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Update

Proposal to simplify Section 89 attracts wide committee support

WASHINGTON—Section 89 non-discrimination rules would be simplified under legislation introduced Friday by Sen. David Pryor, D-Ark.

Sen. Pryor, a Senate Finance Committee member, said nearly half the committee's members are co-sponsoring the bill.

Under the bill, an employer would not have to perform complicated Section 89 non-discrimination tests on a health plan if the plan is available to at least

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Ups and downs

Property/casualty insurer profits fall

By JUDY GREENWALD

Commercial property/casualty insurers are glumly looking ahead to a year of deteriorating combined ratios and declining profits.

While a few observers believe that rates could rise as early as this year, they add that any price increases will not be reflected in this year's—nor perhaps 1990's—results.

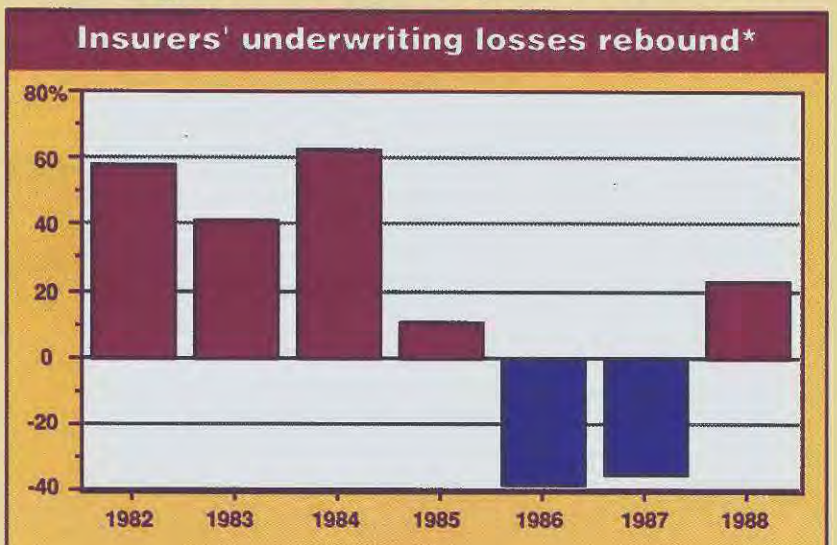
Most observers do not expect the market to turn until 1990 at the earliest, and at least one analyst does not expect prices to rise until 1992.

Meanwhile, property/casualty insurance premiums are not expected to grow more than 5% this year, which will cut into insurers' cash flow and investment income despite higher interest rates, observers say.

And, while catastrophe losses were unusually low in 1988, property/casualty insurers cannot count on their luck holding for another year, many agree.

Even with the low level of catastrophe losses, 27 major commercial insurers surveyed by *Business Insurance* posted a 106.3% combined ratio in 1988, up from 105.1% in 1987.

At the same time, net written premium volume increased a nominal 1.6% to $87.7 billion from $86.3 billion. That compares with a 7.6% increase in a *BI* survey of 1987 results.



"Each quarter in 1989 is going to look progressively worse, and probably through the first half of 1990 as well," predicted Udayan D. Ghose, an analyst with Shearson Lehman Hutton Inc. in New York.

Mr. Ghose said he is betting the cycle will begin to bottom out in the first half of 1990, but "certainly not this year."

"The trend of declining margins

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Rate hikes boost health insurers

By DONNA DiBLASE

Group health indemnity plan premium increases of 20% to 50% over the past two years are helping to heal the group health insurance industry's financial wounds.

Many insurers report improved group health insurance results in 1988, with some pointing out that fourth-quarter profits surged.

However, huge losses on health maintenance organization operations may be dampening some group health insurers' recoveries.

"It finally looks like the rate of group health premium increases is larger than the inflation rate of health care claims," said Denis Callaghan, an analyst with Alex. Brown & Sons in New York.

"And, given that it takes a year to feel the effects of premium increases, the earnings recovery we saw in the fourth quarter is in line with our predictions that health insurers would start to experience a cyclical earnings recovery," he added.

Some health insurance executives predict that insurers' financial results likely will continue to improve as the effects of similar indemnity plan premium increases imposed throughout 1988 and 1989 are felt.

However, insurers also note that they don't expect to reap huge profits on their group health insurance business.

"We've seen some improvement and we probably will see more. But we don't expect that we're going to be on easy street here by any stretch of the imagination," observed John D. Moynahan, an executive vp with Metropolitan Life Insurance Co. in New York.

Insurers and industry observers agree that any earnings rebound reported by group health insurers is primarily the result of increased indemnity plan premiums, not cost containment provisions.

"While the insurers may have done a good job on the revenue side, they may not have done such a good job controlling things on the health care cost side," observed Lawrence B. Leisure, national health care practice leader of TPF&C, the benefit consulting division of Towers, Perrin, Forster & Crosby Inc. in New York.

"Unfortunately, employers are more concerned with controlling costs than with insurers' revenues," Mr. Leisure said.

"I think there's been some positive effect of insurers' utilization review programs, but premium increases are the reason many insurers have seen better results. And, I think we'll continue to see improvement," said Joseph Rosmann, a partner in the actuarial, benefits and compensation consulting practice of Coopers & Lybrand in Chicago.

"The health care inflation trend is not going down," warned Laird Post, a consultant in the Sherman Oaks, Calif., office of The Wyatt Co. "If insurers' financial re-

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Jury sides with insurers in Rely case

By STACY ADLER

CHICAGO—Procter & Gamble Co. must pay out $30 million in defense and indemnity costs before it can tap any of its liability insurance to cover costs related to hundreds of Rely tampon lawsuits, a jury ruled last week.

The U.S. District Court jury in Chicago found that lawsuits filed against P&G stemming from injuries linked to Rely tampons constitute multiple occurrences, even though all of the lawsuits allege bodily injury from the same product.

As a result, Cincinnati-based Procter & Gamble cannot tap any of its liability insurance until it has exhausted a $10 million annual aggregate self-insured retention for each of three policy years at issue, rather than a $1 million per-occurrence retention.

P&G removed Rely tampons from the market in September 1980 after being hit with hundreds of lawsuits by victims of toxic shock syndrome, which several studies linked to the use of high-absorbency tampons like Rely.

Since that time, P&G has been named in more than 900 lawsuits alleging bodily injury stemming from the use of Rely tampons.

P&G notes in court papers that only three verdicts were rendered in Rely lawsuits. In one case, a jury found P&G liable but ordered no damages. The court ordered a retrial, and the case was later settled for $38,000.

Of the other two cases, one resulted in a judgment for P&G and one resulted in a $300,000 compensatory award against the company.

Fewer than five Rely cases still are pending; the rest were either settled or dismissed, P&G says.

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Pollution ruling aids policyholder

By STACY ADLER

CHICAGO—A sweeping ruling by an Illinois appellate court could make it easier for policyholders to win coverage for pollution cleanups.

The pro-policyholder ruling in what had been considered an anti-policyholder jurisdiction is being touted by policyholder attorneys nationwide as a historic coverage litigation victory.

In one of the first rulings of its kind, the Illinois 1st District Court of Appeals ruled March 7 that the pollution exclusion in comprehensive general liability policies is ambiguous because it is not clear whether the exclusion applies to policyholders that hire a third party to dispose of chemical wastes.

The pollution exclusion bars coverage for all forms of pollution that are not "sudden and accidental."

The court also ruled that the term "sudden and accidental" means "unexpected" or "unintended." Insurers had vigorously argued the term meant to happen quickly.

In addition, the appellate court ruled:

- A letter from the U.S. Environmental Protection Agency naming a policyholder as a "potentially responsible party" for a pollution cleanup constitutes a lawsuit for insurance policy purposes.
- Hazardous waste cleanup costs constitute insurable damages under standard CGL policies.
- A policy exclusion barring coverage for pollution on property used by the policyholder does not bar coverage for cleanups at hazardous waste dump sites owned by third parties.

"This is the only Illinois reviewing court that has spoken

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Bush promises his support for state regulation, tort reform
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Raytech files for Chapter 11 to avoid asbestos liabilities
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NEWSPAPER

Update

Bill would ease Section 89 tests

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90% of its employees and mandatory employee contributions are no greater than $6.70 per week for individual coverage and $13.40 per week for dependent coverage. These limits would rise with increases in the minimum wage.

Also, under the bill, only employees who work 30 or more hours a week in 1989 would have to be considered when running the nondiscrimination tests. This benchmark would be lowered to 27.5 hours in 1990 and 25 hours in 1991.

Under the current version of Section 89, employees working at least 17.5 hours a week generally must be included in non-discrimination tests. As a result, firms that employ many part-time employees ineligible for benefits cannot pass the tests.

Another provision of the legislation would exempt non-profit organizations and local government entities that do not employ highly compensated workers from Section 89.

"I see this bill as the first step in reforming Section 89 and I in no way consider this to be the finished product," Sen. Pryor said.

Hotel victims seek $136 million

SAN JUAN, Puerto Rico—Plaintiffs' attorneys are using a judge's interpretation of a liability insurance policy to ask that two insurers pay at least $136 million to survivors of the 1986 San Juan Dupont Plaza hotel fire.

The two American International Group Inc. units wrote $1 million of occurrence-based liability insurance for the hotel.

The New Year's Eve fire at the hotel killed 97 people and injured more than 100 others (*BI,* May 30, 1988; Jan. 12, 1987; Jan. 5, 1987).

The Plaintiffs' Steering Committee, which represents relatives of victims of the fire as well as survivors, filed a motion in San Juan District Court last week identifying 88 "discrete acts or omissions committed by the San Juan Dupont Plaza Corp." and 48 other occurrences stemming from the hotel's selection and purchase of "unreasonably dangerous" products as occurrences under its liability policy.

The motion follows a ruling by San Juan District Court Judge Raymond Acosta that AIG units American International Insurance Co. of Puerto Rico and Insurance Co. of the State of Pennsylvania are responsible for "each discrete act or omission, or series of acts or omissions" by the hotel that "caused damages to plaintiffs."

The committee has asked the court to determine the "number of total discrete acts or omissions, or series of acts or omissions, on the part of the SJDPC."

The committee requests the court determine most of those acts or omissions in the second phase of a trial that began last week.

The first phase of the trial will resolve questions over the ownership and management of the hotel. Subsequent phases of the trial will determine liability of other defendants in the litigation.

Because of a gag order issued by the judge, neither AIG nor the Plaintiffs Steering Committee were willing to comment.

Claims-made ruling decertified

LOS ANGELES—The California Supreme Court late last week decertified a controversial appellate court ruling that claims-made liability policies are unenforceable because they are against public policy.

Decertified opinions cannot be used as precedent in the state.

Insurers nationwide—including the National Assn. of Independent Insurers, the American Insurance Assn. and the Assn. of California Insurance Cos.—rallied to petition the court to either reverse or decertify the ruling (*BI,* March 6; Jan. 16).

Insurers said this ruling—if upheld—would have forced them to either stop writing claims-made policies in California or raise rates. They also said the ruling would jeopardize their financial viability because it would force them to pay claims filed after policies expired for which they had not reserved.

In a related decision, the Supreme Court of Maryland earlier this month let stand a lower court ruling that a medical malpractice claim filed after the expiration of a claims-made policy must be covered because the insurer was not prejudiced by the delay.

Maxicare files for Chapter 11

LOS ANGELES—Maxicare Health Plans Inc. filed for reorganization under Chapter 11 of the Federal Bankruptcy Act last week.

The action affects the parent company, its HealthCare USA Inc. and HealthAmerica Corp. holding companies and all of Maxicare's HMO units, except its Wisconsin unit, which is licensed as an insurance company and has not been placed in rehabilitation. Maxicare also plans to sell its 415,000-member California HMO.

Maxicare will continue to provide medical care to its enrollees and pay its health care providers for all services rendered, the company said in a statement released last week.

Maxicare reported a 1988 third-quarter net loss of $169.7 million and a net loss of $250.5 million for the nine months ended Sept. 30 (*BI,* Dec. 12, 1988). The company has not released full 1988 results.

Under a restructuring plan, the company sold or discontinued 19 HMOs, increased premiums an average of 15% and adopted stricter payment arrangements with its health care providers during 1988.

The company also underwent a senior management change, including ousting co-founders Fred W. Wasserman, who was chairman and chief executive officer, and Pamela K. Anderson, who was president and chief operating officer (*BI,* Aug. 15, 1988).

The company currently serves 1 million members in 12 states.

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Errors & omissions

Blue Cross of California does not have a contract with Lifelink, a California managed care firm, as reported in a Perspective article in the Feb. 20 issue. The article also should have stated that one-third of national HMO firms and 21% of unaffiliated HMOs lost members in 1988. The article suggested these HMOs lost money.

S&L litigation won't ruin accountant E&O market

By MICHAEL SCHACHNER

Litigation brought against 10 accounting firms by a federal agency over their audits of several now-insolvent savings and loan institutions probably will not cause the accountants professional liability market to constrict significantly in the near future, insurers and brokers predict.

Insurers have been well aware that accounting firms providing services to financial institutions are a high-risk category, observers say. And, some observers say they are confident that the accountants will be vindicated.

However, rates for accountants' coverage may rise if defendants in the litigation are held liable, some point out. In addition, the litigation will discourage new players from entering the accountants professional liability market, sources say.

The Federal Home Loan Bank Board is suing the accountants, including three Big Eight accounting firms, over audits of savings and loan institutions dating back as far as 1982 (BI, Jan. 30, 1989).

The three Big Eight firms being sued are Deloitte Haskins & Sells, Coopers & Lybrand and Touche Ross & Co. Seven other regional firms also are named in eight separate cases, with one of the seven named in two cases (see story, page 40).

In total, the board is seeking more than $663 million from the 10 defendants.

Reports place the board's current outstanding obligations for insolvent thrifts at $39 billion.

But sources say the magnitude of the litigation is not causing any immediate reaction in the accountants professional liability market, which has been in a state of uneasy calm while determining the effects of the Tax Reform Act of 1986 and court cases expanding accountants' liability (*BI,* Oct. 10, 1988).

"Underwriters have been aware of these dangers for quite a while," said Rick Cowan, a wholesale unit manager with Fred S. James & Co. Inc. in San Francisco.

Underwriters already "look at CPAs who audit banks very closely," Mr. Cowan said. "There is already a heightened awareness which hasn't reached the point of not writing the coverage. But, scrutiny is up."

And, insurers and brokers point out that the bulk of the lawsuits will not go to trial for at least another year, thus deferring any immediate impact on the marketplace if the accountants are held liable.

Market observers expressed confidence that the courts will not hold accounting firms liable for the S&L insolvencies.

They predict accountants will prove that their audits could not portend circumstances beyond the accountants' control that led to the thrifts' financial troubles.

"To a certain degree they are right when they say there were many other circumstances contributing to

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Regulators in two states probe life/health agents

By DONNA DiBLASE

Insurance regulators in two states are investigating separate cases in which life/health insurance agents allegedly did not place coverage promised to clients.

In one case, the California Insurance Department is seeking to revoke the licenses of Irvine-based Rubell Helm Insurance Services Inc. for, among other things, failing to place stop-loss insurance for self-funded group health and life insurance plans.

The California department charges that Rubell Helm collected millions of dollars in premiums from small employers and multiple employer trusts for the coverage.

The department estimates that as many as 10,000 employees and dependents in the small employer trusts are affected and that $4.3 million in health claims filed under the plans administered by Rubell Helm were unpaid at year-end 1988.

Rubell Helm's president denies the charges.

In a separate case, the Illinois Insurance Department is investigating Oak Brook-based insurance broker James E. Jarvis for allegedly failing to forward between $250,000 and $1 million in health care premiums he collected from 193 employers to four Chicago-area health maintenance organizations.

As a result, some employees have been without health care coverage for several months.

Mr. Jarvis, through his J. Jarvis & Associates Ltd. and Midwest Assn. of Commerce & Industry operations, pooled the health coverage of employers with 10 or fewer workers to qualify the employers for group rates.

In addition, one employee left without health care coverage has filed a lawsuit in DuPage County Circuit Court against Mr. Jarvis' operations and three of the four HMOs. The employee's attorney is seeking class-action status for the suit, which seeks reinstatement of coverage with the HMOs and payment of the plaintiffs' legal costs.

Meanwhile, Mr. Jarvis cannot be located, an Illinois department official noted.

The California department's investigation of Rubell Helm, which began last June, was prompted by information the department received from "someone who was familiar with Rubell Helm and was concerned about there being no placement of insurance and a lack of claims payment," said Chief Investigator Dennis Ward.

Rubell Helm President James B. Helm denied the department's allegations, explaining that the stop-loss coverage was placed with a group of foreign reinsurers led by Hanover Reinsurance Co. of Hanover, West Germany.

"That's a lie that we did not place specific and aggregate stop-loss coverage," Mr. Helm said. "I don't think the department has a clue what we're doing."

Rubell Helm is licensed in California to operate as a life and disability insurance agent and as a health care plan administrator.

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- Four recent workers compensation case rulings by the Ohio State Supreme Court spell both good and bad news for employers. **PAGE 14**
- Bookstores generally are not taking extraordinary risk management measures to counter the threat of attacks by groups offended by 'The Satanic Verses.' **PAGE 16**
- In Speaking Out Clinton E. Miller, an insurance litigation consultant, analyzes when wrongful termination potentially is covered by liability insurance. **PAGE 27**
- Families of the passengers who died aboard the Pan Am jet that crashed Dec. 21 in Scotland likely will reject a settlement offer from the airline's insurers, plaintiffs' attorneys say. **PAGE 31**
- Neither the best of years nor the worst of years might be an apt description of 1988 for insurance brokers, says Stock Analyst Leonard M. Wilson. **PAGE 47**

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Chapter 11 shelters Raytech from claims

By LINDA J. COLLINS

SHELTON, Conn.—Raytech Corp.'s Chapter 11 bankruptcy filing will shield the former parent of asbestos producer Raymark Industries Inc. from mounting asbestos-related lawsuits while it appeals a federal court ruling that said both Raytech and Raymark are liable for the claims.

Shelton, Conn.-based Raytech is appealing to the 9th U.S. Circuit Court of Appeals a December ruling by the U.S. District judge in Oregon that Raymark has successor liability to Raymark.

Plaintiffs' attorneys say that Raytech's March 10 bankruptcy filing sounds a death knell for both Raytech and Raymark, which consistently have taken a hard line in settling asbestos-related claims.

Raytech was forced to file for reorganization under Chapter 11 of the Federal Bankruptcy Act in U.S. Bankruptcy Court in Bridgeport, Conn., not because the company was unprofitable, but because the company "had to stop the litigation while we dealt with the issue of successor liability," said General Counsel Legrande L. Young.

"If the court says there is no successor liability, then we can go on about our business," he said.

Raytech was created as a holding company by Raymark in 1986 to shield Raytech's profitable operations from Raymark's mounting asbestos liabilities (*BI*, Sept. 15, 1986). In the restructuring, Raymark sold its profitable assets to Raytech, without transferring its asbestos liabilities.

Raytech last year sold Raymark to Asbestos Litigation Management Inc., an acquisition and divestiture company whose founders included Raymark executives (*BI*, June 20, 1988).

Raymark, which is named in tens of thousands of asbestos-related suits, is running out of insurance and assets to pay those claimants. That has forced plaintiffs to amend their original suits against Raymark to attempt to pierce Raytech's corporate veil under the theory of successor liability.

Raytech currently is named in more than 1,000 suits, and that number is increasing.

Some 45,000 asbestos suits currently are pending against Raymark, and "new suits are being filed at a rate of about 1,100 a month," said John F. Lynn, president of Litigation Control Corp., which coordinates Raymark's defense effort. In addition, some 36,000 claims have been closed.

While Raymark originally had about $392 million in liability insurance to respond to asbestos claims, it already has disbursed "some $320 million, leaving roughly $72 million," he said.

A Connecticut judge in January ruled that Raymark is entitled to $32 million in coverage from the Connecticut guaranty fund for asbestos-related claims that should have been paid by Transit (*BI*, Feb. 13). The fund is contesting the ruling.

Of Raymark's $40 million in remaining coverage, $30 million in limits were written by Chicago-based Crum & Forster Inc. units International Insurance Co. and International Surplus Lines Insurance Co., and $10 million in limits was written by Hartford, Conn.-based Aetna Casualty & Surety Co.

As its coverage dwindles, Raymark currently is settling claims for an average of less than $100, Mr. Lynn said.

Plaintiffs' attorneys previously have attempted to force Raymark into involuntary bankruptcy, contending the company was not paying claims and was running out of money to pay claims.

The first attempt was dismissed last September, because the plaintiffs held disputed judgments against Raymark and, therefore, had no standing to force it into bankruptcy (*BI*, Sept. 26, 1988).

A second attempt was filed Feb. 13 in the U.S. Bankruptcy Court in Philadelphia by a different group that says it holds unstayed judgments against Raymark (*BI*, March 6). Raymark is appealing the second filing. A hearing has been set for March 28.

After the second attempt to force Raymark into bankruptcy, "a lot of plaintiffs were amending their suits to name Raytech" as a defendant, explained Raymark counsel

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St. Paul suitor tests states' power over acquisitions

By MEG FLETCHER

A New York-based company's quest to acquire 20% of The St. Paul Cos. Inc. threatens state insurance regulators' broad authority to reject potential insurance company owners and investors, regulators and others say.

The proposed acquisition by Alleghany Corp., a financial services company that owns Chicago Title & Trust Co., has spawned a maze of litigation that, observers say, could ultimately be decided by the U.S. Supreme Court.

Alleghany is challenging the constitutionality of state model insurance holding company statutes that give states in which an insurance company is considered domiciled the right to veto acquisitions of 10% or more of the stock of the insurer's parent.

Under these laws, Alleghany not only must obtain regulatory approval for its acquisition in Minnesota, where The St. Paul Cos. and its largest underwriting unit are based, but also in nine states in which other St. Paul affiliates are considered domiciled.

Regulators in Minnesota, New York and California have approved Alleghany's bid, with some restrictions. However, regulators in North Dakota, Nebraska, Indiana and Wisconsin have rebuffed Alleghany's bid, and Alleghany has filed suit to overturn the authority those regulators have regarding its acquisition proposal.

Already, a federal judge in North Dakota has ruled that North Dakota's insurance holding company act is unconstitutional because it unduly interferes with interstate commerce.

Texas regulators still are considering Alleghany's proposal, while the company has not pursued action in Illinois and Delaware in light of the litigation in other states.

