokesman for AIG said the insurer was "assessing the impact" of the case and had no statement while CNA said it was not prepared to comment yet.

Commercial Union also had no comment. ■

update

Court upholds severance pay

Continued from page 2

and by the National Labor Relations Act. However, the court ruled 5-4 that the Maine statute is not pre-empted by ERISA because the statute does not relate to an employee benefit plan.

"ERISA's pre-emption provision does not refer to state laws relating to 'employee benefits,' but to state laws relating to 'employee benefit plans,' " wrote Justice William Brennan. The Maine law requires employers to pay a one-time payment to employees not covered by an expressed contract in the event of a plant closing.

The case, *Fort Halifax Packing Co. Inc. vs. Coyne, Director, Bureau of Labor Standards of Maine, et al.*, stemmed from a suit filed by workers who did not receive severance benefits when they were laid off by the company in 1981. The state's director of the Bureau of Labor Standards then began an action that superseded the workers' suit to enforce the provisions of the Maine law.

Illinois to study St. Paul hike

CHICAGO—The Illinois Insurance Department will review a 66% medical malpractice insurance rate hike proposed by St. Paul Insurance Co. of Illinois.

In response to doctors' complaints that the rate hike, effective July 1, is excessive, a fact-finding hearing is scheduled at 10 a.m. Friday in the State of Illinois Center in Chicago, said Frank Weaver, the department's supervising insurance analyst.

In addition, other doctors considering changing insurers have complained that St. Paul's premiums for tail coverage under its claims-made policies are too high, he added. The insurer typically charges 200% to 300% of the original policy premium, depending upon the duration of the tail and coverage limits, Mr. Weaver said.

The hearing is the first step in the department's review of the proposed rate hike under Illinois' "use and file" rate regulation.

St. Paul wrote about 20% of the medical malpractice insurance premiums in Illinois in 1985, the last year for which statistics are available, Mr. Weaver said.

Ruling may deter Opren claims

LONDON—One-third of the 1,500 British plaintiffs suing Indianapolis-based Eli Lilly & Co. over its anti-arthritis drug Opren may drop their claims following a decision by the United Kingdom Court of Appeal last week, lawyers for the victims say.

The decision upholds a London High Court ruling that total estimated court costs of 6 million pounds ($9.8 million) would have to be borne equally by the 1,500 claimants if the court finds for the defendant. Under British law, the losing party in a court case generally must pay all court costs.

The plaintiffs' lawyers had argued the costs should be borne only by the 1,000 claimants entitled to legal aid from the British government. Many of the 500 claimants not entitled to the legal aid now may drop their claims, because they would be unable to pay their share if the court finds for the defendant, lawyers say.

Court papers filed by the plaintiffs allege that 83 people have died as a possible result of taking the drug. Most of the victims suffered from severe skin irritation when exposed to sunlight or radiant heat after taking the drug, court papers say. Other symptoms linked to the drug include hepatic and respiratory disorders.

The drug was introduced in Britain in October 1980 before being marketed in the United States as Oraflex. Lilly already has settled many U.S. claims, lawyers say.

Last week, lawyers representing most of the U.K. claimants said in a statement that a settlement that had been "nearly achieved" between the claimants, Lilly and the U.K. Committee on the Safety of Medicine, which licensed the drug, has collapsed following the court's decision.

Hilb, Rogal to go public

RICHMOND, Va.—Employee-owned Hilb, Rogal & Hamilton Co., the nation's 14th-largest insurance broker based on 1985 gross revenues of $28.7 million, intends to go public.

The broker filed a registration statement last week with the Securities and Exchange Commission announcing it intends to offer 1.1 million shares of common stock to the public this summer. After the public offering there will be about 3.3 million shares of common stock outstanding, with Hilb employees holding 2.2 million.