"Subjecting" Alleghany's proposal to acquire St. Paul stock to "inconsistent" state regulation in 10 states is a "legislative scheme that constitutes an irrational and unconstitutional burden on interstate commerce, an invasion of an area governed by federal law and an attempt to regulate conduct wholly outside" the states' borders, Alleghany says in court papers filed in North Dakota.

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Bush reiterates vow to back state regulation, tort reform

By DEBORAH SHALOWITZ

WASHINGTON—President Bush is pledging his continuing support for state regulation of the insurance industry and tort reform.

An address delivered by the president espousing many pro-insurance industry views drew thunderous applause last week from a standing-room-only crowd at the annual legislative conference of the Independent Insurance Agents of America in Washington, D.C.

President Bush also reiterated his opposition to mandated employee benefits during his speech.

"I appreciate this industry's role in society," the president said. "We cannot offer protection against fate—but we can prevent the compounding of a tragedy," which is what insurance does. "You add a little bit of comfort to the grieving and predictability for those who are victims of the unpredictable."

However, "you cannot continue to perform. . .if your industry is hamstrung by excessive regulation," the president declared.

"That's why we have worked to remove excessive regulations" by ordering a review of more than 100 government regulations. And, the Bush administration will continue to "work to free small business" of some of the current "excesses of regulation," he added.

"When it comes to necessary regulation of business, I'm committed to letting the states take the lead, not the federal government," the president asserted.

However, he did not specifically address whether he opposes repeal or modification of the McCarran-Ferguson Act, the law that gives insurers limited exemption from federal antitrust laws and grants primary regulation of the insurance industry to the states.

Agents and others attending the IIAA meeting also responded with vigorous and sustained applause to President Bush's remarks supporting tort reform.

"Tort reform is critical to the health of business and volunteer organizations alike," he said.

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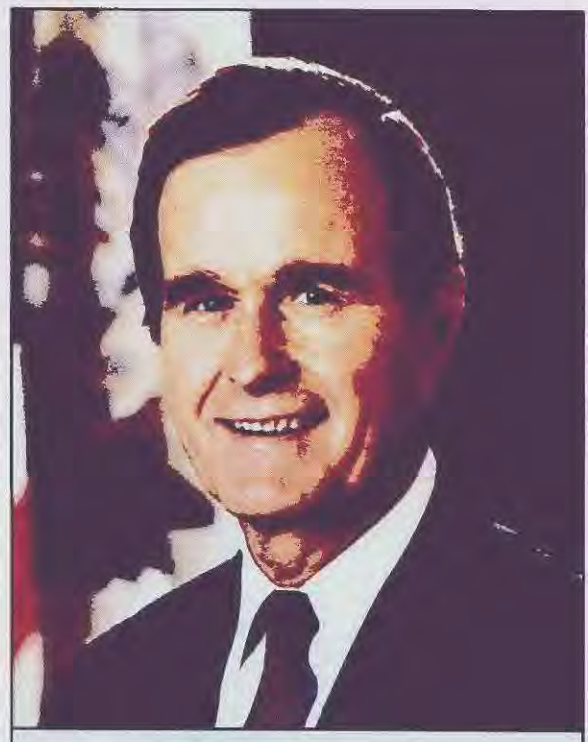

'When it comes to necessary regulation of business, I'm committed to letting the states take the lead,' President Bush says.

RIMS meeting to study benefits in the '90s

By KARI BERMAN

Providing employee benefits in the 1990s and the Bush administration's plans for federal policies affecting employee benefits will be topics of concern among employee benefit and risk managers attending the 27th annual conference of the Risk & Insurance Management Society.

In response, RIMS will offer a special session titled "Employee Benefits—The Next Four Years" during the April 9-14 conference in Atlanta.

This year's conference also will feature seminars on managed care programs, psychiatric and substance abuse care, utilization review, retiree medical benefits and claims data collection and analysis.

And, to help newcomers to employee benefits become more familiar with important issues, RIMS once again will offer a track program that includes employee benefit sessions.

"Employee Benefits—The Next Four Years" will be a popular session for corporate executives concerned with changes that the new presidency might bring, according to Howard Green, associate legislative director at RIMS in New York. The session, to be held in the ballroom on the convention level at the Marriott Marquis Hotel, is open to all conference participants.

Those who attend will "leave the seminar with a better idea of what will be coming down the pipe regarding managed care, Medicaid, parental leave, long-term care and child care issues," Mr. Green added.

The panel discussion will be moderated by Judy Lindenmayer, director of risk management at Boston-based Fidelity Investments. Speakers will include Frank McArdle, manager of Hewitt Associates' Washington, D.C., office, and David Walker, assistant secretary of labor, pension and welfare benefit administration at the U.S. Labor Department.

Although RIMS has not confirmed other speakers for the session, staff members from both the U.S. House of Representatives and the U.S. Senate also are expected to participate.

Atlanta 89

The "Employee Benefits—The Next Four Years" special session will be held on Wednesday, April 12, from 10:45 a.m to 12:15 p.m.

Another session exploring the future of employee benefits will focus on how employers can reduce costs for psychiatric and substance abuse treatment.

"Mental Health Managed Care for the '90s," S22, will be moderated by Ed Laginess, director of risk management at Minneapolis-based Minstar Corp.

During the seminar, Jeff Aycock, assistant vp at Crawford Health Management Services in Atlanta, will discuss how employers can manage mental health care costs by identifying employees' personal problems early so that outpatient, rather than costly inpatient, care can be applied.

In addition, participants will learn how to select mental health and substance abuse treatment providers when Richard Groepper, national account executive at Crawford & Co. in Atlanta, distributes a checklist outlining the most important points to look for when selecting a mental health care provider.

The seminar is slated for Tuesday, April 11, from 9 to 11:30 a.m., and will be repeated on Wednesday, April 12, from 2:30 to 5:00 p.m.

Another seminar at this year's RIMS conference will show employers how to reduce the crippling effects of adverse selection on group health indemnity plans.

During S28, "Reversing the Death Spiral," experts will discuss how employers can "keep both indemnity and managed care programs healthy," said Brian Sweeney, vp and regional financial officer at EQUICOR Inc. in Los Angeles.

For example, panelists will discuss how making premium copayments more competitive between indemnity and HMO options might propel younger and healthier individuals back toward the indemnity plan, he explained.

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Rely coverage

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P&G says it has spent about $[illegible] million in defense, indemnification and other costs related to Rely product liability claims and settlements.

P&G claimed in the coverage dispute that all of the Rely tampon-related lawsuits constituted 'one, continuing occurrence.'

Insurers on the other hand claimed that each lawsuit—alleging different injuries and stemming from different lots of Rely tampons—constituted a separate occurrence.

The jury, after deliberating for three days, voted 7-1 that the Rely tampon lawsuits constitute multiple occurrences and, thus, P&G's self-insured retention for each policy year was $10 million.

P&G attorneys would not comment on the verdict or a possible appeal.

Insurer attorneys say the verdict will help them win similar coverage disputes in the future. In fact, they say the P&G victory is particularly important because a majority of the current case law on this issue favors policyholders.

"This case will stand for the proposition where an insurer and an insured enter into active negotiations that they will be held to their original intent as evidenced by internal documents and witnesses," said Ronald A. Jacks, an attorney with Mayer, Brown & Platt in Chicago, who represented Northbrook Excess & Surplus Insurance Co. in the litigation.

The verdict marks one of the first times a jury has decided a complex insurance coverage dispute.

P&G had requested the jury trial.

The trial stemmed from a lawsuit filed by four of P&G's insurers in early 1984 seeking a declaration that they did not owe all of the more than $30 million in costs associated with the Rely tampon crisis.

P&G filed virtually identical litigation in Cincinnati in 1985. However, that litigation was stayed pending resolution of this case. The Chicago verdict will decide all issues in the Cincinnati case (*BI*, July 1, 1985; April 23, 1984).

The four insurers seeking the coverage ruling in the Chicago court were Northbrook Excess & Surplus Insurance Co., a unit of Allstate Insurance Co.; First State Insurance Co., a Hartford Insurance Group unit; Commercial Union Insurance Co.; and American Employers Insurance Co.

Northbrook was P&G's first-layer umbrella insurer from July 1, 1979, through June 30, 1981. Northbrook wrote $25 million in limits excess of P&G's retention of $1 million per occurrence/$10 million aggregate. The retention includes defense costs.

The Northbrook policy is an indemnity policy, which means P&G retains control over the defense of any lawsuits and Northbrook agrees to reimburse the policyholder for its cost, as defined by the policy.

First State provided $25 million in coverage excess of Northbrook's layer in 1980-81. The First State policy follows form with Northbrook's.

P&G's second-layer excess coverage in 1979-80 was written by Pine Top Insurance Co. of Chicago, which has been ordered liquidated in Illinois (*BI*, June 30, 1986). Pine Top was not a party to the litigation, having settled its dispute with P&G.

Commercial Union provided P&G with first-layer excess coverage in 1978-79 with a $25 million limit excess of P&G's self-insured retention.

American Employers, a CU unit, wrote $50 million in first-layer excess coverage above P&G's retention from 1972 to 1978.

Northbrook had paid P&G $40.7 million as of June 30, 1987, court papers state. However, the insurer contested $23 million in defense-related costs, some of which it had paid. Northbrook also contested P&G's retention interpretation.

The jury found that some of P&G's expenses that have not been paid by insurers were uninsurable. These include $6.5 million in salaries and benefits for P&G permanent employees who gathered data to defend the Rely suits and some $2.8 million in cross-charges related to the litigation made between P&G departments.

However, the jury rejected insurers' arguments that the $5 million P&G spent to sponsor outside research of toxic shock syndrome was not insurable. The jury also granted coverage for the cost of a $3 million computer information system.

The jury also granted coverage for a majority of some $4 million P&G paid in attorneys' fees and office manager bills.

The net result of these rulings, taking into account the funds already paid by the insurers, is that Northbrook owes P&G $2.3 million, an attorney says.

However, while P&G won the battle over these smaller issues, it lost the war over the more costly occurrence issue.

The jury's finding that the lawsuits constitute multiple occurrences means P&G must pay $30 million.

P&G attorney Paul Freehling failed to convince the jury that "there is a single, continuing occurrence beginning with the design of Rely and continuing onward."

P&G's comprehensive general liability policies define occurrence as: "An accident, event or happening including continuous or repeated exposure to conditions which result, during the policy period, in personal injury. . .neither expected nor intended from the standpoint of the insured. . . .All such personal injury. . .caused by one event or by continuous or repeated exposure to substantially the same condition shall be deemed to result from one occurrence."

"The words are very broad and very general," said Mr. Freehling, who is with Pope, Ballard, Sheppard & Fowle in Chicago. "Clearly the poor insured is entitled to any reasonable definition of such an ambiguous term."

"A.H. Robins Co. went into bankruptcy over Dalkon Shield claims and that is what P&G is trying to avoid in this litigation," he said.

However, Northbrook co-trial attorney Paul Schroeder of Jones, Day, Reavis & Pogue in Chicago painted a different picture for the jury.

He told the jurors that P&G, by virtue of its large, self-insured retention, was acting as a primary insurer and should be treated that way.

And, Mr. Schroeder maintained during closing arguments that P&G's insurance and risk management personnel knew the suits constituted multiple occurrences.

He implied that the single-occurrence theory was a creation of P&G's legal department when it realized the extent of P&G's liability.

Attorneys in the case say the jury was exceptionally well-educated—four jurors had college degrees including two with master's degrees.

"This had a tremendous impact," on the verdict, according to insurer attorney Shaun McParland Baldwin, who represented Commercial Union Insurance Co. and American Employers Insurance Co. in the litigation.

"Because a jury trial can be long, there is substantial risk of losing (the jury's) attention," said Ms. Baldwin of Tressler, Soderstrom, Maloney & Priess in Chicago.

In fact, jury members who were interviewed after the trial said they were, at times, overwhelmed by the difficulty of the issues in this case, according to attorneys.

However, Northbrook attorney Mr. Jacks maintained that a jury can handle complex issues. "I have faith in the jury system to handle large, complicated insurance cases if they can be presented in a straightforward, manageable way."

The P&G verdict "might encourage more insurers to submit their cases to juries," he said.

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Northbrook Excess & Surplus Insurance Co. and Pine Top Insurance and First State Insurance Co. vs. Procter & Gamble Co. et al.; U.S. District Court for the Northern District of Illinois Eastern Division, No. 83 C 3150.

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Profit-sharing contributions equal 8.7% of pay

Profit-sharing plans continue to be the primary source of retirement income for employees participating in the plans, according to a recent survey.

Only 28% of the employers surveyed offered a defined benefit pension plan along with their profit-sharing plan.

In addition, employers' profit-sharing contributions in 1987 averaged 8.7% of payroll, about even with the level of contributions over the past five years, the survey shows.

The "1988 Profit Sharing Survey," the 31st such survey conducted by Lincolnshire, Ill.-based Hewitt Associates and the Chicago-based Profit Sharing Council of America, surveyed 433 PSCA members providing 1987 experience information for 458 plans, including 396 profit-sharing plans that also gave payroll information.

The survey found that smaller employers are less likely to offer a pension plan in addition to a profit-sharing plan. For example, only 15.8% of plans with fewer than 50 participants also offered a pension plan, while 60.4% of plans with more than 5,000 participants also offered a pension plan.

The survey also indicates that 82.1% of plans in 1987 were deferred plans, in which shared profits are deposited in a trust with no optional cash payout. That represents a slight decrease from 84.7% of plans in 1986.

And 13.1% of plans are combination plans, in which a predetermined portion of shared profits is paid in cash and the rest is put into a deferred plan. The number of combination plans was unchanged from 1986.

Only 4.8% of plans are cash plans, in which profits are paid directly to plan participants, although this represented a slight increase from 2.2% of plans in 1986.

Overall, employers' level of contributions to profit-sharing plans has changed little in the past five years. In 1987, contributions represented 8.7% of pay; in 1986, 8.8%; in 1985, 8.7%; in 1984, 8.8%; and in 1983, 8.8%.

The highest contributions in 1987 were among finance, insurance and real estate companies, where employer contributions were 9.7% of pay. The lowest contributions were among wholesale/retail trade and service industries, each with employer contributions averaging 7.8% of payroll.

Other profit-sharing contribution rates were: durable goods manufacturing, 9.5% of payroll; non-durable goods manufacturing, 9.0% of payroll; and other non-manufacturing, 7.9% of payroll.

"Although data vary, plans with over 5,000 participants have the lowest average employer contribution," the survey authors note. However, the authors note: "Unlike participants in other size groupings, these participants typically also receive pension benefits."

For example, the average employer contribution to plans with fewer than 50 participants was 10.1% of payroll in 1987, while the average contribution to plans with more than 5,000 participants was 5.7%.

Other average profit-sharing contributions were: plans with 51-99 participants, 7.7%; 100-999 participants, 8.4%; 1,000-4,999 participants, 11.1%.

In addition to employer contributions, 64% of plans in 1987 allowed employee contributions, unchanged from 1986. The majority of these plans—84%—provide for employee contributions on a voluntary basis.

Copies of the "1988 Profit Sharing Survey" are available for $26 95 from the Profit Sharing Council of America, 20 N. Wacker Drive, Suite 1722, Chicago, Ill. 60606; 312-372-3411.

—By Paul D. Winston

Benefit beat

Long-term care plan

First Interstate Bancorp of Los Angeles has introduced a long-term care insurance plan for 38,000 of its active employees, retirees and their spouses.

The plan, which also is open to parents of employees, covers home health care, nursing home care and adult day care.

The plan—underwritten by Travelers Corp. of Hartford, Conn—is fully employee-paid.

Eligible employees can select from two levels of coverage determined by the level of nursing home care they choose. The plan provides either $50 or $100 a day for nursing home coverage, and $25 or $50 a day for home health and adult day care coverage. Amounts are payable after 90 days of covered services have been received.

Depending on the coverage chosen, the plan pays a maximum of $150,000 or $75,000, which is estimated to provide benefits for more than four years of continuous nursing home confinement.

The company is offering the benefit to ease the strain caused by unanticipated chronic-care situations, said First Interstate Vp Betty Williams. The long-term care plan will "help employees and their families prepare financially for such situations later in life," she said.

Under a "paid-up" option, First Interstate employees will receive some benefits even after payments to the plan cease. For example, if, after paying premiums for 10 years an employee opts to cancel the policy, he or she will retain 30% of the daily benefit originally purchased. The paid-up option increases to as much as 75% after 25 years of participation and remains in force until needed.

Workers pay premiums through payroll deductions. Retirees and covered parents may request direct billing from Travelers.

Rates are fixed at the time of enrollment based on age and will not increase as the employee gets older. Travelers sets the rates in four-year age blocks.

Monthly premiums for $50/$25 coverage for an individual 18 to 24 years old is $4.46, while it's $5.52 for someone age 25 to 29.

Employees who opt for the long-term care plan during First Interstate's initial sign-up period can apply without submitting evidence of insurability. Other family members and those who apply at a later date are required to complete a short-form medical questionnaire.

—By Michael Schachner

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Made any benefit changes? Write Michael Schachner, Associate Editor, Business Insurance, 220 E. 42nd St., New York, N.Y. 10017-5806; 212-210-0143.

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As a Network Control Center Help Desk Operator, Kemper's Theresa Harris not only has a big title, she has big responsib lities.

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Connecticut legislator mulls premium tax

HARTFORD, Conn.—A Connecticut state representative is considering asking for a 7.5% state tax on non-health insurance premiums paid by Connecticut policyholders.

"It's simply one of many tax ideas getting kicked around right now," said Rep. Richard T. Mulready, D-West Hartford. "We are looking at a broad-based tax to raise a lot of money. . .and this one is less regressive."

A new premium tax, which would take effect July 1 and is designed to raise more than $450 million to be used to balance the state's $6.9 billion 1988-89 budget, is wholeheartedly opposed by the insurance industry, said a spokesman for the Insurance Assn. of Connecticut.

"We are hoping it won't become an official proposal," he said. "If it does we are prepared to fight it all the way."

In addition, the tax would have an enormous effect on national insurers domiciled in Connecticut such as Hartford Insurance Group, Aetna Life & Casualty Co. and Travelers Corp., he said.

That is because a state retaliatory tax provision permits states to charge a tax on policies written by out-of-state companies if the tax exists in the insurer's state of domicile.

For example, California could charge a 7.5% tax on premiums for policies purchased from Connecticut-domiciled insurers by California residents because of the tax in Connecticut.

"This could have a devastating effect on all policyholders," he said. "Family businesses and big businesses that purchase workers comp, property and liability coverage would have to pay the tax on each policy."

Insurers operating in Connecticut currently pay a 2% state tax on all direct written premiums; the charge is figured into the premium.

Rep. Mulready broached the insurance tax earlier this month. However, he acknowledges that if the idea were to progress into an official proposal, it would have a "less than 50/50 chance of passing."

Rep. Mulready said that if retaliatory taxes came into play, he would likely drop the insurance tax proposal. "We're not out to get the insurance companies," he said.

—By Michael Schachner

Around the states

Kansas tort reform

TOPEKA, Kan.—Kansas Senate Judiciary Committee hearings on a proposed constitutional amendment permitting caps on non-economic damages will begin this month.

Senate Concurrent Resolution No. 1610 gives the Legislature the power to set limits on non-economic damages without spelling out specific levels. The proposed amendment also holds that "the Legislature may not limit non-economic damages awarded against a party causing the injury if such party has been convicted of a crime arising from the conduct causing the injury."

The proposed amendment defines non-economic damages as "losses for which there is no unit value, mathematical formula or rule of calculation and include but shall not be limited to pain and suffering, disability, disfigurement, inconvenience, mental anguish, humiliation, loss of capacity to enjoy life, bereavement, loss of society, loss of companionship, loss of consortium, loss of reputation and other losses which are intangible in nature."

If approved by a majority of the judiciary committee, the amendment must be approved by two-thirds of the Senate and two-thirds of the House before being brought to the voters for approval.

The amendment is not likely to reach voters until the November 1990 general election, although the resolution allows for a special election if approved by the Legislature, said Brad Smoot, chairman of the Topeka-based Kansas Coalition for Tort Reform, which supports the amendment.

Kansas currently has a $250,000 cap on all non-economic damages, which was passed after the state Supreme Court ruled a similar provision applying only to medical malpractice unconstitutional (*BI*, July 4, 1988).

However, that limit is being challenged in a lawsuit brought by a person rendered a quadriplegic in an auto accident. The plaintiff has held that the new law also is unconstitutional because the earlier medical malpractice cap was found unconstitutional.

The state Supreme Court is expected to rule on the constitutionality of the cap later this spring.

—By Mark A. Hofmann

Wisconsin reform

MADISON, Wis.—A bill modifying several applications of joint and several liability under Wisconsin's comparative negligence system has been introduced in both houses of the state Legislature.

In addition, A.B. 150 would cap non-economic damages in medical malpractice cases at $250,000.

The bill would change the state's application of comparative negligence to take into account a plaintiff's portion of fault. Each defendant's liability would be limited to the percentage of his or her negligence divided by the total negligence of all defendants found liable.

A.B. 150 spells out that changes in the joint and several liability doctrine do not apply to defendants whose concerted actions resulted in damages. The bill also allows joint and several liability to continue to apply to "a cause of action for damages resulting from environmental pollution, hazardous waste or substances or waste disposal sites."

In addition, the bill prohibits the application of joint and several liability to punitive damages.

A.B. 150 also reduces a cap on non-economic damages in medical malpractice cased set in 1986 to $250,000. Under current Wisconsin law, plaintiffs are limited to recovering $1,070,170 in non-economic damages caused by the negligence of a medical care provider. That figure reflects changes in the Consumer Price Index since June 1986, when the limit was set at $1 million. That cap expires on Jan. 1, 1991, but A.B. 150 eliminates the 1991 sunset clause.

A.B. 150 is supported by the Madison-based Wisconsin Coalition for Civil Justice, which helped draft the measure. Although some legislative opponents have threatened to stall the bill in committee, "We're doing everything we can to make sure the bill goes somewhere," said P. Maurice Bishea, executive director of the civil justice coalition. Mr. Bishea added that 48 of the Assembly's 99 members have agreed to co-sponsor the bill.

—By Mark A. Hofmann

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Opinions

NAIC panel misses mark

IT IS NOT SURPRISING that groups that do not know the inner workings of the property/casualty insurance industry propose "reform" recommendations that most likely would cause policyholders more harm than good. California's Proposition 103 readily dances into our thoughts.

However, we are surprised that a group of respected insurance regulators is proposing that most advisory ratemaking organizations, like the Insurance Services Office Inc., be prohibited from including profit and expense factors in advisory rates for all lines of property/casualty insurance except workers compensation.