Briefly noted

John W. Hanna, president and chief operating officer of Dallas wholesale broker Maclean, Oddy & Associates Inc. since its inception in July 1983, has left to become president and chief operating officer beginning July 1 of Alexander Howden North America Inc. in Atlanta, a subsidiary of Alexander & Alexander Services Inc. Anita Chanpong is the new president of Maclean, Oddy. . . . The Florida Supreme Court last week denied the request by major property/casualty insurers in the state for a rehearing on the constitutionality of the **Florida Tort Reform & Insurance Act of 1986.** The court upheld most sections of the controversial law in April (*BI*, April 27). . . . The target dates for securing insurance company and non-insurance company investors for **Centre Reinsurance Holdings Ltd.**—a reinsurance holding company being organized by Guy Carpenter & Co. Inc. and Morgan Guaranty Trust Co.—have been pushed back to July 15 and Aug. 26, respectively. The previous target dates were June 22 and July 22, respectively (*BI*, May 18). The target date for closing the private placement has been pushed back to Sept. 3 from July 31. . . . The board of directors of Nashville-based **Hospital Corp. of America** last week approved a definitive agreement to sell 104 acute care hospitals to a new company to be created by an employee stock ownership plan (*BI*, May 26). The transaction, valued at $1.9 billion, is expected to be finalized in the third quarter.

Boeing's liability

Continued from page 1

or Japanese courts. Meanwhile, a JAL official declined to estimate its ultimate liability pending the release of the Japanese government report.

The Aviation Accident Investigation Commission is expected to release its accident report June 15, which will cite the cause of the disaster.

Pieces of the 747's tail section were found 80 to 90 miles away from the crash site, leading investigators to question whether the tail broke apart before the jetliner crashed.

Boeing acknowledged that it was partially responsible for the loss. Immediately after the accident, Boeing conceded that it had made a faulty repair on the aircraft's aft pressure bulkhead in 1978, causing it to crack.

And earlier this year, during the trial of a class-action lawsuit on behalf of about 70 survivors of disaster victims, Boeing admitted in King County Superior Court in Seattle that the faulty repair was one of the causes of the accident.

However, sources in Japan add that JAL was supposed to spot check the Boeing 747 and should have detected any deterioration of the repair.

No one has implied that the design of the Boeing 747—considered to be one of the safest aircraft in the world—was responsible for the crash.

The loss is covered under Boeing's $1 billion aviation product liability insurance coverage that was placed on July 1, 1985, and JAL's 1985 aviation hull and liability insurance, sources in London report.

Boeing retained 25%, or $25 million, of the first $100 million layer, which was led in London by Lloyd's of London aviation underwriter David Dann of the R.J. Kiln syndicate, and followed by the British Aviation Insurance Co. Ltd. and underwriters in the United States, France and London. The coverage was placed by Willis Faber P.L.C. in London and Johnson & Higgins in New York.

A $400 million excess of $100 million layer and a $500 million excess of $500 million layer were also led by Mr. Dann in London.

'No one company has the market expertise or penetration to develop a rate. There would be a chilling effect on the decisions of companies to enter certain lines,' says Mr. O'Day.

Mr. Dann would not comment on the coverage.

JAL's hull and liability insurance was written by Tokio Marine & Fire Insurance Co. Ltd. on behalf of the Japanese Aviation Pool. About 57.5% of the risk is brokered by Willis Faber to London and other world reinsurers, led at Lloyd's by the Ariel syndicate (*BI*, Aug. 19, 1985).

Shortly after the disaster, Boeing's and JAL's liability underwriters temporarily agreed to split claims payments equally to pay the families of the victims quickly. "This was the primary breakdown in order to be in a position to settle the losses without prejudice as soon as possible," said one of the underwriters.

However, no firm decision was made on how the claims payment would be divided until earlier this year when, after reading technical reports, Boeing's underwriters agreed to pay 82.5% of the claims, including those already settled.

By agreement, JAL insurers are negotiating all the settlements and are then reimbursed by Boeing's underwriters, sources say.

However, there has been no agreement on who is responsible for the $35 million hull loss, which JAL's hull underwriters have paid in full.

JAL and Boeing had paid compensation to 131 families of victims as of April 10, according to JAL attorney George Tompkins Jr. at Condon & Forsythe in New York.

Of the claims already paid, underwriters say that Boeing and its insurers have paid more than $87.7 million of the losses, while JAL's insurers have paid more than $8.6 million. However, this will be adjusted to reflect the 82.5%-17.5% split.