The problems that would be created by this prohibition—and by the regulators' recommendation that insurers, rather than advisory organizations, file their own rates—would far outweigh any advantages the proposals offer to policyholders.

The regulators, members of a National Assn. of Insurance Commissioners working group, maintain that forcing an insurer to factor its own expense and profit components into its rates would link those rates more closely to the insurer's own experience. That, they hope, will increase competition and, in turn, benefit policyholders.

While this is an admirable goal, it does not reflect the realities of the marketplace.

First of all, we wonder whether property/casualty insurers swept up into today's competitive environment actually are following the manual rates established by advisory organizations. And, how many insurers followed advisory rates to the letter during the hard market of the mid-1980s?

For the most part, advisory rates—whether or not they include profit and expense factors—are just that: advisory. Most insurers feel free to deviate from these rates to meet their own profit and/or market-share objectives.

The insurers that are most likely to closely follow advisory rates—small, regional insurance companies—are most likely to be hurt by the regulators' proposal. Forcing these companies to establish their own final rates can only increase their costs, which if anything will reduce rather than enhance competition in the marketplace.

In addition, forcing insurers to file their own rates in states that require such filings, rather than allow a rating organization to file rates on their behalf, will deluge state insurance departments with paperwork, forcing them to either hire more staff or reduce other services to keep up with this new burden.

The regulators' recommendations would not totally upend the property/casualty insurance market as would widespread adoption of Proposition 103 clones, the repeal of the McCarran-Ferguson Act or a verdict in favor of states' attorneys general in the antitrust litigation pending against insurance industry defendants. However, we are not convinced the proposed changes in ratemaking practices would be positive for buyers of commercial property/casualty insurance.

We hope that the members of the NAIC working group will make changes in their proposals after listening to comments from regulators at a hearing today at the NAIC zone meeting in Little Rock, Ark., and comments from consumers at an April 4 hearing in Washington, D.C.

And, we encourage risk managers or their representatives to speak at the Washington hearing. For more information about the hearing, call the NAIC at 202-624-7790.

Letters

Success of UR depends on accurate comparison figures

To the editor: I read with interest the article, "Assessing Utilization Review," by Jonathan E. Levin (*BI*, Feb. 20). These mechanical UR effectiveness evaluation techniques have been used by some insurers and UR firms for more than five years. However, such methods do not quantify the effectiveness of a UR program. Rather, these measures reflect the difference between the UR standards and physician standards, neither of which may represent medically necessary quality care.

As Mr. Levin points out, Dr. A may request 10 days of care for a patient's condition while Dr. B. requests six days for a patient with the same condition. If six days is the medically necessary length of stay, approval of seven days for Dr. A's patient does not save an employer the cost of three days of care but, rather, costs the employer an extra day's charge.

As health care actuaries, we have worked with medical professionals to establish optimal recovery information and use this as a guide in reviewing the effectiveness of UR programs. We have found that measuring the deviation from a standard of care that is established for uncomplicated cases and comparing the deviation to the deviation that is justified by the patient's medical condition, the services required or the procedures to be completed is a much better guide to efficiency than counting the days originally approved.

Our retrospective review of patient charts has produced rather startling results in many cases. UR standards that were supposedly very stringent allowed many days of inappropriate care to be delivered.

Employers should have the desire to know how their UR program compares with a very efficient standard of care that is both cost-efficient and of high quality. Until a UR program can show this efficient standard is met a high percentage of the time, the employer should demand improvement. This improvement should be demanded regardless of how many dollars Mr. Levin's mechanical UR assessment indicates were saved.

Dennis J. Hulet
Consulting Actuary
Milliman & Robertson Inc.
Seattle

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Perhaps attorney should not throw stones at insurer

To the editor: Your Feb. 27 article, "ABA Panel Member Hits Reserve Practices," certainly brings to mind the quotation: "He who lives in a glass house should not throw stones."

The ABA panelist, Thomas F. Londgrigan, states that "the insurer (St. Paul) built up large reserves and subsequently hiked medical malpractice insurance premiums, even though physicians won an overwhelming percentage of the medical malpractice cases during that decade."

Jim Wood, an actuary with the Tillinghast division of Towers, Perrin, Forster & Crosby Inc., commented in Tillinghast's Captive Insurance Company Reports that "more than half of med-mal claims files opened are closed with no payment; however, countrywide defense costs are going up faster than the indemnity class of claims."

Perhaps Mr. Londgrigan and his colleagues should look at putting their palatial house in order and complain less "about the hand that feeds them."

E. Richard Crebs
President
Commercial Insurance Alternatives Inc.
St. Helena, Calif.

Section 89 bargain from Rostenkowski closer to extortion

To the editor: *Business Insurance* and employers must not condone extortion by legislators—we certainly don't condone it by anyone else. I refer to your March 6 editorial, "Heed Rostenkowski's Advice."

Representative government is based on the ideal that legislators are responsive to their constituents. Somehow, Rep. Rostenkowski—and his staff—seem to be twisting this process: "Complain and I'll give you something twice as bad" (i.e., call for repeal of Section 89 and we'll tax benefits instead).

Do we really have a chance to repeal Section 89? I doubt it. Would Rep. Rostenkowski and his staff be willing to listen to employers if the screams weren't loud and strident?

Benefits lobbyists have a responsibility to sound the charge on these onerous proposals and laws. Your publication has and must continue to encourage everyone to engage in the lawmaking process—without bowing to extortion.

Pamela D. Mitroff
Manager, Health Care Cost
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RIMS conference

Continued from page 3

Also during the seminar, Dennis Martin, a senior consultant at William M. Mercer Meidinger Hansen Inc.'s Atlanta office, will examine various types of health care benefit delivery systems and advise attendees on how to determine the best plan for their companies.

Martin S. Brown, manager of employee benefits at The Clorox Co. in Oakland, Calif., will moderate the session, which is scheduled for Monday, April 10, from 10 a.m. to 12:30 p.m., and Wednesday, April 12, from 2:30 to 5 p.m.

Controlling health care claim costs by making utilization review procedures mandatory for outpatient as well as inpatient medical procedures will be addressed during S24, "Managing Outpatient Utilization."

The session will be moderated by Patricia Armocida, director of utilization management at the Blue Cross & Blue Shield Assn. in Chicago.

"We hope that our seminar will educate benefit managers on how much they can save employers by performing utilization review on outpatient treatments," said one session speaker, Leslie Michelson, president of Santa Monica, Calif.-based Value Health Science Inc., a UR vendor.

Dr. Richard A. Huset, president of Health Decision Inc., a St. Paul, Minn.-based medical data collection company, also is a scheduled speaker.

The seminar will be offered on Monday, April 10, from 2:30 to 5:30 p.m., and again on Thursday, April 13, from 9 to 11:30 a.m.

Another conference seminar, "New Ways to Trim the Fat in Health Care Delivery," will show employers how to reduce claim costs while obtaining better quality health care for their employees. he session, S25, will be moderated by Joseph G. Charles, group director of employee benefits at Ryder System Inc. in Miami.

During the session, M. Lee Morse, president of Value Rx Inc. in Arlington, Va., will discuss how employers can reduce prescription drug expenses by establishing a preferred provider network with local pharmacies that will offer employees discounted prices for medication in exchange for being part of the network.

Saving employers' money in disability claims through utilization review is the topic that will be covered by Ronald F. Smentek, president of Lombard, Ill.-based Medeval Corp., a medical disability plan consultant for self-insured employers.

And, Stephen White, executive vp of Preferred Healthcare Ltd., in Wilton, Conn., will discuss how companies can reduce costs for inpatient psychiatric care through precertification programs.

Marcia Radosevich, president of Boston-based Health Payment Review Inc., is also a scheduled speaker for S25, which will be held Monday, April 10, from 2:30 to 5:30 p.m., and Thursday, April 13, from 9 to 11:30 a.m.

This year's RIMS conference also will include a seminar on employers' changing medical benefit obligations to their retirees.

During S27, "Retiree Medical Benefits—Tip of the Iceberg," expert speakers will concentrate on recent court decisions and accounting rule changes related to retiree health care benefits, as well as cost-effective funding alternatives employers should consider when trying to reduce retiree medical costs.

"We want to stress the importance of designing plans that take the future costs of medical care into consideration and plan for the increases. Employers have to stop promising retiree benefits that they may not be able to deliver and start using employer-funded or profit-sharing programs instead," said W. Leon Smith, a partner at the Dallas office of Touche Ross & Co. and the coordinator of the seminar.

Also during the session, Jerry Cearsoss, an accountant at Touche Ross in New York, will speak on the importance of including inflationary costs for future retiree benefits in annual reports.

S27 will be held on Tuesday, April 11, from 2:30 to 5 p.m., and again on Friday, April 14, from 9 to 11:30 a.m.

The importance of using data to effectively manage health care costs will be the focus of S30, "Using Claims Information to Select Cost Control Methods."

Bruce Smith, benefits director at Adolph Coors Co. in Golden, Colo., will moderate the seminar highlighting the kinds of data that companies should compile to create benefit plans tailored to both employer and employee needs.

Daniel S. Brunner, president of Affordable Healthcare Concepts in Sacramento, Calif., will discuss why data can be useful, while David Barton, vp of sales at Control Data Benefit Services in Dallas, will discuss data collection for utilization review services.

David Anderson, a health care consultant at Control Data Corp. in Minneapolis, will direct his remarks toward claims analysis for assessing and improving risk management programs. The seminar, S30, will be offered Thursday, April 13. from 2:30 to 5 p.m.

Other RIMS sessions this year will focus on risk management topics such as relaxation of European trade barriers in 1992, worker and community right-to-know regulations, outdoor and indoor environmental pollution and the antitrust litigation pending against insurance industry defendants (*BI,* March 6).

In addition to "Employee Benefits Issues—The Next Four Years," the employee benefits special session, another session open to all conference participants will feature a debate over state vs. federal regulation of the insurance industry between consumer advocate Ralph Nader and Washington, D.C., insurance attorney George Bernstein.

"State vs. Federal Regulation of Insurance—Should All Roads Lead to Washington?" will be held in the ballroom on the convention level at the Marriott Marquis Hotel on Wednesday, April 12, from 9 to 10:30 a.m. The debate will be moderated by Bill Monroe, former TV anchorman and executive producer of "Meet the Press."

This year's conference luncheon speakers will be Pulitzer Prize-winning journalist Jack Anderson and Micheal H. Mescon, dean of the College of Business Administration at Georgia State University in Atlanta. Mr. Anderson will speak on Tuesday, while Mr. Mescon will speak on Thursday. Both luncheons will be held at the Marriott Marquis from 12:30 to 2:15 p.m.

More than 400 booths will make up the 1989 exhibition to be held at the Atlanta Merchandise Mart at 240 Peachtree St. N.W., which is located downtown near the RIMS hotel area. The exhibition will be open from Sunday, April 9, through Thursday, April 13.

Registration fees for the RIMS conference are $595 for RIMS members and $695 for non-members. Fees for a partial week are $475 for members and $575 for non-members. One-day registrants pay $195. A total of 4,084 participants had registered for the conference as of March 14.

Because the advance registration deadline through RIMS was March 17, attendees now must wait to register at the conference. However, due to demand many sessions are already filled to capacity (see story, page 11).

Late registrants are advised to call one of the eight RIMS hotels directly to reserve rooms at the special conference rates. The hotels are: Atlanta Hilton & Towers; Holiday Inn Downtown; Hyatt Regency Atlanta; Atlanta Marriott Marquis; Pierremont Plaza Hotel; Quality Inn-Habersham; Radisson Hotel Atlanta; and Westin Peachtree Plaza.

For more information, contact the RIMS Conference Department, 205 E. 42nd St., New York. N.Y. 10017; 212-286-9292. ■

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Some RIMS sessions filled to capacity

Several conference seminars and track programs scheduled for this year's Risk & Insurance Management Society conference have been filled to capacity.

The following sessions are closed to preregistration as of Monday, March 13:

- S32, "Cutting Through to the Reinsurance Markets," on Monday, April 10. However, the Wednesday session still is open.
- S33, "Establishing Proper Risk Retention Levels—An Analytical Alternative," both Tuesday, April 11, and Thursday, April 13.
- S35, "Forecasting Losses for Budgeting & Cost Control," Tuesday, April 11. However, the Thursday session still is open.
- S44, "CFO & Risk Manager—Working Together to Forge a Stronger Risk Management Program" (RIMS members only), Thursday, April 13. However, the Monday session still is open.
- S49, "Keeping It Together—Centralized Risk Management in a Decentralized Organization," both Tuesday, April 11, and Thursday, April 13.
- S50, "The Long-term Solutions Afforded By Today's Special Insurance Markets," Monday, April 10. However, the Wednesday session still is open.
- S51, "Managing Contractor/Vendor Exposures," both Monday, April 10, and Thursday, April 13.
- S55, "Risk Management in Mergers, Acquisitions & Divestitures," Thursday, April 13. The Tuesday session is nearly filled.
- S64, "Gaposis—50 Common (But Often Unknown) Coverage Defects," both Monday, April 10, and Wednesday, April 13.
- S65, "How Does Your Excess Liability Program Stack Up," Monday, April 10. The Thursday session still is open.
- S66, "Liability Policy Wording Maximized," Monday, April 10. However, the Thursday session still is open.
- S67, "The Next Hard Market—When? What to Do Now?," Thursday, April 13, which is the only session offered.
- S71, "Europe Without Borders by 1992—Impact on Multinational Risk Managers," Monday, April 10. However, the Wednesday session still is open.
- S78, "Claims Management for Self-insureds," both Wednesday, April 12, and Friday, April 14.
- S81, "Managing Legal Fees—Alternatives to Wallet-ectomy," Monday, April 10. However, the Wednesday session still is open.
- S98, "Cost-Containment Strategies for Workers Compensation," Tuesday, April 11. However, the Thursday session still is open.
- S101, "Workers Compensation Challenges in the Next Decade," Thursday, April 13, which is the only session offered.
- S102, "Workers Compensation—The Challenge of Self-insurance," Tuesday, April 11, which is the only session offered.

Following are the track programs that are closed:

- T6, "Insurance Coverages & the Industry—Nuts & Bolts," Tuesday, April 11. The Thursday session still is open.
- T8, "Primary Financing Alternatives for Casualty Risks," Friday, April 14. However, the Wednesday session still is open.
- T11, "Risk Identification/Analysis," Friday, April 14. However, the Tuesday session still is open.
- T13, "So You're a Risk Manager Now. . ." (RIMS members only), Monday, April 10. However, the Thursday session still is open.
- T14, "Workers Compensation Claims—A View Behind the Scene," Monday, April 10. However, the Wednesday session still is open. ■

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President Bush

Continued from page 3

"When local governments cannot build playgrounds, when businesses are bankrupted, when mothers struggle to find an obstetrician. . .it is time to consider limiting some of these outrageous settlements," he said.

Although he did not mention specific tort reforms in his speech, among the reforms Mr. Bush advocated during his presidential campaign were:

- Modification of joint and several liability.
- Restoration of a fault-based standard of recovery.
- Expanded use of alternative dispute resolution mechanisms, such as binding arbitration and mediation (*BI*, Oct. 17, 1988).

In his speech last week, the president exhorted another pro-business platform when he criticized proposals to mandate employee benefits, like employer-provided health insurance.

Pointing out that more than half

'Tort reform is critical to the health of business. . . .' President Bush. points out.

of the nation's workers are employed by small businesses with fewer than 500 employees, President Bush said he opposes "any onerous new burden" that might jeopardize those jobs.

"In an area of tight budgets, there's always the temptation to drop the burden of social programs on the backs of the employers."

"But these policies—born, I would say, of the best of intentions—can have unintended and counterproductive consequences. It's up to business and labor to negotiate their differences. . . .Burdensome mandated benefits serve neither business nor labor."

During the last congressional session, a bill sponsored by Sen. Edward Kennedy, D-Mass., that would have required employers to offer group health care coverage meeting minimum federal standards died after clearing the Senate Labor and Human Resources Committee. A revised version of the bill is expected to be introduced this spring (*BI*, Jan. 16).

"We've seen what happens in other countries, where mandated benefit programs create obstacles to productivity and growth and, thus, to new job creation," Mr. Bush told the IIAA.

"We cannot build a better America if we weigh down our own productive sector with mandated new burdens." ■

At issue

Should continuing education requirements be mandatory for insurance brokers?

Lee Conklin
risk manager
Horn & Hardart,
New York

I don't think there should be any laws that brokers should continue their education. However, responsible brokers are already doing this because they have to maintain pace with the changing world. Our society is pretty complex as it is, but it becomes ridiculous when you have to start regulating what becomes good common sense.

Sheila P. Roberts
director-risk management and insurance
Time Inc.,
New York

It should be required, and most major brokers have in-house programs. As things change in the insurance environment—new laws, policy forms etc.—it becomes necessary for brokers to keep up with the changes and how they apply to various businesses so they can inform their risk management clients.

Bruce Klein
vp/corporate counsel
Belding Hemingway Co. Inc.,
New York

Definitely. We feel we must continue to educate ourselves to become good risk managers. If brokers don't feel obligated to keep up with the same things, then they are remiss in their duties. Most major brokers, however, appear to be doing so as evidenced by the fact that they are getting their account executives into the A.R.M. program.

Richard Hundza
risk manager
Southdown Inc.,
Houston

I expect brokers to be knowledgable on current market conditions and knowledgable on current insurance policies and form. However, I would rather have brokers spend time talking with the different markets themselves and within their own organizations than waste time on formal classes that wouldn't address those issues.

Compiled by Christine Woolsey

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Employers Reinsurance Corporation

Court rejects suit against comp insurer

By MEG FLETCHER

COLUMBIA, S.C.—A worker injured after a safety inspection of the worksite by his employer's workers compensation insurer cannot sue the insurer for damages, the South Carolina Supreme Court says.

The court ruled last month that a workers compensation insurer in South Carolina is liable only for routine benefit payments in connection with its voluntary safety inspection of a policyholder's premises.

This is a "very significant" decision in South Carolina, said Eric Oxfeld, counsel for the Washington-based American Insurance Assn.

"It is the first time that South Carolina considered this (issue) as directly on point," said Thomas Salane, a partner with Turner, Padget, Graham & Laney of Columbia, S.C., who filed an amicus brief on behalf of the AIA.

In most states, courts have ruled similarly or, in cases when state courts have ruled otherwise, legislatures subsequently have extended an employer's immunity shield to work comp insurers, he said.

The decision will help both employers and workers because insurers will not be discouraged from either making inspections—which help ensure worksite safety—or writing workers comp coverage, Mr. Oxfeld said.

If the court had ruled for the plaintiff, it would have led to increased "rates and made coverage harder to get," said Jon Harkavy, director of governmental affairs for the New York-based Risk & Insurance Management Society Inc.

Loss prevention and safety are an integral part of workers compensation and RIMS hopes that will continue, he said.

The court noted that insurers "perform safety inspections to assess risk and reduce on-the-job injuries in order to minimize benefit payments and premium increases."

"In such a case, safety inspections would be integral to the function of a workers compensation carrier," the court said.

However, immunity should not be granted if an insurance company is not acting as the employer's work comp insurer when it performs inspections, the court ruled.

"A carrier may contract with an employer as an independent provider of safety inspections undertaking the employer's legal duty to provide a reasonably safe work place. In this situation, the carrier would be performing as a third party and would not be immune from liability," the court said.

Evidence of a third-party agreement between an employer and an insurer that only conducted safety inspections for the employer may include specific contractual language or payment of additional fees for these services, the court said.

The ruling centers around a lawsuit filed by Edgar Ancrum, whose arms were severed when his clothing caught in an unshielded gear while working in Stoller Chemical Co.'s fertilizer manufacturing plant in Adams Run, S.C. He sued the company's work comp insurer, Baltimore-based United States Fidelity & Guaranty Co., for performing an allegedly negligent safety inspection.

Mr. Ancrum's attorney, Mark C. Tanenbaum of Charleston, S.C., is asking the state Supreme Court to review its decision.

That court rendered its decision after the U.S. District Court for South Carolina requested an interpretation of state workers comp law. The case will return to the federal court, which will determine the role USF&G played in this case. ■

1989 RIMS

1 APRIL 3 RIMS Preview

Business Insurance will publish its 4th Annual RIMS Preview Issue — including our RIMS 'Take-Out' section — it's the perfect kick-off for the RIMS Conference in Atlanta.

More than 154,000 BI readers will look for last minute details and an update of program and speaker changes at RIMS '89.

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Ohio work comp rulings are mixed bag

By MEG FLETCHER

COLUMBUS, Ohio—Four recent workers compensation case rulings by the Ohio State Supreme Court spell both good and bad news for employers.

In a decision aimed at speeding decisions about the permanency of work-related injuries, the high court invalidated the Ohio Industrial Commission's policy of allowing hearing officers to continue temporary total disability benefits for a small class of claimants who appear to be permanently disabled.

Employers that had brought the case had argued that hearing officers lacked the authority to continue temporary disability payments in these types of work comp cases.

However, the justices denied the employers' request that they be reimbursed "from either the claimant or the State Surplus Fund for all temporary total compensation paid subsequent to the determination that the claimant's condition was permanent."

In the past, employers had been able to receive reimbursement for the cost of most disputed benefits that employers successfully appealed.

One attorney who represents employers said the decision "does more harm than good."

In a second case, the justices declared unconstitutional a 1976 amendment to the state's constitution that attempted to increase death benefits to some survivors of job-related death victims.

However, the court has recently agreed to rehear the case on a request from the Ohio AFL-CIO, said Robin Obetz, a partner in the Columbus, Ohio, office of Vorys, Sater, Seymour & Pease.

Other recent state Supreme Court decisions clarify the situations in which a self-insured employer may recover damages against a third party and reaffirm the specific grounds on which a claim of intentional tort can be brought against an employer.

In its decision regarding the state Industrial Commission, the Ohio Supreme Court barred the commission from allowing hearing officers to continue injured workers' temporary total disability benefits for claimants who appear to be permanently disabled but who are waiting for official approval of that status from the commission.

The high court justices ruled that "the commission policy attempts to enlarge the class of claimants currently eligible for temporary total compensation," even though only the state General Assembly can make policy decisions that affect the terms and conditions under which workers' compensation benefits are paid.

"The problem the commission policy seeks to redress is caused by the sometimes lengthy interval between the decision to terminate temporary total compensation due to permanency and the decision to grant or deny permanent total disability," the high court decision said.

"While hearing officers have initial authority to terminate temporary total compensation, a claimant must wait for a commission determination of his permanent total disability application.