Boeing, however, says that it and its underwriters have paid about $75 million in claims so far.

One underwriter said the discrepancy may be due to additional expenses imposed on Boeing, such as underwriters' contributions to pay for a memorial to be built on the crash site.

Boeing's underwriters also have paid about $1.9 million in legal fees, while JAL's insurers have paid $85,000 for search and rescue and $84,000 for third-party property damage claims.

Boeing's underwriters are estimating that they will be responsible for more than $205 million in outstanding claims, while JAL's underwriters will be responsible for paying more than $40 million in outstanding losses.

As of April 10, Boeing and JAL had settled with 126 families of the 474 Japanese passengers killed in the crash, according to Mr. Tompkins. Of the remaining 348 survivors of Japanese crash victims, Boeing and JAL continue to negotiate in Japan with 228; 71 are litigating in Seattle; two are litigating in Japan; and 47 have neither sued nor settled pending release of the accident report.

In late April, the 71 Japanese families suing in Seattle voluntarily dismissed JAL from their suit, leaving Boeing as their only defendant.

Of the 22 non-Japanese passengers killed, JAL and Boeing have settled with the families of five, bringing total settlements as of April 10 to 131. Ten other survivors of non-Japanese victims are suing Boeing, while survivors of two other non-Japanese victims—both Americans—are suing both Boeing and JAL.

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Free-lance writer David Kilburn in Tokyo also contributed to this article.

McCarran-Ferguson

Continued from page 1

ers say ISO would not be allowed to analyze claims information for members.

At the same time, insurers say ISO would not be free to publish or furnish advisory rates, a restriction that could increase costs and make coverage more difficult to obtain.

"The ISO rate gives companies a benchmark," notes David Pratt, vp-federal affairs for the American Insurance Assn. in Washington.

Without ISO analysis and advisory rates, insurers—especially smaller companies—would have to hire more actuaries and consultants, which would inflate the price of insurance.

In addition, insurers would be reluctant to enter new lines of business in the absence of advisory rates, some say.

"No one company has the market expertise or penetration to develop a rate," observed Tom O'Day, associate vp in the Washington office of the Alliance of American Insurers. "There would be a chilling effect on the decisions of companies to enter certain lines of business," he maintained.

The Metzenbaum legislation also says insurers could—without violating federal antitrust laws—engage in joint underwriting activities, like providing coverage through pool arrangements. Such activities would be permissible so long as pools are subject to active supervision by a state regulatory agency or if the pools "do not not unreasonably restrain trade," according to the legislation.

No firm decision was made on how the claims payment would be divided until earlier this year when, after reading technical reports, Boeing's underwriters agreed to pay 82.5% of the claims.

Since the legislation does not define what is a restraint of trade, insurers that participate in pools could be hit with antitrust suits, industry lobbyists say.

For example, a disgruntled consumer who does not like the terms and conditions of coverage offered by a pool might charge restraint of trade and sue, Mr. O'Day said.

Because of the fear of litigation, "Insurers might withdraw from all but the most highly state supervised joint activities," Mr. O'Day said.

"Some insurers participate in pools almost as a public service," he said. "They would not do so if they feared getting slapped with an antitrust suit and treble damages."

Industry critics dismiss such arguments as specious, contending that beneficial joint insurer activities always would be upheld by courts.

"Even with a McCarran-Ferguson repeal, pro-consumer activity would pass court muster," predicted J. Robert Hunter, president of the National Insurance Consumer Organization in Alexandria, Va.

Overall, insurance industry spokesmen described the Metzenbaum legislation as a solution in search of a problem. For example, they say there is no evidence that repeal or modification of the McCarran-Ferguson Act would have prevented the last liability insurance crisis or would prevent a future crisis.

Insurers concede that certain industry activity during the liability crisis outraged the public, raising new questions about the McCarran-Ferguson Act.

For example, a wave of indignation erupted last year when several major insurers pulled out of the West Virginia medical malpractice insurance market and created a major crisis until the state legislature passed a tort reform bill (*BI*, June 2, 1986).

But Mr. O'Day says if the insurers' action in West Virginia had been found to be an illegal boycott, such action would not have been shielded from antitrust law by the McCarran-Ferguson Act.

Indeed, under the act, the antitrust exemption does not apply to an agreement to boycott, coerce or intimidate, he explained.

While the three major property/casualty trade associations—the Alliance, the AIA and the National Assn. of Independent Insurers—are united in their opposition to any changes to the McCarran-Ferguson Act, support for limiting insurers' immunity from federal antitrust law has been increasing.

For example, two organizations for small business—the National Federation of Independent Business and the Small Business Legislative Council—have endorsed a partial repeal of McCarran-Ferguson.

In addition, a former top industry official said last week that the McCarran-Ferguson Act may no longer be necessary.

"One wonders if McCarran-Ferguson has not served its purposes," said former AIA President T. Lawrence Jones in testimony before the Senate Judiciary Committee.

"Today there is real competition throughout the industry. Advisory organizations operate in compliance with strict antitrust laws. State regulation is mature and firmly established. State taxation is in place and secure," said Mr. Jones, who now is counsel to the law firm of Hunton & Williams in Washington.

Because congressional support for changes to the McCarran-Ferguson Act is increasing, Mr. Hunter says it is only a matter of time before Congress makes substantial changes to the McCarran-Ferguson Act.

"Something like (the Metzenbaum bill) will pass. The momentum is there," he says (see story, page 3).

But one industry lobbyist says amending the McCarran-Ferguson Act has yet to attract bipartisan support. "You have four very liberal Democrats. Where are the moderate Democrats and the Republicans?" the lobbyist asked.

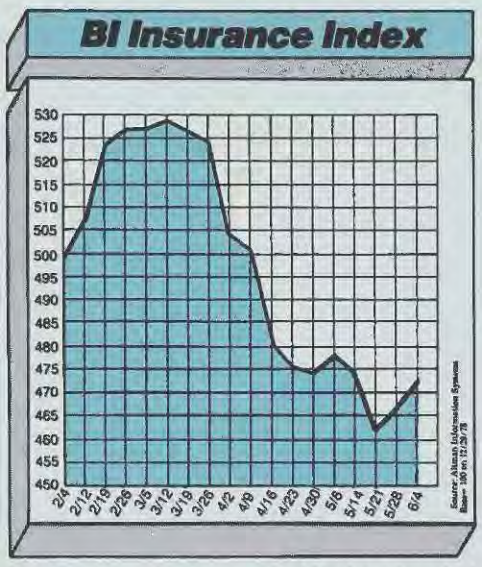
And other industry groups, including the Risk & Insurance Management Society Inc., remain opposed to amending the McCarran-Ferguson Act.

"No one has convinced me that tinkering around with the McCarran-Ferguson Act would make an iota of difference in increasing competitiveness in the industry," said Jon Harkavy, RIMS' general counsel and director of governmental affairs in New York.

"Certain collective activity can be very good. Do you want to discourage the type of activity that may be very beneficial to the buyer?" Mr. Harkavy asked.

If Congress really wanted to do something meaningful to increase competition, it should crack down on states that unfairly interfere with risk retention groups as well as pass legislation to allow businesses to take tax deductions for contributions to self-funded loss reserves, Mr. Harkavy said. ■

BI Insurance Index



The *Business Insurance* stock index closed at 473.0 on June 4, up 5.1 points from 466.9 on May 28. Out of 63 insurance industry stocks monitored, 37 posted gains, 13 declined and 13 remained unchanged at the end of the period. Leading advances for the week were posted by: Hanover Insurance Group, up 9.2%; Provident Life & Accident Insurance Co., up 8.7%; Nobel Insurance Ltd., up 8.5%; Tokio Marine & Fire Insurance Ltd., up 8%; Hartford Steam Boiler Inspection & Insurance Co., also up 8%; Torchmark Corp., up 7.4%; and Kemper Corp., up 7.1%. Declining issues for the period were led by: Crown Life Insurance Co., down 19.4%; Protective Life Corp., down 13.0%; Trenwick Group Inc., down 4.8%; The Home Group Inc., down 4.5%; UNUM Corp., down 3.7%; Continental Corp., down 2%; and USF&G Corp., also down 2%. The *Business Insurance* index climbed 1.3% for the period, trailing the New York Stock Exchange Composite, which grew by 1.6%, and the Standard & Poor's 500 average, which grew 1.5%. However, the *BI* index outpaced the Dow Jones 30 Industrials, which rose only 0.7% for the period.