The court declared unconstitutional a 1976 amendment that attempted to increase some death benefits.

While such payments are retroactive, there is potential for hardship," it said.

"The commission would appear to be in the best position to remedy this situation," the justices said.

They proposed eliminating the current delay by having the adjudicator hear the issue of continuing temporary total benefits simultaneously with the claimant's motion for permanent total disability.

Prompt rulings would allow claimants eligible for permanent total disability compensation to receive payments immediately upon termination of temporary total benefits, the justices said.

"Such a solution appears fair and sensible to all concerned: Not only does it reduce temporary financial hardship to the claimant, but it also keeps the State Insurance Fund or self-insured employer from, in effect, subsidizing the commission's seeming inability to process permanent total disability applications more expeditiously," the justices said.

The court applied its ruling only to future cases, so claimants already declared to have a permanent condition but awaiting a hearing would not suffer hardship.

However, the court directed the industrial commission to hold the permanency hearings as soon as possible.

The Ohio Manufacturers' Assn. said it is difficult for employers to applaud the decision because the court refused to apply its ruling to claimants currently receiving temporary total benefits whose conditions appear to have become permanent.

In addition, the portion of the ruling addressing disputed benefits upsets "the long-standing procedure of reimbursing employers for payments incorrectly made," the association said.

As a result, "the case does more harm than good," said Mr. Obetz, who is executive secretary of the Ohio Self-Insurers Assn.

Continued on next page

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Continued from previous page

Employers have requested that the court rehear the case, but that is considered unlikely, Mr. Obetz added.

The decision was rendered in four consolidated cases, known as *Eaton Corp. vs. Lancaster*, which involved three employers with operations in Ohio: Eaton Corp., GCC Beverages Inc. and Firestone Tire & Rubber Co.

In the other cases, the court:

- Declared unconstitutional a 1976 amendment to the state's constitution that attempted to increase death benefits to some dependents of workers who die as a result of job-related injuries or diseases.

That amendment allowed the benefit payment to be increased to 100% from two-thirds of the statewide average weekly wage in some cases where death is due to an injury received or occupational disease first diagnosed after Jan. 1, 1976.

At issue was whether the amount of death benefits for claimants who were entirely financially dependant upon a decedent can be controlled by date of decedent's injury and by degree of disability at death and whether this classification violates the equal protection clauses of the Ohio and U.S. constitutions.

The court found in *State, ex.rel. Doersam vs. Indus. Comm.* that the classification of claimants violates the equal protection clause and reinstated payment at the two-thirds rate.

"Several hundred recipients of workers compensation death benefits stand to have their weekly payments slashed by one-third" as a result of this decision, according to the Ohio AFL-CIO.

However, the final effect is uncertain because the high court has agreed to labor's request to rehear the case.

- Clarifies under what conditions a self-insured employer can recover damages against a third party, putting those employers on equal footing with most other employers.

The high court ruled that a self-insured employer that has paid medical expenses and workers compensation benefits may not recover damages against the third party who negligently caused the employee's injury unless there was a legal relationship—which was based on contract or warranty—between the employer and the third party.

The same standard already had applied to employers that purchased workers compensation insurance through Ohio's exclusive state fund. And the standard applied to those whose premiums had increased because of an employee's injury.

If a contract or warranty relationship exists, damages are recoverable against the third party in an action for breach of contract, the court ruled in *Cincinnati Bell Tel. Co. vs. Straley*, which consolidated several cases involving several employers.

In the most recent case, the court ruled that "it is our intention that today's holding will apply to self-insured employers seeking reimbursement of workers' compensation payments as well as to state fund employers seeking damages for increased premiums."

- Reaffirmed the specific grounds on which a claim of intentional tort can be brought against an employer.

In *Mitchell vs. Lawson*, the justices dismissed a complaint against Lawson Milk Co. stemming from the 1985 death of a convenience store clerk who was shot by robbers while on the job.

The administrator of the clerk's estate alleged that Lawson's had committed an intentional tort by failing to provide adequate security or training in handling violent situations.

However, the high court found that the facts did not meet the criteria established in an earlier decision that found that "a claim of intentional tort against an employer will be dismissed as failing to establish that the pleader is entitled to relief unless the complaint alleges facts showing that the employer: (1) specifically desired to injure the employee or (2) knew that injury to an employee was certain or substantially certain to result from the employer's act and despite this knowledge, still proceeded." ■

Employers have requested that the court rehear the state Industrial Commission's case.

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Bookstores downplay risk of attacks

By KARI BERMAN

Bookstores generally are not taking extraordinary risk management provisions to counter the threat of attacks by groups offended by Salman Rushdie's "The Satanic Verses."

Bookstores around the country—including two California stores that were recently bombed—refuse to either pull Mr. Rushdie's work from their shelves or not display the book when new shipments of the quickly sold-out book are received. They cite Mr. Rushdie's right to artistic expression and literary freedom.

Instead, some stores are attempting to minimize their risk by adding security or shortening their hours.

And, many bookstores have not contacted their insurers about the special risks created by Mr. Rushdie's novel.

One of the California stores confirmed it was insured for damage caused by the bombing, and other bookstores say they believe their property insurance policies would cover damages caused by attacks triggered by "The Satanic Verses."

Brokers say insurers have not indicated they would deny coverage to any bookstore bombed because it stocks Mr. Rushdie's book, but one broker observed that insurers could try to deny coverage under exclusions governing acts of war or terrorism.

Insurers would not comment on coverage for any potential attacks.

Moslems decry that "The Satanic Verses" blasphemes their religion, and Iran's Ayatollah Ruhollah Khomeini has offered $5 million for the death of Mr. Rushdie, a British subject who is in hiding.

Bookstores maintain that neither political- nor religious-motivated violence has a place in the literary world and that Mr. Rushdie's book will be treated like any other publication.

The two Berkeley, Calif., bookstores bombed last month subscribe to that philosophy.

Firebombs were thrown through the front windows of a Waldenbooks store and Cody's Books, both of which had sold out their copies of "The Satanic Verses" on Feb. 28.

The police bomb squad defused an additional bomb planted inside Cody's. And, a bomb threat was called into the Waldenbooks store the day after the store was bombed, but it was a hoax.

No individual or group has claimed responsibility for either bombing.

"We do not know who is responsible, but we highly suspect that it is related to our selling 'The Satanic Verses,' " said Steven Root, an assistant manager at the Waldenbooks store.

Mr. Root estimated that the store sustained about $1,000 of damage.

The damage is fully covered by insurance, but neither Mr. Root nor a Waldenbooks' spokeswoman at its Stamford, Conn., headquarters would name the insurer.

While all Waldenbooks stores will continue selling "The Satanic Verses," the Berkeley store has added a 24-hour security guard.

"We are a little jumpy, but when it arrives, we won't treat 'The Satanic Verses' any differently" from other books the store carries, Mr. Root said.

However, in light of the store's recent problems, the store will not display Mr. Rushdie's book as prominently as it displays some other books, Mr. Root said.

"We may not hide it in the back, but we aren't going to display it in the windows or be provocative with it either."

Cody's Books also plans to continue selling Mr. Rushdie's book when the store receives more copies, according to a store spokesman.

But, Cody's "has shortened its hours and heightened security," he pointed out.

The spokesman would not disclose the amount of damage the store sustained from the bombing or whether the damage was covered by insurance.

Despite the California bombings, it has been business as usual at most bookstores across the nation, many of which have sold out their copies of "The Satanic Verses" and are awaiting new shipments.

When "politics invade the literary realm, it is a crime that should not be tolerated," said Stuart Brent owner of Stuart Brent Books in Chicago.

Mr. Brent said he is not afraid of displaying Mr. Rushdie's novel, but he is concerned about how the controversy surrounding Mr. Rushdie's book will affect the literary arena.

"Death threats, bombings and bounties resulting from an author's works can greatly weaken an already endangered literary culture, and it is important that independent bookstores don't become pawns of the stupidity," he said.

Bill Rickman, president of Kroch's & Brentano's Inc., a Chicago-based bookstore chain with 17 outlets, said that all branches would sell Mr. Rushdie's book when shipments arrive and that the stores will not take any special risk management procedures.

Mr. Rickman said the bookstore chain did not experience any problems because of its decision to carry Mr. Rushdie's book when it was in stock.

However, he noted: "We did contact our insurer and are satisfied that we are covered for any damages." He would not identify the insurer.

In New York, Bookforum, an independent bookstore that primarily services students attending Columbia University, has not been threatened or damaged, despite the fact that it receives about 75 inquiries about "The Satanic Verses" daily and is awaiting another shipment of the novel, said Manager Sajun Rubel.

"We have not had any threats or problems so far, and we haven't contacted our insurance company,

Continued on next page

Between the lender's risk and the lender's reward

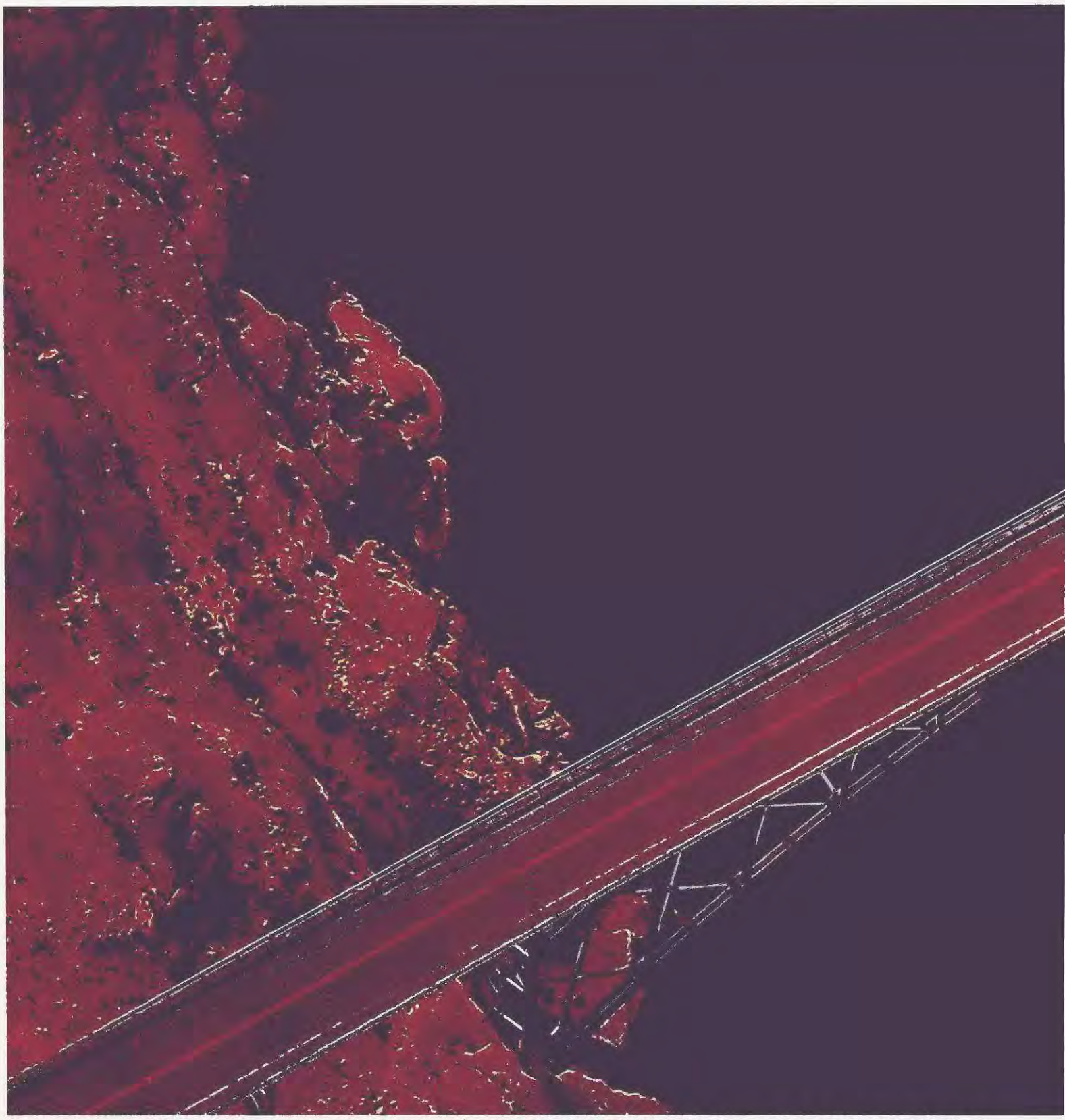

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Photo: AP/Wide World

A bomb damaged Cody's Books, a store in Berkeley, Calif.

Continued from previous page

because it hasn't been a concern. I assume we are insured if anything does happen," Mr. Rubel said.

"We are not changing the way we would normally display the book in the store, but we probably won't encourage the kooks by putting it in the window," he added.

Jack Cella, manager of The Seminary Cooperative Bookstores Inc. in Chicago, reports that the store did not contact its insurer before deciding to continue selling "The Satanic Verses."

"We never pulled copies off of the shelves and we never would," Mr. Cella asserted. "I think that the fear of the death threats is overrated."

Some bookstores that had pulled Mr. Rushdie's book from their shelves have since reversed their policy.

For example, Lenard Riggio, chief executive officer of New York-based B. Dalton Booksellers Co., reversed his Feb. 17 decision to pull the book from the chain's 1,000 locations.

Mr. Riggio changed his mind after employees were consulted and unanimously agreed that the book should be placed back on the shelves, a spokeswoman explained.

The spokeswoman would not comment on any risk management steps the store may take.

Property/casualty insurance brokers speculate that property and general liability insurance policies purchased by bookstores would cover any property damage and bodily injury claims resulting from bombing or other types of attacks.

"Most of the damages resulting from a firebombing or similar type of attack would be covered under the vandalism clause included in an all-risk (property) policy," said Norman Barham, director of property/casualty at Johnson & Higgins in New York.

"A general all-risk policy should cover any damages bookstores might have as a result of carrying the book," agreed Walter Kaye, president of Walter Kaye Associates in New York.

Business interruption losses also would also be covered under an all-risk policy, according to Mr. Barham.

However, "if a store closes in response to a bomb threat that is a false alarm, the policy will not pay for the lost day of business," Mr. Barham explained.

And, Mr. Kaye warned that insurers could attempt to deny coverage to a bookstore that sells Mr. Rushdie's book and sustains bomb damage by arguing that the stores knew that selling the book would result in an increased hazard not covered under its all-risk policy.

However, it is unlikely that insurers would attempt to deny coverage under an all-risk policy by invoking the acts-of-war or terrorism exclusion, Mr. Barham said.

For example, no group has claimed responsibility for the two Berkeley bombings so it cannot be determined whether the bombings were acts of terrorism, he explained. In such cases, insurers most likely will conclude the damage resulted from vandalism or malicious mischief, which are covered under all-risk property policies.

However, insurers could exclude coverage on the acts-of-war or terrorism exclusion if the Iranian government or a terrorist group claimed responsibility for an attack, commented James Enellow, an account executive at Marsh & McLennan Cos. Inc. in New York. ■

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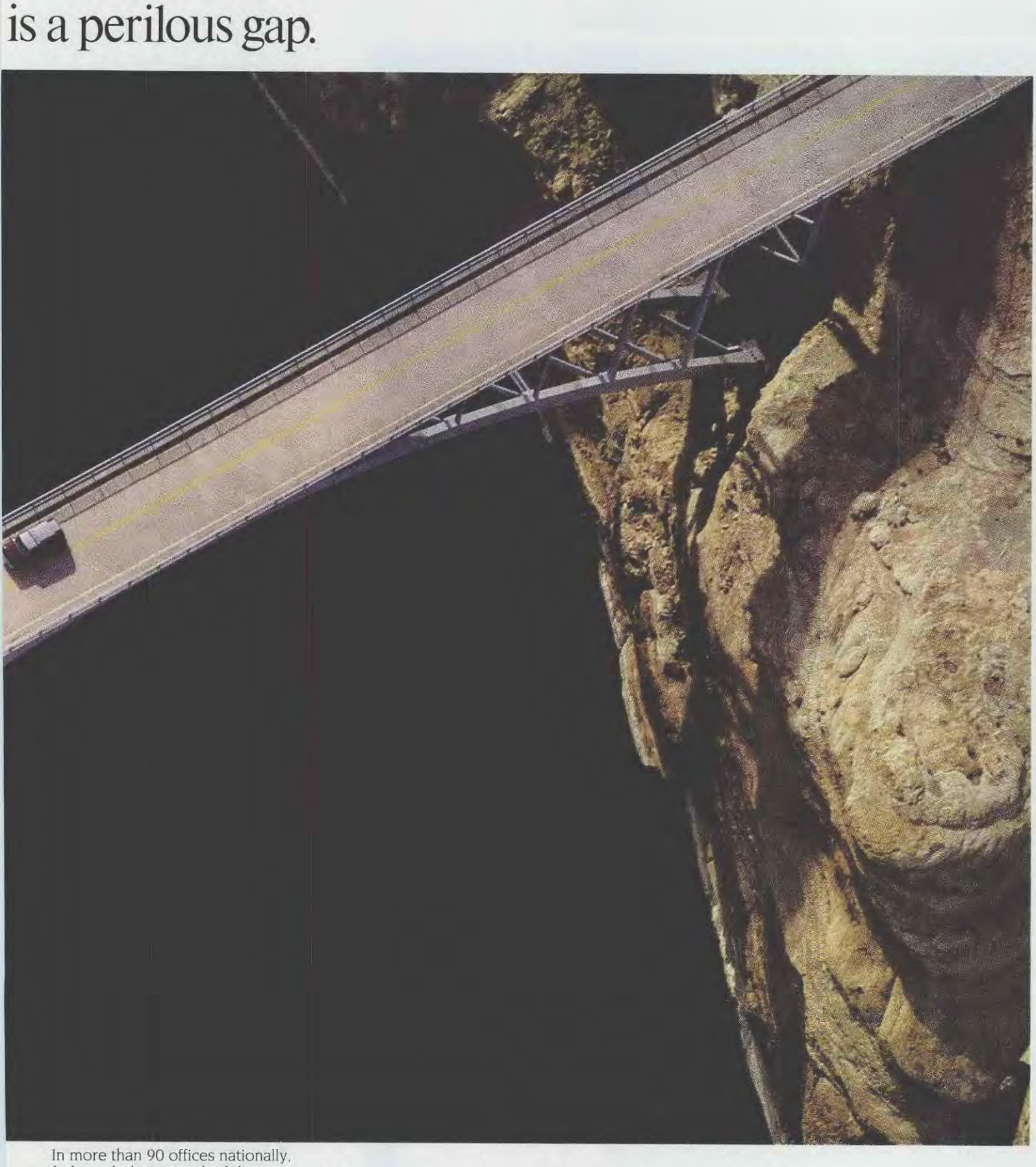

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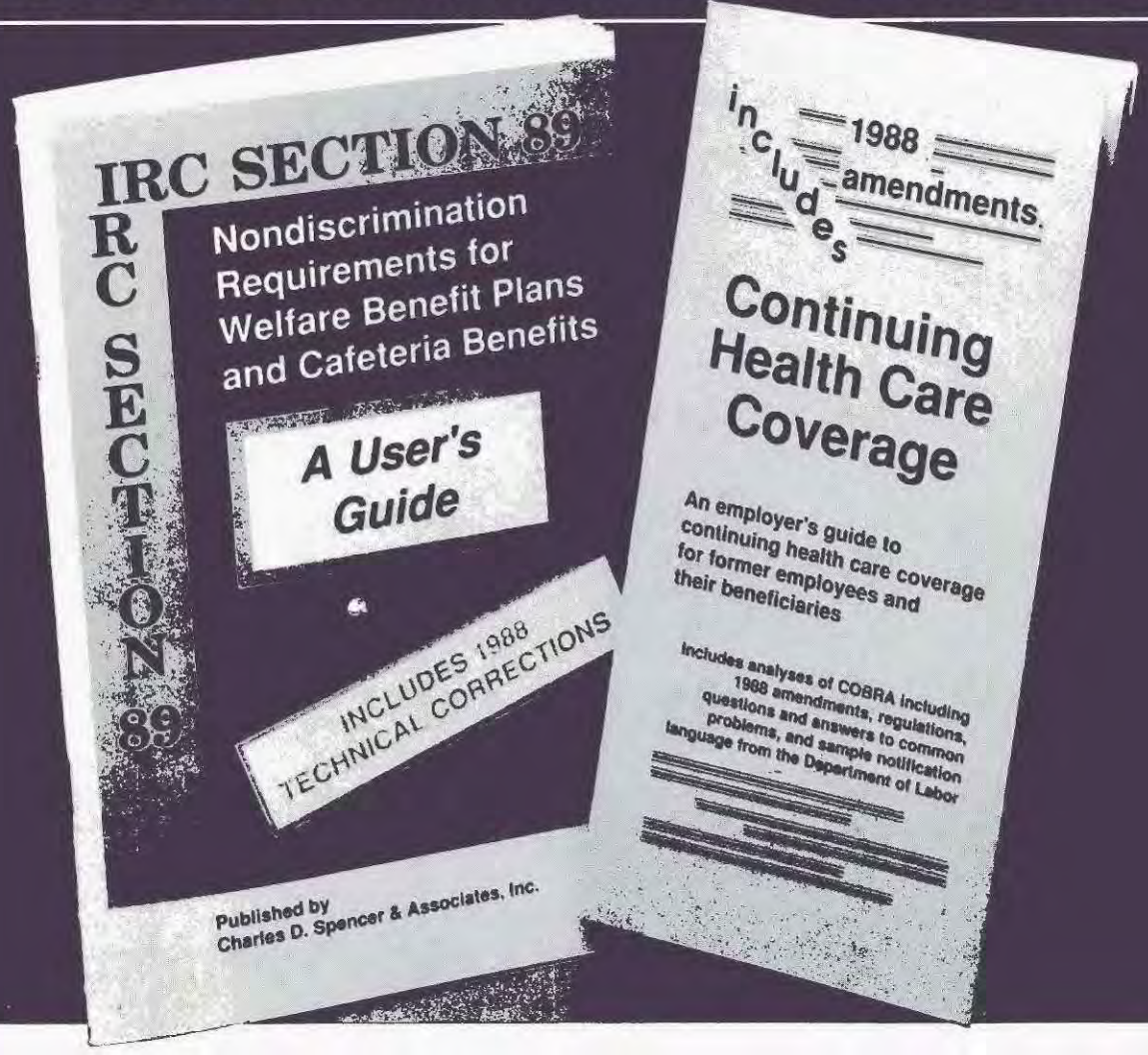

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Bermuda briefs

Mentor liquidators stalled in Peat Marwick lawsuit

By ROGER SCOTTON

HAMILTON, Bermuda—Liquidators of Mentor Insurance Ltd. may take several months to decide whether to appeal a U.S. judge's dismissal of their negligence suit against the insolvent reinsurer's accountants or take their complaint to Bermuda's courts.