British Issues

June 2 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High	1 Week Low
Comml Union	315	10.9	17.8	5.7	322	315
Genl Accident	970	10.5	38.3	4.0	985	970
Gdn Royal Exch	939	11.7	46.5	5.0	945	938
Royal	448	7.8	21.2	4.7	475	456
Sun Alliance	870	10.0	32.2	3.7	870	839
Brokers						
CE Heath	488	14.6	34.5	7.0	506	485
Hogg Robinson	479	14.1	15.7	3.3	452	445
JH Minet	327	10.7	12.9	3.9	327	314
Sedg Grp	300	13.6	16.4	5.5	304	299
Stew Wrightson	448	12.4	17.8	4.0	448	446
Willis Faber	449	15.0	14.8	3.3	449	442

Source: Philip Olsen/Alan Clifton, Insurance Industry Specialists Kitcat & Aitken Stockbrokers, London

First-quarter results show premium increases easing

By MYRON M. PICOULT

Special to Business Insurance

RATE-CUTTING IN commercial property lines has sparked considerable commentary about whether the reductions will become more severe and whether this mentality will quickly spread to other lines.

It is not surprising that rate adjustments are occurring in the property area, given that commercial property rates were among the first to stabilize in 1984-1985 and that the line has experienced very good underwriting results because of the low level of catastrophe losses. In effect, rate increases overshot their projected mark. It also should be noted that rates peaked six to eight months ago.

Mr. Picoult

In both good and bad underwriting cycles, "war stories" always surface, and this period is no different. More often than not, comments about rate adjustments are devoid of specifics and/or qualifications, and comments from some insurance brokers imply that the worst is likely, while others provide a more tempered perspective.

There are some risks that went into the excess/surplus market because of the lack of availability in the primary market. Some of that business now is flowing back to the primary arena at more realistic rates. If these are the accounts a broker is talking about, then it should be explained clearly.

The term "competition" is used very loosely by industry observers. It can mean more of a willingness to write business as well as rate cutting. The days of the massive rate increases are clearly over, but we still expect modest rate increases in various liability lines through the end of 1987.

Notwithstanding the commentary, we find it hard to believe that "quality-oriented" companies are permitting their underwriters to compromise the integrity of their property books so soon by cutting rates to the bone. The quality companies are clearly being more selective about the risks they underwrite, which is evident in the slowdown in the industry's first-quarter premium gain.

One of this industry's problems in the past was it would write the business and not worry about the bottom line. Now that some companies are trying to watch their top-line growth as rate gains slow, industry pundits are complaining. You can't have is both it both ways, folks!

Our first-quarter study of property/casualty insurers showed some interesting trends and variances. On average, net premiums written for the 21 companies we survey rose 12.5% during the quarter, a clear slowdown from the torrid pace set in 1986. Eleven companies were below the average, nine were above, and one was right on the mark. We saw everything from a 1% decline for USF&G Corp. to a 33.2% gain for American International Group Inc. Fourteen companies still posted double-digit premium volume increases. Earned premiums, reflecting the benefits of earlier rate gains, rose 18.9%.

Net investment income expanded 10.8% as yields continued to slide and companies struggled with the implications of the Tax Reform Act and the best way to maximize their net operating losses, but nonetheless keep an eye on the alternative minimum tax.

The combined ratio improved to 104.0% from 109.5%. All of the improvement was in the loss ratio, as the expense ratio actually rose 0.5%. Five underwriters recorded combined ratio below 100% and one was at par. The best ratio, 96.3% as posted by GIECO Corp., followed by Chubb Corp. at 97.4%. Overall, 10 companies were below the average and 11 were above.

Looking at some statutory ratios, the net premium-to-surplus ratio among the group improved slightly to the 2.3-to-1 level, while the reserve-to-surplus ratio moved up to almost 2.7-to-1. The latter ratio continues to reflect the reserve conservatism of many companies. On average, loss reserves increased 19% while paid claims rose 3.5%.