A New York Supreme Court judge last month conditionally dismissed the liquidators' suit on the grounds of forum non conveniens (*BI*, March 13).

But the liquidators' next step may be influenced by a ruling expected from the 5th U.S. Circuit Court of Appeals in May on the proper forum for a another lawsuit filed by the liquidators against Mentor's parent, New Orleans-based Ocean Drilling & Exploration Co., and other parties.

Court-appointed Mentor liquidators Charles W. Kempe Jr. and Michael J. Arnold of Arthur Young & Co. sued the accountants—Peat, Marwick, Mitchell & Co. of Bermuda and Peat, Marwick, Mitchell & Co. of New York—last December for allegedly failing to uncover a fraudulent scheme involving excess-of-loss reinsurance contracts between Mentor and Pinnacle Reinsurance Co. Ltd.

The Bermuda and New York practices of Peat Marwick, now known as KPMG Peat Marwick, were Mentor's accountants from 1982 to 1984.

According to the liquidators' complaint, "Peat committed malpractice by certifying and rendering unqualified opinions on financial statements of Mentor and (its immediate parent) Mentor Holding Corp. that were materially false and misleading."

Specifically, the liquidators allege that Peat Marwick should have discerned that three excess-of-loss contracts did not represent sufficient transfer of risk and were merely deposit arrangements with Pinnacle.

The liquidators charged that each contract was secured by a letter of credit that Peat Marwick should have reviewed.

"Those letters of credit expressly provide that partial drawings of monies are prohibited and that they could be honored only after a period of 10 years," said the complaint. "Thus, the terms of the letters of credit put Peat on notice, or should have, that regardless of the terms of the reinsurance contracts it was understood by the parties that there would be no payments by Pinnacle to Mentor for a period of 10 years."

"Additionally, Peat negligently failed to insist on the application of generally accepted accounting principles in its audit of Mentor's 1982 financial statements in that it failed to insist on any disclosure or, alternatively failed to make any disclosure of the Pinnacle contract," the liquidators charged.

The liquidators also point to other "indicia" that should have put Peat Marwick on notice that the contracts were not risk bearing. These include, among others, that Peat Marwick negligently failed:

- To recognize that the profit commission clause in the first contract in effect fixed the amount of money that Mentor would receive from Pinnacle, thereby eliminating any underwriting risk.
- To determine that Mentor was not rendering loss experience reports to Pinnacle as required by the provisions of the contracts or that requests for reimbursement were not being made by Mentor to Pinnacle pursuant to the contracts.
- To request and review Pinnacle's proposal to reinsure Mentor and failure to determine how the amount of premium Pinnacle charged Mentor was calculated.

The liquidators charge that Mentor's parent, ODECO, "caused Mentor to agree with Pinnacle that no payment would be made to Mentor for a period of 10 years."

"Mentor was the victim of a scheme or artifice to defraud perpetrated by ODECO and ODECO's

Continued on next page

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management, among others. The object of the scheme "was to inflate artificially Mentor's earnings for the purposes of promoting the economic interests of ODECO and other of its affiliates," the liquidators charged.

"As a result of the scheme, Mentor was caused to incur hundreds of millions of dollars in debt that it would not otherwise have incurred had its true financial condition been known, eventually resulting in its liquidation," the complaint said.

The liquidators' massive fraud suit filed in 1986 against ODECO and 10 other defendants was dismissed last year on the grounds of forum non conveniens (*BI*, April 25, 1988). Messrs. Kempe and Arnold appealed that decision to the 5th U.S. Circuit Court of Appeals, which is expected to issue a ruling in May.

Cambridge Re claims

Twenty-two creditors of insolvent Cambridge Reinsurance Ltd. are objecting to the joint liquidators' actuarial calculations of their claims.

The creditors filed their appeals with the Bermuda Supreme Court before a court-ordered deadline of Feb. 28 (*BI*, Jan. 2).

A spokesman for joint liquidators David Lines and Gerry Weiss said the liquidators have not yet ascertained how many underwriting years are in dispute or the value of the reinsurance contracts involved.

The spokesman explained that a creditor must file a separate appeal for individual underwriting years.

But the liquidators are pleased that only 22 of the more than 3,000 Cambridge creditors were appealing the valuations. "It could have been worse," the spokesman said.

The spokesman said he believed that most objections cited the valuation factors used by the liquidators to determine claims, employing unprecedented actuarial methods to establish liabilities (*BI*, March 16, 1987).

Cambridge, a subsidiary of Nova Scotia-based National Sea Products Ltd., collapsed in 1985 with total debts of about $80 million. Cambridge now is insolvent by $63.6 million.

The liquidators will re-examine the valuations that are being appealed, the spokesman said. The first cash dividend declaration date of March 31 is unlikely to be affected by this process, the spokesman added.

Rather than hold up the cash distribution, the liquidators plan to reserve fully against amounts owed to the 22 creditors appealing their valuations, who can expect to receive payment once their appeals have been resolved, the spokesman explained.

Belvedere premiums up

Bermuda-based Belvedere Insurance Co. Ltd., a unit of New York-based Belvedere Corp., reported an 18% increase in earned premiums to $22.1 million during the company's 1988 financial year.

But the company, which specializes in financial reinsurance and reinsurance programs for captives, stresses that its premium-to-surplus ratio remains a conservative 1.1-to-1.

Profits were down slightly to $3.3 million from $3.9 million in 1987, but Belvedere President Colin O'Connor says this level of net income represents a return on equity of 16.3%.

In his report to shareholders, Mr. O'Connor says the company concluded that it was appropriate to increase its provision for unrecoverable reinsurance by almost $1.4 million. He says this had the effect of raising its combined ratio to 111.7% in 1988 from 105.5% in 1987.

"Our approach to this problem is prudent and clear-sighted: Estimated ultimate amounts due from companies in liquidation, rehabilitation or otherwise in poor financial condition are written off on a conservative scale of up to 100%, depending on the situation of each company," Mr. O'Connor said.

Mr. O'Connor also noted that "in the latter part of 1988, we concluded a joint underwriting agreement with Hannover (Reinsurance Corp.), specifically for the underwriting of financial reinsurance, principally loss transfers and surplus aid products."

Belvedere—along with Brittany Insurance Co. Ltd., Hudson Reinsurance Co. Ltd. and Hannover Re—"also developed a new captive reinsurance underwriting facility with a gross capacity of $1.5 million. Increasing competition in both of these areas makes it unlikely that we will experience any sudden increase in business volume," Mr. O'Connor said.

"We intend to concentrate on marketing these specialized facilities and hope to benefit from the next upturn in the cycle," Mr. O'Connor said.

Meanwhile, a majority shareholder in Belvedere's U.S. parent said recently that it was shopping for a buyer for its 49% stake in the company (*BI*, March 13). ■

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Lloyd's fund may aid defrauded members

By CAROLYN ALDRED

London

LONDON—Lloyd's of London plans to establish a fund to compensate Lloyd's members who suffer losses because of fraud and dishonesty by insolvent underwriting agents.

The Lloyd's proposal calls for compensating members for claims against insolvent underwriting agents when the claims "relate to fraud, other dishonesty or failure to account for money received on the part of the insolvent agent," according to a consultative document that was published earlier this month.

Lloyd's is accepting comments on the proposal now through Aug. 31.

According to the proposal, members would receive 100% of the first 20,000 pounds ($34,400) per claim and 75% of the next 40,000 pounds ($68,800), with a maximum compensation per member of 50,000 pounds ($86,000).

The total compensation available to members is likely to be between 30 million pounds ($51.6 million) and 50 million pounds ($86 million) annually.

The Corporation of Lloyd's would finance the plan solely through a levy on agents if the total value of claims in the year is less than 33% of the fund's maximum payout.

However, if claims exceeded that benchmark, the remainder of the fund would be financed by Lloyd's members.

The proposals do not include any compensation for alleged negligent underwriting because "in the (Lloyd's) Council's view there is normally no ready distinction between losses which arise from negligent underwriting and those which are an inevitable risk in the business of underwriting.

"To cover such claims would be tantamount to the mutualization of the risks all members accept when they join the Society," the document states.

"The Council believes that should there be a major failure of an agent because of underwriting negligence, the individual names on the syndicates concerned rather than the Society as a whole should accept responsibility for the losses involved," according to the document.

Meanwhile, Lloyd's also plans to increase the capital and solvency margins that are required of managing agents and members' agents.

In another consultative document published this month, Lloyd's proposes to increase managing agents' fixed capital requirement to 100,000 pounds ($172,000) and members' agents' required fixed capital to 150,000 pounds ($258,000).

Under Lloyd's existing registration process, "agents with less than 25,000 pounds in paid-up share capital are unlikely to be considered to have an adequate financial position (and) new applicants are unlikely to be approved unless total capital is at least 50,000 pounds for a managing agent and 100,000 for a members' agent," the document notes.

In determining the revised requirements, Lloyd's considered "the aggregate amount of fixed capital which is necessary to support the market capacity," the document explains.

Of the 222 underwriting agents sampled by Lloyd's, "the aggregate levels of fixed capital available at Dec. 31, 1987, represented 0.3% of market capacity and it is generally felt that an increase in the underlying strength of agents is required," according to the document.

Agents also will be required to maintain a net current asset margin at all times equal to three months of the agent's recurring expenditures, according to the proposal.

In addition, Lloyd's proposes to introduce a requirement that an agent's net assets—gross assets minus liabilities—exceed the minimum fixed capital requirements and exceed 0.2% of an agent's gross premium underwriting limit plus net profit commission.

This margin will increase to 0.25% one year after the proposal takes effect.

Under the proposals, the new fixed capital requirement will take effect on July 1, 1990, and the new current asset requirement will take effect on July 1, 1991.

Comments on the proposals should be made to Lloyd's before Aug. 31.

At a recent press conference, Lloyd's Chief Executive Alan Lord said the proposed requirements "will not necessarily lead to a decline in the number of agencies" operating at Lloyd's.

However, some executives in the market disagree, and at least one agency has publicly declared its willingness to acquire smaller agencies unable to meet Lloyd's "far more stringent financial requirements."

The largest Lloyd's underwriting agency, Sturge Holdings P.L.C., believes "that the growing regulatory and competitive demands on Lloyd's agents during the next few years will make it increasingly difficult for independent agencies to continue in business," said Chairman David Coleridge at Sturge's annual general meeting in London earlier this month.

"It is inevitable that many Lloyd's agents will have to seek ways of securing their future. We are in an almost unique position to provide a means to secure their future by offering to acquire their holdings, either for cash or shares," he added.

Sturge currently is one of only two Lloyd's underwriting agencies listed on the London Stock Exchange.

Meanwhile, underwriting agency London Wall Holdings P.L.C. last week announced plans to acquire two Lloyd's members' agents, which together represent 368 members with a premium capacity of 110 million pounds ($182.9 million).

The acquisition of Towry Law (Underwriting Agencies) Ltd. and Fielding & Partners (Agencies) Ltd. will increase the number of members managed by London Wall to 1,462 with a total premium capacity of 432 million pounds ($743 million) for 1989.

"The new regulatory requirements in Lloyd's have increased

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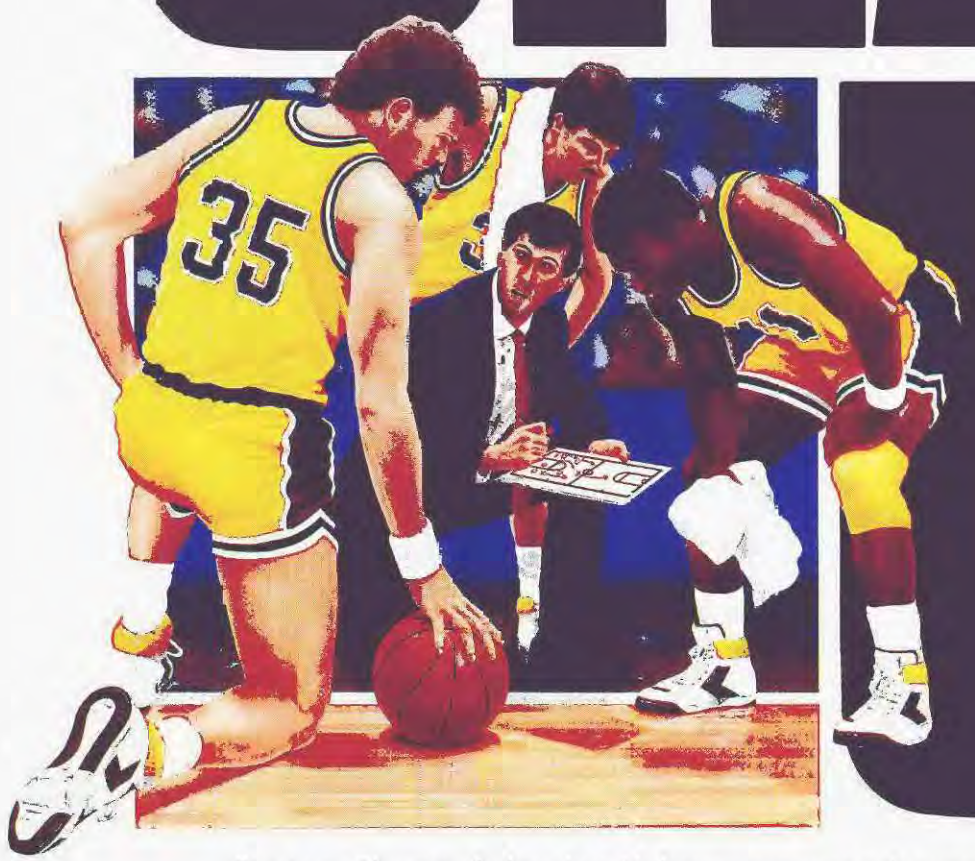

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the workload, and developments in the market over the last few years have emphasized the need for members' agencies to gain access to a wider range of syndicates and to introduce new computer technology," said Robin Warrender, chairman of London Wall.

"The inevitable result of this process is that agencies are amalgamating into larger units, and we regard 1,500 names as being an optimum size in today's market conditions," he added.

Syndicate shares

Lloyd's of London could boost its capacity by allowing Lloyd's members to buy and sell shares in syndicates, according to a London-based economic think tank.

Trading syndicate membership in the same way shares of a corporation are traded on a stock market would end current restrictive practices at Lloyd's, allowing members to diversify their portfolios, says a paper published this month by the Institute of Economic Affairs.

Under the proposals by economic consultant Robert Miller, members of syndicates would have the right to sell their shares in the syndicates to other members of Lloyd's of London.

Shares could be bought by all underwriting members of the Lloyd's market. The shares would then be traded on a computerized trading system through members' agents, which would act as brokers, charging commissions on the transactions.

Currently, members are placed in syndicates by their members' agents based on which syndicates the members' agents have access to and which of those syndicates have capacity for new members.

As a result, Lloyd's members do "not have access to all the syndicates in the same way that an investor on the stock market can choose among all the companies quoted on the stock exchange," according to Mr. Miller.

"This inefficiency in the Lloyd's market is likely to have a number of serious consequences" including heavy losses by some members who are unable to diversify their portfolios and reduced capacity of the market to supply "stop-loss" insurance to limit a member's total losses, he said.

Consequently "the capacity of Lloyd's to do insurance business may be restricted," Mr. Miller said.

"Potential (members) may be reluctant to become members because the risks are too high due to the inability to diversify their portfolio," he said.

In addition, a member's "investment" in a syndicate currently can be changed only once a year, said Mr. Miller.

Trading syndicate shares would produce a form of syndicate pricing, encourage more in-depth analysis of syndicate performance and make it "easier to form an accurate judgment of the syndicate's prospects and to decide whether or not to buy, sell or maintain membership of a syndicate," the paper says.

Also, members "who may have few connections at Lloyd's will be on a par with the Lloyd's insiders" who work in the market, the paper notes.

"One intriguing feature of the proposal is that some syndicates might trade at negative prices (so that) someone on such a syndicate would have to pay a sum in order to leave the syndicate," Mr. Miller notes.

Members "unlucky enough to be on a loss-making syndicate would be able to limit their loss by an immediate sale of the share in the market," he explains.

Currently, members must wait three years under Lloyd's three-year accounting system to determine their losses—or longer if the particular underwriting year is left open.

Sedgwick plan

London-based broker Sedgwick Group P.L.C. is restructuring all European operations into one integrated retail insurance brokerage and risk management services organization.

Sedgwick Europe Group Ltd. will have more than 2,000 employees in 56 offices throughout Europe.

According to Rob White-Cooper, chairman of Sedgwick Europe, the reorganization is part of Sedgwick's development to become a "truly European broker."

Meanwhile, "increased emphasis is being placed on utilizing Sedgwick's risk management expertise across Europe" with the formation of a subsidiary company called European Risk Management Services Ltd., according to a Sedgwick statement.

Claims collection

London broker Alexander Howden Reinsurance Brokers Ltd. is forming a consulting unit to help insurers and reinsurers collect environmental and asbestos-related claims.

International Loss Recovery Services aims to offer accelerated reinsurance claims collection on a fee basis for environmental toxic tort claims arising from policies often dating back decades.

"It has been obvious for some time that there is a need for accelerating toxic tort recoveries," said Michael Stephens, managing director of claims operation for AHRB, a subsidiary of New York-based Alexander & Alexander Services Inc.

The fee-based service, which will be available to non-Howden clients, is an extension of the claims recovery service already offered to Howden clients by AHRB, said Mr. Stephens.

Many insurers and reinsurers are experiencing problems with reinsurance collections for asbestos liability and property claims as well as pollution claims, said Ian Jordan, who will head ILRS.

ILRS "initially will be looking towards the U.S. market, which is having significant recovery problems, particularly with the forthcoming introduction of 90-day reinsurance collections," said Mr. Jordan, formerly a claims controller with NRG London Reinsurance Co. Ltd.

A proposal by a National Assn. of Insurance Commissioners' task force would require ceding insurers to deduct from capital and surplus an amount equal to 20% of reinsurance recoveries that are more than 90 days overdue (*BI*, Oct. 17, 1988).

Insurers' results

British insurer Royal Insurance Holdings P.L.C.'s profits dropped 18% in 1988 after it increased reserves for U.S. claims by 22%.

Pretax profits for the London-based multiline insurance group fell to 223.4 million pounds ($404.4 million at 1988 year-end rates) in 1988 from 274 million pounds ($515.1 million at 1987 year-end rates) in 1987.

Total premiums also fell, to 3.97 billion pounds ($7.2 billion) from 4.03 billion pounds ($7.6 billion), though property/casualty premium revenues increased slightly to 3.3 billion pounds ($6 billion) from 3.2 billion pounds ($6 billion).

Results from the group's operations outside the United States were "excellent," said Chief Executive Alan Horsford, who noted that non-U.S. property/casualty profits increased 191% to 207.6 million pounds ($375.8 million) from 71.3 million pounds ($134 million).

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However, the result for Royal U.S.A. "was severely impacted" by a special addition of $200 million to bolster reserves for U.S. claims attributable to 1985 and prior underwriting years, said Mr. Horsford.

The special provision was made after a review of claims data by Royal's actuaries, actuaries for the group's auditor and consulting actuary Tillinghast, a unit of Towers, Perrin, Forster & Crosby Inc., said a Royal spokesman.

Meanwhile, Royal also has boosted reserves for U.S. claims for the 1988 underwriting year by $318 million.

As a result of both additional provisions, Royal's reserves for U.S. claims now total $2.9 billion, up 22% from $2.3 billion at year-end 1987, according to a spokesman for the company.

This is "probably in excess of what most U.S. companies would have done, but we believe during 1988 a disturbing new trend developed (in U.S. claims) which we needed to reserve for," said the spokesman.

Meanwhile, other insurers in the United Kingdom are posting increased profits, despite poor underwriting results from U.S.-based business.

Perth, Scotland-based General Accident Fire & Life Assurance Corp. P.L.C. reported 1988 pretax profits of 290.3 million pounds ($525.4 million), up 42% from 204.4 million pounds ($384.3 million) in 1987.

Premium volume increased 20.8% to 2.9 billion pounds ($5.2 billion) from 2.4 billion pounds ($4.5 billion) in 1987.

A reduction in industrial fire damage in the United Kingdom and reduced claims frequency overall helped produce an underwriting profit of 45.8 million pounds ($82.9 million), compared with an underwriting loss of 18.6 million pounds ($35 million) in 1987.

However, in the United States, General Accident's underwriting loss increased 24.3% to 41.9 million pounds ($75.8 million) from a loss of 33.7 million pounds ($63.4 million) in 1987.

London-based Commercial Union Assurance Co. P.L.C. also announced that pretax profits increased 19% in 1988, despite an increased underwriting loss from U.S. business.

Pretax profits increased to 201.8 million pounds ($365.3 million) from 170.1 million pounds ($319.8 million) in 1987, while total premium revenues increased slightly to almost 3 billion pounds ($5.4 billion) from 2.9 billion pounds ($5.4 billion).

In the United Kingdom, Commercial Union's pretax profit rose 36.4% to 187.5 million pounds ($339.4 million) from 137.5 million pounds ($258.5 million), while the group's U.S. operations produced a pretax loss of 15 million pounds ($27.2 million) compared with a 1987 loss of 3.5 million pounds ($6.6 million).

"The (U.S.) market remained competitive in commercial lines with further pressure on rating levels," said a CU statement.

"Nevertheless, our strategy of concentrating on the more stable small to medium risk sectors enabled average rate increases for the year to be obtained of 7% in both personal and commercial lines," the statement continued.

Looking ahead, "one of our principal objectives is to develop our European businesses and take advantage of the growth and deregulation in the European Community," said Chief Executive Tony Brend.

HRGM acquisition

London broker Hogg Robinson & Gardner Mountain P.L.C. is acquiring 51% of small London broker Hobbs & Partners Ltd., which specializes in placing business from France.

The acquisition involves an immediate cash payment of 45,000 pounds ($77,400) plus additional deferred payments linked to profits over the next three years.

Option arrangements will allow HRGM the right to buy the outstanding 49% portion after three years.

The total amount payable by HRGM if the options are exercised is estimated to be about 1 million pounds ($1.7 million).

Hobbs' pretax 1988 profits totaled about 240,000 pounds ($434,400). ■

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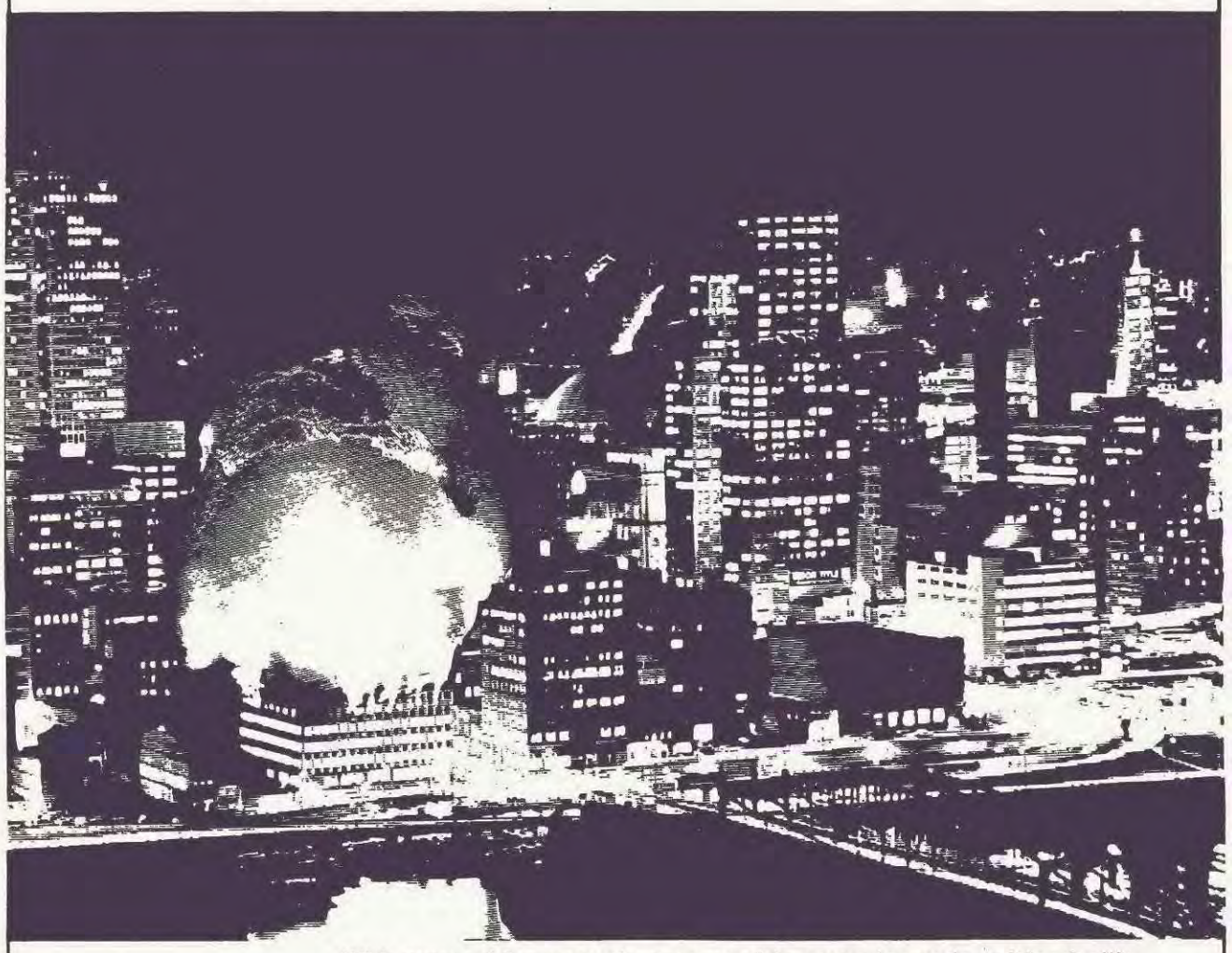

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Comings & goings: buyers

Syntex Corp. names Spence risk manager

David Spence, 30, has been promoted to risk manager of Syntex Corp. in Palo Alto, Calif. In this position he oversees worldwide property/casualty insurance administration and risk management for the pharmaceutical and agribusiness firm. He replaces Jack Mantor, who retired, and reports to Alan B. Stevenson, vp-treasurer. Previously Mr. Spence was insurance manager at the company. He holds a bachelor of business administration degree from the University of Wisconsin. In addition, he has earned the Associate in Risk Management designation and is past president and treasurer of the Santa Clara Valley Chapter of the Risk & Insurance Management Society Inc.

* * *

Jan Russert was named director of risk management at Lexington Development Corp. in Arlington Heights, Ill. In this newly created position she oversees all property/casualty insurance and loss prevention activities for the home builder. She reports to Wayne Moretti, executive vp and chief financial officer. Prior to joining Lexington, Ms. Russert served as senior insurance analyst for Volkswagen of America Inc. in Troy, Mich. She received a bachelor of science degree from Arizona State University in Tempe. She is a member of the Northeastern Illinois Chapter of the Risk & Insurance Management Society Inc. In addition, Ms. Russert holds the Associate in Risk Management and Occupational Safety & Health Technician designations and an Illinois broker's license.

Ms. Russert

* * *

Robert D. Sipprell Jr., 44, has been named manager of insurance plans at First Wachovia Corp. in Winston-Salem, N.C. In this position he is responsible for the health and welfare benefit plans of the interstate bank holding company's 14,000 employees. He replaces **Betty Wilkes**, who left the company, and reports to Dennis Lee, vp and manager of compensation and benefits. Prior to joining First Wachovia, Mr. Sipprell was manager of human resources at Integon Insurance Co. in Winston-Salem. He holds a bachelor of arts degree from Bethany College in Bethany, W.Va., and a master of business administration degree from Michigan State University in East Lansing. In addition, Mr. Sipprell is a member of the Forsyth Medicine/Business Coalition, a group of health care sponsors and providers.

* * *

William H. Michel named corporate risk and insurance manager for Parker Hannifin Corp. in Cleveland. In this position he is responsible for managing the domestic and foreign risk management, property/casualty insurance and claims programs for Parker Hannifin. He replaces **Craig T. Mockler**, who left the company to join Sudbury Inc. in Cleveland, and reports to Wallace C. Young, treasurer. Prior to joining Parker Hannifin, which produces motion control components and systems, Mr. Michel was risk manager for First National Supermarkets Inc. in Windsor Locks, Conn. He holds a bachelor of arts degree from the College of Wooster in Wooster, Ohio, and a doctor of law degree from the University of Michigan at Ann Arbor. Mr. Michel is a member of the Cleveland-Akron Chapter of the Risk & Insurance Management Society Inc. and the Self-Insured Group of Ohio.

•

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Wrongful termination

Some claims may be covered by general liability policies

By Clinton E. Miller

WRONGFUL TERMINATION claims are not always excluded, nor are they always covered, under most standard form general liability policies. The myth in the insurance industry that an employee cannot be "negligently" terminated is only a myth. What follows is an analysis of when wrongful termination is—or "potentially" is—covered by a liability insurance policy and when it is not.

First, there are some preliminary claims rules to keep in mind. Before any final conclusion can be reached by an insurer, a prompt, thorough and objective investigation is mandatory. This is by virtue of the implied-in-law covenant of good faith and fair dealings as well as the fiduciary duties owed by the insurer to all policyholders. In other words, the insurer must acquire all reasonably available facts before denial of a wrongful termination claim.

Moreover, a prudent insurer will never issue a "closed door" denial letter to its policyholder but, rather, will ask for the policyholder's thoughts and evidence that may be inconsistent with the insurer's position of no coverage. Additionally, a prudent insurer will always operate under an initial "non-waiver agreement" so the policyholder cannot subsequently make an argument of waiver and estoppel on the part of the insurance company for not reserving potential defenses at the initial stage.

Lastly, if the insurance company discovers any contract or policy defenses that appear viable after the initial investigation, the insurer should convert from a non-waiver agreement to a "reservation of rights" stance. The insurance company's reservation of rights letter should be modeled after California Insurance Code Section 790.3(H)13.

In the first step of analysis of a wrongful termination claim, the insurer must determine if there are any contract defenses. The first thing that the insurer will look for is whether the insurance policy was "in force" on the date of the loss.

Some considerations will entail whether the policyholder or the insurer canceled the policy prior to the date of loss or if there is a "gap" in coverage that coincides with the date of loss. The insurance company will also look at the possibility of *reformation* issues such as mistakes by either the policyholder or the insurer in the formation stage of the insurance contract. Moreover, the insurance company will look to any issues of *recision* of the insurance contract in the event that there is evidence of willful misinterpretation of any material facts.

This preliminary investigation of contract defenses is important because without a contract, there is no duty to defend or indemnify the policyholder.

If there are no contract defenses, the insurance company will proceed to the second defense barrier in an attempt to establish any policy defenses. Currently, the premier policy defense is the allegation on the part of the insurance company that there is no occurrence. As a general rule, standard form general liability policies only pay for occurrence-type losses.

What is an occurrence? Generally an occurrence is an accident. However, what is an accident? An accident is generally an event or happening that was not intended nor expected by the policyholder to result in harm or injury to persons or property.

Moreover, the underwriting intent as to whether the policyholder intended or expected a result to follow his or her voluntary act is to be judged from the standpoint of the policyholder. That is, the underwriting intent, as evidenced by the insurance policy language "from the standpoint of the insured," is a subjective test of intent and not what a reasonable, prudent person would surmise, based on the conduct of the policyholder prior to or during the act of wrongfully terminating an employee. (See *Meyer vs. Pacific Employer's Insurance Co.*, (1965) 233 CA2d 321, 326.) If a wrongful termination claim is to be denied, due to the want of an "accident," the burden of proof is on the insurer to prove that the policyholder had a subjective intent to harm or injure the fired employee.

How can the insurer prove this subjective intent? I don't know. However, the insurer, if it is to deny a wrongful termination claim based on a non-occurrence must prove—beyond a reasonable doubt?—that the policyholder had a subjective intent to harm the wrongfully terminated employee.

For example, the policyholder states: "Yes, I terminated the plaintiff (ex-employee) but no, I did not intend nor expect the termination to result in any harm to the plaintiff."

How can the insurance company refute the policyholder's subjective state of mind? (See *State Farm Fire & Casualty Co. vs. Estate of Jenner*, USCA 9th, No. 87 2153, Sept. 8, 1988). I would suggest that the insurer cannot afford to call the policyholder a liar and expose itself to a second lawsuit for defamation. Remember the fiduciary duties that are owed to the policyholder by the insurance company.

Speaking out

Additionally, the insurer must give as much consideration—51%—to finding coverage or potential coverage for the policyholder as it does in attempting to establish theories on which coverage can be denied. (See *Egan vs. Mutual of Omaha Insurance Co.*, (1979) 24 CA3d 809.) Moreover, the standard in the insurance industry is to give the benefit of the doubt for coverage to the policyholder.

The question then becomes: Can the insurance industry attempt to establish an objective test of a policyholder's intent or expectations?

California Insurance Code Section 533 deals with the exclusion of insurance coverage for "willful" acts committed by a policyholder. Note that it does not say "intentional" acts. Nowhere in code language nor in most standard form general liability policies is the word or term "intentional" ever used! Also, willful and intentional have different legal definitions.

The burden of proof is on the insurer to prove all facts to establish that an exclusion is applicable; that the policyholder had a preconceived design to inflict injury; or that the subjective intent of the policyholder was to cause injury to a wrongfully terminated employee at the time of the act.

However, it is not unusual for both the insurance industry and the courts in California to use the words "willful" and "intentional" interchangeably. This analysis, though, will follow the majority rule that willful is a controlling term regarding "occurrence" coverage issues.

Since neither the standard form general liability policies nor the insurance code define "willful," then one must look to case law for a definition. California courts generally have defined willful as a "preconceived design to inflict injury." It is suggested that preconceived is tantamount to premeditation. (See *Clemmer vs. Hartford Insurance Co.*, (1978) 22 C3d 865, 887.)

On the other hand, *if* the insurer can get past the expressed policy language (subjective intent rule) and establish objectively that the policyholder did, in fact, have a "preconceived design to inflict injury" on the wrongfully terminated employee (plaintiff), then there is no "occurrence." If that is the case, then the insurer has its "willful" act and the wrongful termination claim will lack an "occurrence."

Hence, no coverage will apply to the policyholder's claim. However, premeditation on the part of the policyholder will usually be required to illustrate a "preconceived design to inflict injury."

However, which "test" is controlling: the subjective test in the insurance policy; not intended nor expected injury or harm following the policyholder's wrongful termination of the plaintiff (from the standpoint of the policyholder); or California Insurance Code Section 533, which objectively exempts the insurer from liability under the policy for willful acts (preconceived design to inflict injury)?

Probably the policy language or subjective intent rule will prevail over the insurance code. In any event, an in-depth investigation is mandatory to attempt to ascertain either the subjective intent of the policyholder, as expressed in insurance policy language, or the objective intent of the policyholder under the insurance code. The burden of proof is on the insurer to prove all facts to establish that an exclusion is applicable; that the policyholder had a preconceived design to inflict injury; or that the subjective intent of the policyholder was to cause injury to a wrongfully terminated employee at the time of the act.

If your analysis gets to the second step—determining whether there is an occurrence—examine the following collateral "intent" issues:

- Mental capacity. Did the policyholder have the mental capacity to formulate a preconceived design to inflict injury on the wrongfully terminated employee? That is, was the policyholder's act of wrongful termination "willful?"

Additionally, not only must the wrongful termination be preconceived but the policyholder must have foreseen a resulting injury—without an injury, there would be no damages, and without damages, there would be no sustainable cause of action.

- Dual intent. To defeat an occurrence, the insurer must prove two intentional acts. First, that the policyholder wrongfully terminated the employee intentionally and, second, the intentional wrongful termination was intended to cause the wrongfully terminated employee injury. (See *USF&G vs. American Employee Insurance Co.*, (1984) 159 CA3d 277 and 284.)

Even if the insurer can prove that the policyholder "subjectively" intended to wrongfully terminate the employee *and* intended to injure the wrongfully terminated employee; or,

Continued on next page

Clinton E. Miller is an insurance litigation consultant in San Jose, Calif., specializing in insurance bad faith. Mr. Miller, who holds a doctor of law degree, is a licensed independent insurance adjuster and private investigator.

Wrongful termination may be covered

Continued from previous page
the insurer can prove objectively that the policyholder willfully and wrongfully terminated the employee with a "preconceived design to inflict injury," the insurer's case is still not won!

For example, if the insurance policy covers more than one policyholder and the other policyholder is "innocent," you must go back to Square One of your analysis. This is a trap for a lot of insurance companies.

Each "innocent" policyholder has independent coverage under the policy. Hence, the insurer must prove that *each* policyholder willfully intended the wrongfully terminated employee to be terminated and that *each* policyholder intended that the wrongfully terminated employee be injured as a result of the termination. (See *Arenson vs. National Auto & Casualty Insurance Co.*, (1955) 45 C2d 81, 84.)

For example, a supervisor terminates an employee without authority or just cause. Additionally, if the supervisor's superiors did not take part in or ratify the wrongful termination, the superiors would have coverage (negligent supervision of supervisors by superiors, hence, no intent issue). This scenario assumes the superiors were "insureds" as defined by the insurance policy. (See *American States Insurance Co. vs. Borbor*, 9th Cir. (1987) 826 F2d 888.)

Remember, to the "innocent" policyholder, the loss is unexpected and unforeseen. (*Arenson vs. National Auto & Casualty Insurance Co.*)

The insurance company must also consider legal doctrines, its own corporate claims policies and general principles of insurance law that may tip the scales of what is an "occurrence" or what is a non-occurrence. These additional considerations are necessary since wrongful termination-type claims currently fall into the gray zone of an insurable risk. It is felt that the lack of responsible policy language by insurers, to eliminate coverage issues, will leave insurers in a poor bargaining position before the courts.

The insurer is going to end up paying certain types of claims—like wrongful termination—whether it likes it or not.

For example, the insurance company must consider:

- Statutory requirements of clear policy language. It is a statutory requirement that the policy be explicit. (See California Insurance Code, Subsection 11580.1 (B)2,(3); and *National Auto & Casualty Insurance Co. vs. Contreras*, (1987) 193 CA3d 831.) Some risks are simply a cost rather than a risk of the insurance business. That is, the insurer is going to end up paying certain types of claims—like wrongful termination—whether it likes it or not.
- Doctrine of reasonable expectation. First is the expectation of the policyholder that wrongful termination-type law suits would be covered by its standard form general liability policy, which must be a *reasonable* expectation. If it is determined that the policyholder's expectations are reasonable by an objective standard of proof, then the insurer will be hard-pressed to argue that the implied underwriting intent (occurrence) was to exclude wrongful termination-type claims.

Additionally, the insurer may be embarrassed to explain why such a "special risk" as wrongful termination exposure was not expressly excluded so the policy intent was clear. (*Reserve Insurance Co. vs. Pisciotta*, (1982) 30 C3d 800, 807-808.)

- Ambiguity. The insurer has a duty to avoid any ambiguity of intent when an expressed or implied exclusion is capable of two or more different constructions. If a wrongful termination is an implied exclusion and not conspicuously, plainly and clearly excluded, the insurer will have to defend and indemnify the policyholder. (See *Gray vs. Zurich Insurance Co.*, (1966) 65 C2d 263, 271-272; *Steven vs. Fidelity & Casualty Co.*, (1962) 58 C2d 862; *Travelers Insurance Co. vs. Lesher*, (1986) 187 CA3d 187; and *Ponder vs. Blue Cross Insurance Co.*, (1983) 145 CA3d 709, 719.)
- Rule of ambiguities. Uncertainty as to coverage—of wrongful termination, for example—will be resolved against the insurer. (*Silberg vs. California Life Insurance Co.*, (1974) 11 C3d 452.) In addition, ambiguities must be judged as of the purchase date of the policy. (See *Ponder vs. Blue Cross.*)
- Multiple occurrences. Although there may be only one wrongful termination action, there may be two "occurrences!" The second occurrence will be an important issue, even if the wrongful termination was willful or justified. The second occurrence issue will deal with the manner in which the termination took place.

The insurer has a duty to avoid any ambiguity of intent when an expressed or implied exclusion is capable of two or more different constructions.

For example, assume an employee is terminated for just cause. However, if the manner in which the employee was terminated was without dignity or was done in an unprofessional manner that was embarrassing to the employee, then that conduct may result in a negligent infliction of emotional distress action. Even if the willful termination is excluded (non-occurrence), the negligent or abusive manner of terminating the employee would be a covered occurrence.

- Insurer's duty to point out certain limitations. A conspicuous, plain and clearly communicated exclusion is mandatory if the policyholder could not have reasonably expected the exclusion (for wrongful termination) to be in the policy and the exclusion applies to an activity of which the policyholder is at "special risk" (such as the policyholder has employees and is doing business in a state like California) and the insurer knew of the special risks of the policyholder!

The failure of the insurer to point out "special risk" limitations in a policy (like wrongful termination claims) at the formation stage of the insurance contract will probably result in an adverse ruling against the insurer in favor of the policyholder for coverage for wrongful termination litigation. (By analogy, see *Aetna Casualty & Surety Co. vs. Velasco*, (1987) 194 CA3d 1441.)

Is wrongful termination a "special risk" to California employers? Yes! (See *Underwriters Insurance Co. vs. Purdie*, (1983) 145 CA3d 57.)

- Concurrent proximation causation. If the policyholder has committed, in part, a non-occurrence act (a willful act) and an "occurrence" act (negligence), must the insurer defend a suit against the policyholder and indemnify the policyholder in whole or in part? The general rule is that the insurer must defend the entire suit, both non-occurrences and occurrences, but will not have to indemnify for any non-occurrence damages.

There is always a duty to defend. Prudent insurers never deny a claim until they have conducted a prompt, thorough and objective investigation.

- Third-party negligence. Assume, for example, that the policyholder hires an independent private investigator to check out or build a case for a basis to terminate an employee. If the private investigator fails to fairly and thoroughly or objectively investigate the employee, and the employee is terminated on the basis of the private investigator's investigation, would this third-party investigation be an occurrence (i.e., hiring the negligent private investigator)? Probably yes. The private investigator's negligence would be imputed to the employer.
- Single insuring agreement. Since most standard form general liability policies are basically "all risk" policies, anything and everything that can happen to the policyholder is covered *unless* expressly or "impliedly" excluded in the policy.
- Insurer's corporate claims policy. The claims manual, the underwriting manual and the marketing manual at all three levels—local, regional and home office—offer considerable insight into the insurance company's philosophy on how to handle claims against their policyholders and themselves. Examples of corporate policy interpretations or intent are sometimes found in the manuals noted above, especially in the underwriting manual.

Moreover, if the policyholder expressly or impliedly requested wrongful termination coverage or the insurer expressly or impliedly promised wrongful termination coverage and it was not issued in the policy or endorsement, the policyholder may have wrongful termination coverage by way of the insurance company's own errors and omissions policy.

Another example is when the corporate claims policy may be to give the policyholder the benefit of the doubt on some coverage issues (i.e., waive potential policy defenses). (See *Continental Casualty Co. vs. Phoenix Construction Co.*, (1956) 46 C2d 423, 38.)

Another example is when there is a high probability that there is no coverage for a wrongful termination claim; that is, the policyholder willfully and subjectively and wrongfully terminated an employee. However, the insurer may still provide a defense and indemnify. Why? Usually because the policyholder generates hundreds of thousands of premium dollars, the policyholder has a good frequency and severity of claims record and the insurer can buy out of the wrongful termination claim for $15,000 or less.

Additionally, the claims payment can go from a special banking account of the insurer, directly to the policyholder's own personal checking account without leaving a paper trail in the claims file. This way, the insurer will not establish a precedent of waiver of an implied or expressed exclusion as it pertains to wrongful termination claims.

- Claim industry standards. One might look at how other standard form general liability insurers are handling the problem of wrongful termination as an occurrence- or a non-occurrence-type claim. If most insurance companies are compromising and paying wrongful termination claims, that could be the standard in the insurance industry to show wrongful termination claims *are* "occurrences."

Additionally, if most insurers are compromising wrongful termination claims without any declaratory relief action consideration, this would be additional evidence of the insurance industry's private opinion that wrongful termination claims are covered "occurrences."

- Duty to defend. There is *always* a duty to defend. Prudent insurers never deny a claim until they have conducted a prompt, thorough and objective investigation. This type of investigation can be by pre-discovery investigation or by discovery investigation.