As expected, property/casualty earnings were up strongly at 171.0%. It should be stressed that the 1986 figure was not all that healthy to begin with. Furthermore, it should be noted that the "fresh start" adjustment also had something to do with the gain (see story, page 1).

When looking at consolidated earnings, the gain for our group of companies was almost 62%. When the fresh start adjustment is pulled out, the increase moderates to the 39% level.

As we noted several weeks ago, many companies seem to be using the fresh start adjustment as a means to further correct some reserve deficiencies that have not been totally eradicated. Once the companies have corrected this, they should go on to their reinsurance recoverables, where considerable work is needed.

The recent stock market activity of the property/casualty stocks shows that investors are more intent on focusing on the industry's past propensity to shoot itself in both feet. It is very possible that this could be a lost cycle in terms of stock market recognition. As unfortunate as that may be, it should not dissuade "quality companies" from sticking to the basics and trying to maintain the integrity of their books of business. There is nothing wrong with slower growth or even negative growth if it means a better profit picture. There is no reason for managements to expose their capital if a reasonable return cannot be garnered.

Insurance brokers would do well to recognize that unrealistic rates will not serve their clients well. Hence, they do not help the situation by telling tales. If the tales are real, then fingers should be pointed publicly at the culprits. It must be remembered that all parties to the business bear some responsibility for the last underwriting debacle. ■

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Outhwaite agency releases report

LONDON—Liabilities primarily arising from asbestos-related claims on reinsurance run-off policies written in 1982 by two Lloyd's syndicates managed by R.H.M. Outhwaite (Underwriting Agencies) Ltd. total 248.5 million pounds ($367.8 million at year-end 1986 exchange rates), according to the syndicates' just-released 1986 annual report.

Outstanding losses on run-off contracts estimated by policyholders increased 18% to 150.6 million pounds ($222.9 million) from 127.1 million pounds ($184.3 million) in 1985, while incurred-but-not-reported losses jumped 43% to 71.9 million pounds ($106.4 million) from 50.4 million ($73.1 million), according to the 1986 report. The remaining 26 million pounds ($38.5 million) of the syndicates' liability stems from other business.

Several of the run-off policies are currently being disputed by the Outhwaite syndicates (*BI*, May 4). The total estimated liability for the contracts in dispute amounts to more than 75 million pounds ($122.2 million), confirmed agency Chairman Maurice Hussey, who noted that the agency has commenced arbitration proceedings with a few of the ceding insurers.

According to the annual report, reserves of 78.6 million pounds ($116.3 million) have been retained to "meet all known and unknown outstanding liabilities at Dec. 31, 1986." The remaining liabilities will be covered by special reinsurance policies, including "time and distance" policies, under which "amounts are collectible at different dates based on our projections of likely cash requirements," says the report.

The full indemnity value for these policies totals 190.1 million pounds ($281.3 million), including a time and distance policy with a limit of 67.5 million pounds ($99.9 million) purchased last year.

About two-thirds of the special reinsurance policies are placed with Bermuda-based Pinnacle Reinsurance Co. Ltd., said Mr. Hussey. The others are with several different reinsurers, he said.

"There are no problems regarding collections under any of these contracts," says underwriter Richard Outhwaite in the report.

All the payments are backed by letters of credit or security fund agreements, except for a final payment of 50.7 million pounds ($75 million) due in 2006, according to the report. ■