Because thorough investigations are truly time consuming, there is always a duty to defend the policyholder *until* the investigation is completed and/or the policyholder withdraws its claim or a favorable declaratory action is secured by the insurer. Short of that, it is probably suicidal for an insurer, in this day and age, to deny any tender of a defense without substantial grounds to do so.

Additionally, the duty to defend is manifested at the outset of litigation. The duty to defend an

Continued on next page

RMIS tips for RIMS conference

AS THE RISK & Insurance Management Society Inc. conference draws closer, attendees are excitedly making final plans—one of which may be checking flight arrangements and airlines on strike to ensure they get to Atlanta and back!

Planning is really the key factor before a major conference. In the past, I've talked about the sensory overload facing the risk manager as he or she attends multiple sessions, lectures, hospitality suites, dinner appointments and so forth on a vast array of risk and insurance-related topics. Adding a review of several risk management information systems during this hectic week can be quite unfruitful if you are not well-organized enough to ask the right questions from weary vendors who may have given the same presentation 20 to 30 times before your arrival.

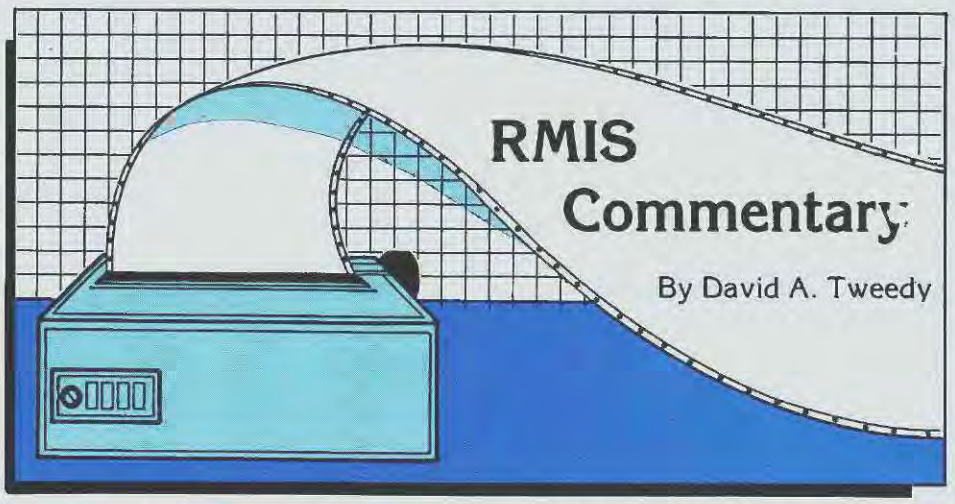
This year, as in the last two years' columns prior to the RIMS conference, I would like to provide a primer to assist the risk management professional in the RMIS review process.

In the midst of the certain chaos existing in the exhibition hall, the well-organized system reviewer will be able to maximize his or her time, gathering useful initial data in the system review process. In fact, now is a very good time to perform that needs analysis as you assess the virtues/weaknesses of your present system. I believe that competitive property/casualty insurance market in combination with the departure of Anistics Inc. from the mainframe market and the addition of several new vendors touting cost-efficient microcomputer products makes for an exciting and opportune time for system purchases and upgrades.

Here are a few helpful hints in preparation for this time as you search for the ultimate RMIS:

✔ Perform a miniature needs analysis before the conference. It's a good idea to revisit your needs analysis every two to three years to be certain that the system you have is appropriate for your current needs and your needs over the next five years. If you have questions about your current system's ability in any particular area, you should run through the mechanism of updating your needs analysis (i.e., system capabilities, reports necessary, costs, etc.). The same holds true for assessing your current vendor's capabilities, especially in light of recent developments.

✔ Prearrange visits with specific vendors. As part of the mini needs analysis, you should also pre-select two to three vendors with which you would like to visit during the conference. Obviously these vendors have systems that generally are providing capabilities (or costs) that are appropriate for your current operation. Pre-arrange meetings to fit your schedule. That will allow a smooth, uninterrupted time whereby you may view the demonstration, ask questions, obtain material and so forth in a relaxed fashion.



Avoid the tendency to focus on a new system's "bells and whistles" unless they are functional, cost-effective and meet a need.

To obtain the names of the vendors and a particular contact you'd like to see, either check the *Business Insurance* survey of RMIS vendors (*BI*, July 18, 1988) or Betterley Risk Management Commentary's August 1988 review.

Also please note that some vendors with good systems may not be present in the exhibition area but, rather, have separate suites for demonstrations by appointment only.

✔ Attend RMIS-related workshops and seminars. This year, as in past years, there will be several sessions related to the subject of risk management information systems. In addition to the one I will coordinate (S59, "How to Design and Select the Right System"), there are two other RMIS-related sessions of interest: S57, "2000 Claims On My PC," and S-58, "Electronic Spreadsheet Clinic."

✔ Prepare a checklist for each vendor/system. Preferably each checklist should include specific questions geared to the particular vendor. For example, you would not want to discuss time-share costs with a stand-alone vendor. Nevertheless, many questions are standard in nature and can be asked of any vendor. Such questions also aid in the comparison process.

Designing such checklists can be as simplistic or comprehensive as desired. I would suggest breaking down the list into major subsections, such as:

- Hardware used (and ability to interface with current hardware).
- Software provided (modules available), including documentation.
- Training available.
- Costs.
- Client lists.
- Future plans.
- Organizational data on the vendor.

I also would strongly advise collecting as much promotional material as possible (especially demo disks) to either take back with you or have mailed to your office where you will have an opportunity to perform a better review.

✔ Arrange a user meeting. This is a good opportunity to meet with your fellow colleagues and users of your present (or desired) RMIS vendor. You can obtain client lists from your vendor beforehand and prearrange a meeting in Atlanta. This is especially useful if you're considering the purchase of a new system.

✔ Plan a post-conference analysis. Regardless of the temptation to take care of the mounting stacks of work that have accumulated on your desk during your week's absence, you must plan for some time to spend analyzing the information you obtain at the RIMS conference. It is better you perform this analysis as quickly as possible since the information is most fresh in your mind. Perhaps you would want to make phone calls to various clients of vendors/systems you found interesting or you may use the opportunity to ask additional questions of those vendors in a more controlled environment.

As any seasoned veteran of conferences will tell you, planning is the foundation of ensuring a successful week. Prearranging meetings, documenting specific checklists and following through on evaluating the gathered data will return excellent results.

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

Wrongful termination may be covered

Continued from previous page

insured is a recognized, reasonable expectation of the policyholder.

In addition, complaints can be modified by the wrongfully terminated employee during the progression of litigation to include occurrence causes of action.

The mere possibility that a complaint can be amended to include potential causes of action against the policyholder triggers the duty to defend the policyholder.

And, a jury may find the policyholder liable for something less than a willful act such as negligence, which would trigger the duty to defend the policyholder. (See *Gray vs. Zurich*.)

In addition, the insurer may not rely on the "hindsight" test as a defense as to why the insurer refused to defend the policyholder at the outset of litigation.

Prudent insurers defend up to a summary judgment level or a successful declaratory relief act level of litigation, just to be on the safe side.

(For the hindsight test defense, see *Mullen vs. Glen Falls Insurance Co.*, (1977) 73 CA3d 163, 173.)

- Criminal battery. If the criminal statute requires "specific intent to injure" and the policyholder did not have the requisite state of mind, that would be an occurrence and a duty to defend would be necessary.

(See *Allstate Insurance Co. vs. Overton*, (1984) 160 CA3d 843.)

- Second-degree murder. There is no element of willful in the act or crime of second-degree murder, hence an "occurrence" would require a duty to defend. (See *Clemmer vs. Hartford Insurance Co.*) As a general rule, the duty to defend is absolute unless the tort claim has an element of malice (malicious prosecution) or the crime has an element of premeditation (first-degree murder in California).

In conclusion, if the insurer is to defeat coverage of wrongful termination claims in a standard form general liability policy based on lack of an occurrence, it must prove a non-occurrence.

Below are three types of non-occurrences:

- The insurer must prove that the policyholder *subjectively* expected or *subjectively* intended a resulting injury as a result of wrongful termination of an employee. (Implied exclusion theory based on policy language.)
- Or, the insurer must prove that the policyholder "willfully" terminated the employee; i.e., that the policyholder wrongfully terminated the employee with a preconceived design to inflict injury. (Implied exclusion theory based on the California Insurance Code Section 533.)
- Another theory is that the insurer must conspicuously, plainly and clearly exclude wrongful termination from coverage in order to negate any reasonable expectations of the policyholder that wrongful termination suits would naturally be a covered occurrence.

(Expressed exclusion in the policy or by way of an endorsement.)

Lawrence Agency names new president

William J. Mather has been named president of Lawrence Agency Corp. of Schenectady, N.Y. a unit of Lawrence Group Inc.

Mr. Mather joined Lawrence Group in 1970 and most recently was president of Senate Insurance Co., another Lawrence unit, and chief marketing officer for Lawrence Insurance Group.

Besides overseeing Lawrence Agency Corp., the nation's 29th largest brokerage based on 1987 revenues, Mr. Mather also will oversee A.W. Lawrence & Co. Inc., which provides association marketing and loss control services; Lawrence United Corp., which provides agency/brokerage services through independent agencies and acquires new agencies for Lawrence; and Lawrence Healthcare Administrative Services Inc., which administers employee benefits claims.

Also at Lawrence Agency Corp., **John R. Tomassi** was appointed senior vp and chief operating officer.

Other agent/broker changes:

Jerry Renske promoted to co-chairman of Alexander & Alexander of Ohio Inc. in Columbus. Also, **Ralph E. Hodges** named managing vp of the Columbus office.

Timothy N. Thalman, **Michael J. Marsolek** and **Larry E. DeBoer** promoted to senior vps of Bayly, Martin & Fay Inc. of Los Angeles.

John K. Latham Jr. joined Markel Service Inc. of Richmond, Va., as executive vp and chief operating officer, a newly created position. In his previous position, Mr. Latham was senior vp-operations with Virginia Professional Underwriters Inc.

John S. Emery named senior vp of Marsh & McLennan Inc. in Seattle.

Joseph A. Keenan appointed president of BCA Corp. of Ardmore, Pa.

Ronald L. Spicer joined Corroon & Black/Stump, Harvey & Cook Inc. as vp and production manager. Previously, Mr. Spicer was vp and production manager with Alexander & Alexander Inc. in Atlanta.

Paul M. Shimer joined Johnson & Higgins of New York as vp and senior international benefit consultant. Most recently, Mr. Shimer was head of the Eastern marketing region in New York for The Travelers Corp.

Jeff B. Weiner promoted to executive vp of Morton D. Weiner & Co. of Miami.

Linda R. Griffing promoted to president of Jardine Emett & Chandler Hawaii Inc. in Honolulu.

Mark R. Erion promoted to senior vp/chief financial officer and **David L. Eslick** to senior vp of Frederick Rauh & Co. of Cincinnati.

Ron Moreland joined Edward Jacobs & Co. of San Mateo, Calif., as vp-special risks. Most recently, Mr. Moreland was underwriting manager for CIGNA Special Risk Facilities in San Francisco.

Charles J. Helling promoted to executive vp of Laub Group Inc. of Milwaukee. Also, **Kenneth T. Sipiora** promoted to senior vp-commercial lines.

David William Harper joined Sullivan, Kelly & Associates Inc. of Los Angeles as vp. Most recently, Mr. Harper was an account executive with Associated Agencies Inc. of California.

Comings & goings: industry

Insurers

Robert J. Schleyer promoted to president of United Casualty Insurance Co. of America of Chicago. Mr. Schleyer succeeds Richard C. Vie, who continues as president of United Insurance Co. of America, the parent company of United Casualty. Both are subsidiaries of Los Angeles-based Teledyne Inc.

Reinsurance

Greg Perzell and **John H. Howard** joined G.J. Sullivan Co. Reinsurance of Los Angeles as treaty producer/vps. Mr. Perzell, who will be based in the home office, was previously account executive/vp with Sullivan Payne Co. Mr. Howard, who will be based in New York, also was previously an account executive/vp with Sullivan Payne.

Thomas J. Gallagher promoted to senior vp of Prudential Reinsurance Co. of Newark, N.J.

Excess/surplus

John L. Brozowski joined The London Agency Inc., an Atlanta-based managing general agency, as vp. Previously, Mr. Brozowski was executive vp of Crump Re Inc.

Glenda Matthews named vp-casualty at Stewart Smith Southwest Inc. of Dallas, a unit of Willis Faber Holdings Inc.

Other suppliers

Jeff Fortier joined J.W. Terrill Inc. of St. Louis as vp-commercial property/casualty. In his previous position, Mr. Fortier was underwriting manager for Aetna Life & Casualty Co.

Mr. Fortier

Ernest Buys promoted to vp-operations for PCS Public Contract Systems of Scottsdale, Ariz., a division of PCS Inc.

Maureen A. McGinnis joined actuarial and employee benefits consulting firm Donlon & Rysz Inc. of Chicago as benefits consultant. Most recenlty, Ms. McGinnis was benefits manager at Montgomery Ward & Co.

Martin Fry, **Glenn Langton**, **Chris Latham** and **Greg Taylor** joined Coopers & Lybrand's Actuarial, Benefits & Compensation Group as partners. Mr. Fry will be based in the Melbourne, Australia, office while Messrs. Langston, Latham and Taylor will be based in the Sydney, Australia, office. All four previously were partners of William M. Mercer-Campbell, Cook & Knight.

Michael A. Mentuck named vp of insurance appraiser M.F. Bank & Co. Inc. of Salem, Mass. Mr. Mentuck will be based in the Boston office.

Rich Glenn Jr. joined UniRisk Inc. of San Francisco as senior consultant. Most recently, Mr. Glenn was a principal of Glenn, Nyhan & Associates, a national insurance brokerage and risk management firm he helped found in 1980. ■

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Info

• A video explaining **federal antitrust laws** as applied to the insruance industry is available from the National Committee on Property Insurance. The 15-minute program, "Antitrust: A Compliance Blueprint," features a discussion between Francis A. Mancini, counsel and assistant to the president at NCPI, and Thane Scott, an antitrust attorney with the Boston law firm of Palmer & Dodge. For more information on free rental of the video, contact NCPI, 10 Winthrop Square, Boston, Mass. 02110; 617-423-4620.

• **"Self-Funding of Health Care Benefits"** discusses the extent and popularity of self-funding benefits, as well as risk management, regulatory and tax implications in a comprehensive reference guide available through the International Foundation of Employee Benefit Plans. The book is written by Carlton Harker, who is president of the employee benefit actuarial consulting firm ACS Group of Winston-Salem, N.C. Copies are available to IFEBP members for $32 and to non-members for $40. Prepaid orders for publication No. ISBN 0-89154-356-2 should be made to the Publications Department, International Foundation of Employee Benefit Plans, P.O. Box 69, Brookfield, Wis. 53008-0069; 414-786-6700.

• Copies of the 28-page "Start Taking Charge" booklet offering tips to **reduce stress** are available for distribution to employees. The booklet is published in conjunction with The Hope Heart Institute in Seattle, which also publishes the HOPE Health Letter. Articles discuss building self-esteem, myths about stress, 52 proven stress reducers and how to deal with anger. The minimum quantity order is 10 and the price for 10 to 24 booklets is $1.45 per copy. For quantities of more than 25, the unit price drops to $1.19, and the price drops as low as 81 cents each for orders of 20,000 copies. Orders may be sent to the International Health Awareness Center, 350 E. Michigan St., Suite 301, Kalamazoo, Mich. 49007-3851; 616-343-0770.

• The Oregon Department of Insurance and Finance has developed a three-part workplace program for addressing **acquired immune deficiency syndrome**. "The Manager's Guidebook" includes a six-step employer response plan including workplace policy formation, employers' legal obligations and an education program for management. "The Employee's Guidebook" includes a medical overview of AIDS, employee rights and responsibilities, infection control procedures and resources for additional information. "The Infection Control Guide" is a training presentation that discusses the steps to be taken when a workplace injury involves bleeding. The entire set is $11.50 and payment should be made to Department of Insurance and Finance, AIDS Education Materials, 21 Labor and Industries Building, Salem, Ore. 97310; 503-378-3200.

• A booklet summarizing the 1986 and 1987 program results of Health Risk Management Inc., an independent supplier of **hospital utilization review and managed health care** services, is available. The "HRM Fact Book" displays hospital utilization rates and the negotiated cost per hospital stay of HRM clients in comparison with HMOs and indemnity plans without managed care. Free copies are available by writing HRM, Department A, 8000 W. 78th St., Minneapolis, Minn. 55435; 800-824-3882.

• **"Public Officials Liability: Exposures and Coverages"** is a report published in the Betterley Risk Management Commentary published by Betterley Risk Consultants Inc. The study reviews the causes of claims involving public officials and discusses the availability of insurance to protect against these risks. Copies are $25 each and are available from Betterley Risk Consultants Inc., Department 1188, 446 Main St., Worcester Plaza, Worcester, Mass. 01608; 508-754-1704.

• **"Underwriting Guidelines for Property Insurance Plans"** is a manual detailing the latest underwriting techniques for the residual property market. Features updating the manual—originally issued in 1981—include a discussion of coastal area building codes, immediate certification and interim coverage and information on the Automated Property Loss Underwriting System. The manual is published by Property Insurance Plans Service Office, a division of the National Committee on Property Insurance. Copies are free to NCPI members and are $35 each for non-members. Written requests should be made to NCPI, 10 Winthrop Square, Boston, Mass. 02110; 617-423-4620.

• "Stripping Away the Barriers to a Healthy Heart" is an educational booklet discussing the **lifestyle factors that contribute to heart disease**. Included are diet and exercise tips aimed at preventing heart disease. Employers may receive a free copy by sending a request on company letterhead or with a business card enclosed. Up to 49 additional copies are $1.25 each, with quantity discounts available for more than 50. To order request product No. 1282 from Krames Communications, Department BHH; 312 90th St., Daly City, Calif. 94015-1898; 415-994-8800.

• **"General Liability Insurance: What it Covers,"** a booklet intended to give policyholders a working knowledge of liability insurance the policies, is a condensed version of the book by the same name. The booklet explains the three ways a business can become liable to pay damages: By committing a tort, because of a contract and because a law holds a business responsible. Author James R. Jorgensen also discusses the exclusions to the CGL policy. The booklet is $4 and the complete book, which is aimed at professional agents and risk managers, is $19.95 prepaid. Copies are available from BJ Publications, P.O. Box 791851; San Antonio, Texas 78279; 512-340-0348.

• **"Chemical Hazards in Building Materials"** is a 20-page loss control booklet examining some of the most common building materials, their potential health effects and ways to control exposure. Copies are available for $8 each by contacting the Alliance of American Insurers, Order Department, 1501 Woodfield Road, Suite 400 West, Schaumburg, Ill. 60173; 312-330-8587.

• A new handbook on how to explain **environmental pollution exposure and risk** is available free from the American Chemical Society. "Chemical Risk Communication—Preparing for Community Interest in Chemical Release Data," was prepared in anticipation of increased demand by the public for information about chemical risks following a July 1, 1988, federal rule that requires chemical manufacturers to report chemical inventories, waste treatment programs and chemical emissions into the environment for more than 300 chemicals. For a free copy of the handbook, send a self-addressed mailing label to Tanja Lewis, Department of Government Relations & Science Policy, American Chemical Society, 1155 16th St. N.W., Washington, D.C 20036.

• **"AIDS: An Employer's Guidebook"** is available from the U.S. Chamber of Commerce. Written by James Klein, current deputy executive director of the Assn. of Private Pension & Welfare Plans in Washington, D.C., and formerly with the Chamber, the book suggests programs and responses to the spread of acquired immune deficiency syndrome. Considerations such as disability and workers compensation questions, tort claims, right of privacy, hiring and firing decisions and AIDS testing and screening also are discussed. The guidebook is $20 for Chamber members and $33 for non-members and is available by requesting publication No. 0088 from the U.S. Chamber of Commerce, Publications Fulfillment, 1615 H St. N.W., Washington, D.C. 20062.

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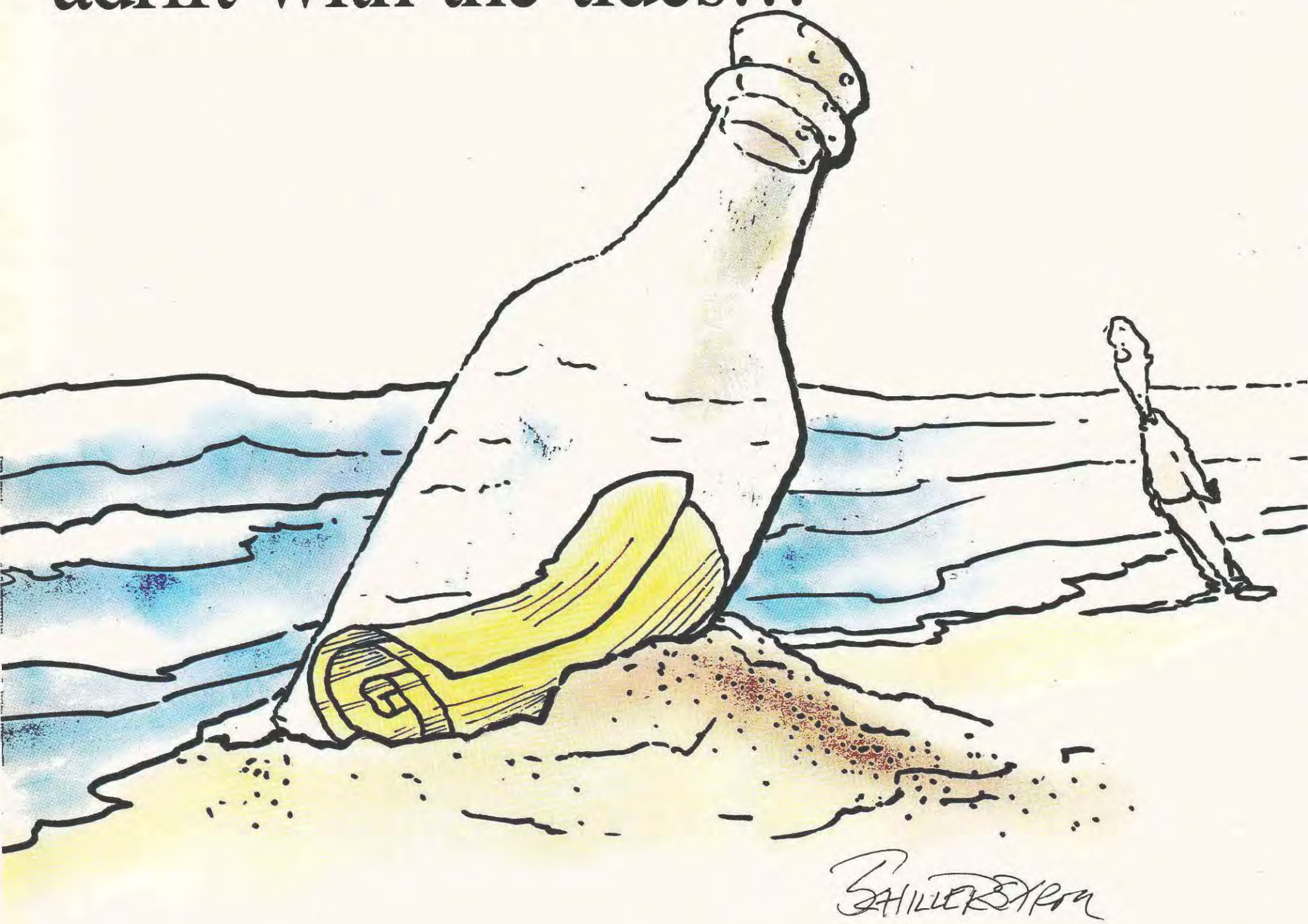

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Most employers oppose benefit tax: Study

By DEBORAH SHALOWITZ

Washington

WASHINGTON—Approximately 70% of employee benefit managers and consultants responding to a new survey say they oppose taxing employees on the value of employer-provided benefits.