BI Industry Stock Report

June 4, 1987 5/29/87 thru 6/4/87

Brokers		Price	% Chg.	P/E	$ Div.	% Yld.	High	Low	Vol.(000)
Alexander & Alexander Svcs	NYSE	25.25	3.6	30.1	1.00	4.0	25.63	24.75	965.2
Baldwin & Lyons Inc	OTC	19.00	2.7	7.9	0.20	1.1	22.00	18.50	3.3
Corroon & Black Corp	NYSE	29.13	5.0	13.5	0.84	2.9	29.13	27.75	212.0
Gallagher Arthur J & Co	OTC	20.50	-0.6	15.8	0.40	2.0	21.00	20.50	120.6
Hall Frank B & Co Inc	NYSE	13.00	1.0	0.0	0.00	0.0	13.00	12.13[a]	306.0
Marsh & Mclennan Cos Inc	NYSE	61.88	2.1	16.9	2.40	3.9	61.88	59.63	658.2
Poe & Assoc Inc	OTC	12.25	0.0	15.5	0.40	3.3	12.25	12.25	3.6
AGENTS/BROKERS	AVERAGE			15.1		3.1			
Conglomerates & Holding Cos.									
Anderson Clayton(Ranger/PanAm)	NYSE	65.63	0.0	18.8	0.00	0.0	0.00	0.00	0.0
Armco Inc	NYSE	11.38	0.0	0.0	0.00	0.0	11.38	11.13	784.8
Berkley W R Corp	OTC	27.00	0.9	9.2	0.28	1.0	27.00	26.00	117.5
Berkshire Hathaway Inc Del	OTC	3360.00	-0.3	111.6	0.00	0.0	3380.00	3360.00	0.7
CIGNA Corp	NYSE	60.00	0.8	8.6	2.80	4.7	60.00	59.25	986.8
CNA Finl Corp (CNA)	NYSE	52.50	2.9	12.0	0.00	0.0	52.50	50.25	164.8
General Re Corp	NYSE	53.00	4.2	16.3	1.00	1.9	53.00	50.75	1,199.9
ITT (Hartford Group)	NYSE	57.88	4.3	14.8	1.00	1.7	57.88	55.75	2,668.6
Sears Roebuck & Co. (Allstate)	NYSE	51.13	-2.6	13.3	2.00	3.9	51.25	50.00	4,305.1
Transamerica Corp (Occidental)	NYSE	33.38	-1.8	7.5	1.76	5.3	33.50	32.50	636.9
CONGLOMERATES/HOLDING COS.	AVERAGE			59.3		0.2			
Insurers									
Aetna Life & Cas Co	NYSE	57.63	0.2	8.8	2.76	4.8	57.63	57.25	2,257.5
American General Corp	NYSE	37.88	4.5	10.2	1.25	3.3	37.88	36.00	1,588.0
Amern Heritage Life Invt Co	NYSE	33.00	3.3	16.7	0.96	2.9	33.00	32.75	2.7
American Indty Finl Corp	OTC	13.75	0.0	0.0	1.12	8.1	13.75	13.38[a]	34.2
American Intl Group Inc	NYSE	67.50	5.3	14.9	0.25	0.4	67.50	64.38	1,505.8
Aneco Reins Ltd	OTC	3.00	0.0	12.0	0.00	0.0	3.00	3.00	13.6
Avemco Corp	NYSE	43.13	1.8	31.3	0.28	0.6	43.13	42.25	22.3
Business Mens Assurn Co Amer	OTC	26.50	0.5	0.0	1.10	4.2	26.50	26.00	124.7
Chubb Corp	NYSE	60.25	2.8	9.5	1.68	2.8	60.25	58.00	491.8
Combined Intl Corp	NYSE	25.50	0.0	9.0	1.20	4.7	25.50	25.50	81.7
Continental Corp	NYSE	43.25	-2.0	9.8	2.60	6.0	43.75	42.25	736.2
Crown Life Ins Co	OTC	250.00	-19.4	8.6	6.40	2.6	310.00	250.00	0.2
Durham Corp	OTC	33.25	2.3	19.6	0.92	2.8	33.25	32.25	4.1
Farmers Group Inc	OTC	42.50	1.2	13.4	1.20	2.8	43.00	42.25	854.6
Fairmont Finl Inc	AMEX	17.63	0.0	9.9	0.00	0.0	0.00	0.00	0.0
Fireman Fd Corp	NYSE	37.00	2.8	12.7	0.40	1.1	37.00	35.50	662.6
Fremont Gen Corp	OTC	16.13	2.4	0.0	0.60	3.7	16.13	15.50	154.0
Great West Life Assurn Co	OTC	700.00	0.0	14.4	18.00	2.6	0.00	0.00	0.0
Home Group Inc	AMEX	18.75	-4.5	4.8	0.20	1.1	19.38	18.75	449.2
Hanover Ins Co	OTC	32.75	9.2	7.8	0.36	1.1	32.75	30.25	185.0
Harleysville Group Inc	OTC	15.00	-0.8	4.7	0.40	2.7	15.13	15.00	26.0
Hartford Steam Boiler Insptn	OTC	34.00	7.9	14.8	1.00	2.9	34.00	32.63	181.6
Kans City Life Ins	OTC	28.00	1.8	10.8	0.96	3.4	28.00	27.50	10.4
Kemper Corp	OTC	32.25	7.1	11.2	0.60	1.9	32.25	30.75	902.9
Liberty Corp S C	NYSE	38.00	-0.3	13.7	0.72	1.9	38.13	37.75	17.0
Lincoln Natl Corp Ind	NYSE	49.38	0.3	10.4	2.16	4.4	49.38	49.00	319.1
Mission Ins Group Inc	PAC	1.50	0.0	0.0	0.00	0.0	4.38	0.69	3.5
Monumental Corp	OTC	55.63	0.0	18.8	0.00	0.0	55.63	55.63	1.1
Nac Re Corp	OTC	24.75	4.2	32.6	0.00	0.0	24.75	23.75	145.1
Nobel Ins Ltd	OTC	12.75	8.5	9.6	0.37	2.9	12.75	10.75[a]	174.4
Northwestern Natl Life Ins	OTC	25.38	1.0	7.2	0.96	3.8	25.50	25.13	183.9
Ohio Cas Corp	OTC	45.00	4.0	12.8	1.68	3.7	45.00	44.00	128.8
Old Rep Intl Corp	OTC	28.00	4.2	10.0	0.80	2.9	28.00	26.75	295.8
Orion Cap Corp	NYSE	21.88	4.2	0.0	0.76	3.5	22.00	20.88	109.2
Protective Corp	OTC	12.50	-13.0	10.2	0.70	5.6	14.50	12.50[a]	237.8
Provident Life & Acc Ins Co	OTC	21.88	8.7	12.1	0.84	3.8	21.88	20.63	397.3
St Paul Cos Inc	OTC	45.75	3.4	10.6	1.76	3.8	45.75	44.00	886.4
SAFECO Corp	OTC	58.00	3.1	10.8	1.92	3.3	58.00	56.50	486.4
Scor U S Corp	OTC	11.25	0.0	13.4	0.00	0.0	11.25	11.25	64.1
Seibels Bruce Group Inc	OTC	15.50	1.6	96.9	0.80	5.2	15.50	14.75	17.7
Selective Ins Group Inc	OTC	25.00	2.0	9.7	0.92	3.7	25.00	24.13	123.2
Statesman Group Inc	OTC	4.50	0.0	0.0	0.05	1.1	4.56	4.50	134.7
Tokio Marine & Fire Ins Co	OTC	88.00	0.0	98.9	0.17	0.2	88.00	88.00	19.2
Torchmark Corp	NYSE	27.13	7.4	9.7	1.20	4.4	27.13	26.50	673.9
Travelers Corp	NYSE	43.25	-1.4	9.2	2.28	5.3	43.50	43.13	1,656.8
Trenwick Group Inc	OTC	15.00	-4.8	25.4	0.00	0.0	15.75	15.00	216.6
United Fire & Cas Co	OTC	28.25	0.0	9.0	0.96	3.4	28.50	28.25	2.9
United States Fid & Gty Co	NYSE	38.38	-1.9	9.2	2.48	6.5	38.38	37.13	2,227.5
Unum Corp	NYSE	22.50	-3.7	0.0	0.40	1.8	23.50	22.25	820.4
Uslife Corp	NYSE	38.25	3.0	9.8	1.20	3.1	38.25	37.25	266.0
Washington Natl Corp	NYSE	24.25	0.0	12.5	1.08	4.5	24.63	24.25	58.9
Zenith Natl Ins Corp	OTC	20.50	-1.2	11.8	0.80	3.9	21.50	20.50	128.5
INSURANCE COMPANIES	AVERAGE			12.1		2.7			

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