However, if employee benefits were taxed, 61% of respondents said the tax should not be restricted to highly paid employees.

Many types of employee benefits—including group health and group term life insurance with a value of less than $50,000—are not included as taxable income to employees.

The survey of 185 employers and consultants was released last week by the Washington, D.C.-based Employers Council on Flexible Compensation.

The ECFC also announced that a coalition of business and other groups has formed to urge Congress not to tax employee benefits.

Members of the coalition include the U.S. Chamber of Commerce, the American Assn. of Private Pension & Welfare Plans, the AFL-CIO, the Health Insurance Assn. of America and the National Consumers League.

"Taxing employee benefits would reverse four decades of congressional support of tax incentives to spur the expansion of private benefit plans and would hurt millions of American workers," states a letter sent March 14 by the coalition to members of Congress. "We urge you to oppose such taxation."

Taxing employee benefits is "both bad tax policy and bad health policy," the letter continues. "The development of private employee group health insurance has opened channels of insurance to millions of workers regardless of age, sex, physical condition or character of employment. In doing so, the contributions of employers and employees have drastically reduced the pressure on charities, social and governmental services in general and Medicare and Medicaid in particular."

Filing fines

The Labor Department plans to assess penalties of up to $1,000 per day on employee benefit plan administrators that fail to file complete and timely annual financial reports.

The penalties, which will implement section 502(c) of the Employee Retirement Income Security Act, will apply to annual reports that must be filed for plan years beginning on or after Jan. 1, 1988, said a March 1 notice in the Federal Register.

The Labor Department also announced that employee benefit plans governed by ERISA must file annual reports on revised forms for plan years starting in 1988.

According to the Pension and Welfare Benefits Administration, the revised forms eliminate unnecessary information, solicit new information and simplify certain categories.

For example, under the new regulation, Form 5500—which must be filed by plans covering 100 or more participants—now includes:

- A new schedule C listing the plan's trustees; service providers, such as accountants, actuaries and investment managers; the compensation these service providers received; and a list of terminated service providers.
- An explanation of the reason for terminating service providers and an opportunity for terminated accountants and actuaries to comment on the stated reason for service termination.
- A restructuring of the statement of assets and liabilities and a more detailed break-out of administrative expenses of a plan.

Waste-handling cost

Compliance with a new federal standard requiring employers to follow certain safety procedures and train workers who handle toxic wastes will cost employers about $153.4 million annually, according to the Occupational Safety and Health Administration.

Workers protected by the new standard, which was published in the March 6 Federal Register, include firefighters, police officers, ambulance and hazardous materials personnel who respond to hazardous waste spills. It also applied to people working at hazardous waste storage, treatment and disposal facilities.

OSHA estimates the new standard will prevent 20 cancer deaths annually and from six to 20 deaths per year from cardiovascular, neurological, liver and renal disorders. OSHA also says the rule will prevent 1,925 injuries involving 18,700 lost work days annually.

The standard also is expected to prevent at least six deaths each year due to such causes as explosions, fires or releases of toxic gas.

The standard requires, among other things:

- Development by each hazardous waste site employer of a safety and health program designed to identify, evaluate and control safety and health standards and provide for emergency response.
- Training of employees before they are allowed to engage in hazardous waste operations or emergency response that could expose them to safety and health hazards.
- A preliminary evaluation by a trained person of a site's characteristics prior to entry to identify potential site hazards and to aid in the selection of appropriate employee protection methods.
- Implementation of a site control program to prevent contamination by employees. At a minimum this program must consist of a site map, site work zones, site communications, safe work practices and identification of the nearest medical assistance. Also required is the use of a "buddy system" as a protective measure in particularly hazardous situations so that employees can keep watch on one another to provide quick aid.
- Medical surveillance at least annually and at the end of employment for all employees exposed to any particular hazardous substance at or above established exposure levels. Medical surveillance also must by conducted if a worker is exposed by unexpected or emergency release.
- Air monitoring to identify and quantify hazardous substance levels.
- Implementation of a decontamination procedure before any employee or equipment may leave an area of potential hazardous exposure.

IIAA quits council

The Independent Insurance Agents of America is resigning from the board of directors of the Small Business Legislative Council because of the SBLC's support for repeal of the McCarran-Ferguson Act.

The SBLC, a Washington, D.C.-based coalition of 90 trade associations, sent a letter Jan. 31 to Congress urging repeal of the insurance industry's limited exemption from federal antitrust laws.

In the letter, the SLBC charged that "insurance companies throughout the nation are permitted to engage in anti-competitive activities."

Repeal of McCarran-Ferguson will "bring down auto, medical malpractice, general liability and workers compensation insurance rates," wrote SBLC Chairman Wayne Smith.

Furthermore, "companies would become more competitive—not just by lowering their prices, but by insuring people the industry has historically been reluctant to insure, by basing their rates on criteria different from those the industry has traditionally used and by defining their territories differently than the industry has traditionally defined them," the letter stated.

In response to the letter, the IIAA late last month resigned from the SBLC.

"It is unconscionable that a group whose purpose is to represent the interests of small business people has allowed itself to be so misled," declared Paul Equale, the IIAA's vp of government affairs.

"In reality, repeal of McCarran-Ferguson would cause an unparalleled upheaval in the insurance marketplace, forcing many small insurance companies out of business and severely constricting the consumer's access to available and affordable insurance products."

Firm contests fines

Empire Kosher Foods Inc. is contesting $1.4 million in fines levied against the company for alleged violations of federal safety and health standards.

The Occupational Safety and Health Administration proposed the fines against Empire Feb. 28 for allegedly not protecting workers against the dangers of repetitive motion injuries and illnesses and excessive noise.

OSHA said many of the alleged safety and health violations were willful—those in which an employer either knew that a condition constituted a violation or was aware that a hazardous condition existed and made no reasonable effort to correct it.

OSHA also charged that the Mifflintown, Pa.-based specialty food company violated federal injury and illness recordkeeping rules.

J. Ronald Swanger, executive vp of Empire, said the size of the fines is excessive, especially since Empire cooperated fully with OSHA's investigation. ■

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Alleghany bid

Continued from page 3

Instead, Alleghany argues that only the insurance department in the state in which an insurance holding company is domiciled should review an acquisition proposal, according to Theodore Somerville, Allegheny's vp and general counsel.

However, regulators and others contend that more than one state should rule on a proposed acquisition because such a system better protects policyholders in the states in which the insurer's subsidiaries are considered domiciled.

Regulators and attorneys warn that the litigation could have broad implications for policyholders.

"I don't think many people know about (the litigation), and if they did, it would knock their socks off," said Samuel Bolinger, deputy Indiana attorney general.

This is "the most serious challenge" ever made to states' model holding company statutes "because potentially it could lead to the unraveling of state regulation of insurance," said Eric Oxfeld, counsel to the Washington, D.C.-based American Insurance Assn. The AIA, in conjunction with the American Council of Life Insurance, has filed briefs supporting the regulators.

"This is the most determined challenge to insurance holding company statutes," said St. Paul's attorney Richard Urowsky, a partner with Sullivan & Cromwell in New York.

The litigation has a nationwide impact: 46 states and the District of Columbia have enacted statutes based on the Insurance Holding Company System Regulatory Act, a model law promulgated by the National Assn. of Insurance Commissioners.

In addition, Pennsylvania and Wisconsin also have adopted related legislation or regulations, according to the NAIC's model regulation service. Only Florida and Louisiana have failed to adopt any such legislation.

Under most states' statutes, a party seeking to purchase at least a 10% interest in a domestic insurer or a company that owns a domestic insurer must outline its plans in a "Form A" filing and obtain state regulators' approval. Ten percent is considered a "controlling" interest in an insurer, according to the NAIC model.

A regulator can reject the purchase if he or she decides, following a hearing, that the proposal would jeopardize policyholders' interests. The jeopardy could stem from questions concerning the purchaser's competence, experience or integrity. Or, it could result from other factors, including the fear that competition would be reduced following the acquisition or that the purchasers would make material changes in the insurer's business or corporate structure.

Regulators and others fear that if states' broad authority to approve changes in ownership is struck down, they would be powerless to stop unscrupulous parties from gaining control of insurance companies solely to loot their assets, leaving policyholders out in the cold.

In addition, other insurers would be damaged since the burden of an insurer insolvency may fall on state guaranty funds, which are financed through insurer assessments, Mr. Oxfeld said.

Without the model insurance company holding acts, regulators are "basically impotent," said Nebraska Insurance Director William McCartney.

"I can see legitimate concerns that regulators may have," said William Anderson, assistant vp and security analyst with Duff & Phelps Inc. in Chicago. "If a company has a significant book of business in a state, the regulator should have some say" over a significant acquisition, he said.

"I'm supportive of the current system" because it protects policyholders' interests, agreed Gloria Vogel, associate director at Bear, Stearns & Co. Inc., a securities firm in New York.

And, the AIA and the ACLI state in a brief filed in Indiana that the state "has a legitimate and manifest interest in the competence and integrity of those who control its insurers."

"If the acquirer is not responsible, competent and scrupulous in its management of the insurer, the company may be stripped of its assets, leaving its policyholders without protection. Even with the best system of regulation, the reporters are full of cases involving the demise, liquidation and 'rehabilitation' of insurance companies run by incompetent or unscrupulous management to the detriment of policyholders," the brief says.

Therefore, it is "critical to Indiana—and the policyholders its insurance laws protect—to establish upfront the solvency, competence and trustworthiness of those who seek control of its domestic insurers," the AIA and ACLI contend.

Others, though, question whether all states in which a holding company's units are domiciled should review an acquisition.

"I don't think they should have to go through a 50-state gauntlet," said Jon Harkavy, director of governmental affairs for the Risk & Insurance Management Society Inc. in New York.

Requiring such an approval process is like "giving lifelong tenure to the management of insurance companies," he said, adding that approach shields insurance company managements from market forces.

Alleghany initiated its bid in November 1987 when it informed the 10 states in which St. Paul units are domiciled that it intended to buy 10% or more of St. Paul's stock. Alleghany has thus far spent more than $200 million to buy nearly 10% of the insurer's shares.

Alleghany executives acknowledge that the company has since decided to seek 20% of St. Paul.

In addition, Alleghany has considered the feasibility of a complete takeover of St. Paul, according to internal company memos that were released during the states' hearings on the proposal (see story, page 37).

However, Mr. Somerville says Alleghany still plans to acquire only 20% of St. Paul's stock.

Despite this assurance, the internal memos, coupled with Alleghany's history of acquiring substantial equity positions in companies for a short period of time and then selling the stock at a profit, has caused some insurance commissioners to question Alleghany's credibility.

A few regulators concluded that Alleghany either was likely to subsequently seek a greater stake in St. Paul or use its 20% ownership to draw on St. Paul's assets without further regulatory intervention.

For example, North Dakota Insurance Commissioner Earl Pomeroy wrote last year in his decision rejecting Alleghany's purchase proposal that ". . .conditional approval to acquire additional stock up to 20% could allow Alleghany to later acquire 'effective control' of the St. Paul" by forcing the insurer "to repurchase its shares without prior review and approval of this office."

In addition, St. Paul says in a written statement that it is "convinced, based on information secured from Alleghany's own files during the discovery process, that Alleghany ultimately wants to acquire control of The St. Paul Cos. and would then break up and sell of pieces of the company for the benefit of Alleghany shareholders."

"We believe their intentions are detrimental to our insurance policyholders whose interests deserve to be considered at least as equally as those of Alleghany's shareholders," St. Paul said.

St. Paul argues that Alleghany could reduce St. Paul's surplus, which would hurt policyholders that purchase long-tail coverage like medical malpractice insurance, a St. Paul specialty, says Mr. Urowsky, St. Paul's attorney.

The regulators that have rejected Alleghany's bid generally argue that Allegheny has not met its burden of proof to show that the purchase of St. Paul stock would not negatively impact policyholders in their states.

For example, Nebraska Insurance Director McCartney ruled: "The financial condition of Alleghany is such as would jeopardize the financial stability of St. Paul or prejudice the interests of its policyholders."

In addition, "the plans and proposals which the acquiring party has to liquidate the domestic insurer, cause to declare dividends or make other distributions, sell any of its assets, consolidate or merge it with any person, make any material change in its business or corporate structure or management, are unfair and prejudicial to the policyholders of the insurer," Mr. McCartney said.

The Nebraska regulator also charged that "the competence and experience of Alleghany management, which would control the operations of St. Paul and its subsidiaries if Alleghany acquired control, are such that it is not in the interest of the public and the policyholders of St. Paul to permit Alleghany to make the proposed acquisition," the documents say.

North Dakota's Mr. Pomeroy said in his written rejection: "Alleghany has plans and proposals to liquidate the St. Paul assets or consolidate or merge it with another person, and to make other material changes in The St. Paul's business, corporate structure and management. . .These plans are unfair and unreasonable to policyholders of The St. Paul and not in the public interest."

He also questioned the competence and experience of Alleghany's management to run St. Paul.

Former Indiana Insurance Commissioner Harry Eakin rejected Allegheny's request because he said the acquiring parties failed to meet the burden of proof that the acquisition would not hurt Indiana-domiciled St. Paul units or that Alleghany would not liquidate or sell assets that may be "unfair and unreasonable" to Indiana policyholders.

Some of the regulators were especially concerned about prospective changes that might affect St. Paul units that play an important role in their states' insurance markets, especially in the medical malpractice insurance market.

For example, St. Paul Property & Casualty Insurance Co., the Nebraska-based St. Paul subsidiary, writes medical malpractice insurance for 70% of the doctors in the state, said Nebraska's Mr. McCartney.

Alleghany, however, says that suggestions that it could force St. Paul to take actions when holding only 20% of the insurers stock are ludicrous.

When observers see how "independent-minded and tenacious" St. Paul's management has been in opposing Alleghany's plan, it appears "very unlikely" that 20% would be "a controlling interest in the common meaning of the term," said Alleghany's Mr. Somerville.

Alleghany also responds to the regulators' arguments by noting its

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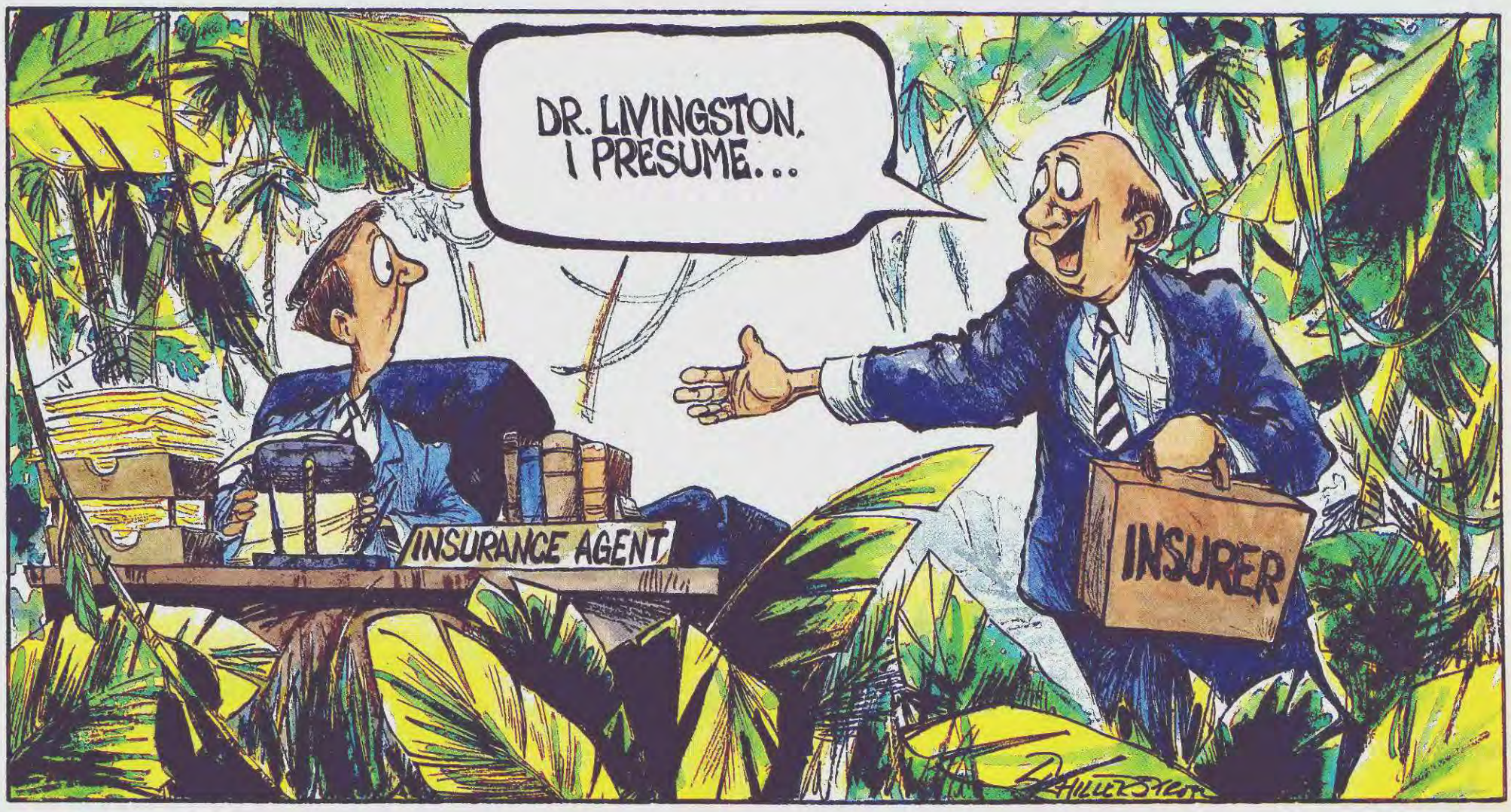

On common ground

Insurers, agents step up efforts to foster positive relationships

By LAURA MAZZUCA and LINDA J. COLLINS

Relationships nurtured by insurers and their agents since the end of the hard property/casualty insurance market of the mid-1980s are bearing fruit.

Insurers and producers concede that some major problems still must be ironed out. But, both groups now say they at least are communicating with each other.

Insurers and agents are attempting to galvanize their relationships through better communication efforts. For example:

- To facilitate an exchange of ideas for improving business and sharing market perspectives, insurers are focusing on company-sponsored producer councils to address agents' concerns.
- Producer associations have established programs in which association officials meet with insurance company executives regularly.
- Producers are working on their own to keep in constant touch with the insurers they represent.

Relationships between many producers and insurers reached a low two years ago as the property/casualty insurance market began pulling out of the most severe hard market in history.

In response to complaints by many agents and brokers that insurers had abandoned them when the market tightened in the mid-1980s, insurers noted many producers had severed long-standing relationships during the prior competitive market to gain the lowest rates for clients or to take advantage of more attractive incentives from other companies.

That problem now is moot because a year ago insurers ended the "culling process" began during the last hard market to cut their agency forces, said Jeffrey M. Yates, executive vp and general counsel of the Independent Insurance Agents of America.

"Generally, companies are appointing the same number or slightly fewer agents," he said. But, when they do appoint agencies, "they're being a lot more careful."

Ray C. Thomas, senior vp of marketing operations for CIGNA Corp. in Hartford, Conn., agreed that insurers now are more careful in agent selection.

"We are very cognizant in looking for appointments that are not whimsical or cycle driven" and look for producers who offer "productivity and operating efficiency" and other "survivor qualities," Mr. Thomas explained.

"There is a great deal more care taken" in the appointment process than there was a decade ago, noted R. Keith Like, executive vp-commercial lines group for Kemper Group of Long Grove, Ill.

"We used to appoint maybe 100 agents in the hopes that 20 would survive. Now we appoint 20 and expect all of them to survive," Mr. Like explained.

"We study their books of business much more carefully and we match much more studiously what the agent is looking for with what we are looking for. We

Continued on next page

Preferred programs coming under fire from some agents

By LAURA MAZZUCA

Top Brass. Excel. MVP. Elite. These words all connote VIPs: "very important producers."

Indeed, members of insurers' preferred agent programs are singled out and rewarded by insurers for producing large and profitable books of business and for exhibiting a high degree of professionalism.

But, while these exclusive producer clubs have grown in size and importance over the last decade, preferred agent programs concern some agents—including those who belong to them.

Some complain the arrangements are available only to large producers, leaving small agencies that cannot meet the minimum premium volume production requirements in the cold.

Others believe preferred producer programs can make insurers and agents beholden to each other, which may compromise the "independence" of independent agents.

Yet, preferred agent programs are flourishing, both because they have been instrumental in helping agencies and insurers grow and because they provide a system for providing incentives and rewards for prolific producers.

The advantages agents and brokers gain from preferred status include higher commissions, preferred

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Insurer Topics

Insurer topics

Agent concerns

Continued from previous page

tions at Bayly, Martin & Fay International Inc. of Fort Worth, Texas, which ranked as the 10th-largest U.S. broker based on 1987 revenues.

"The companies are coming after me," concurred Robert L. Sanford, president of Smyth, Sanford & Gerard Inc., a New York brokerage.

"When the market's soft, they buy me lunch; when it's hard, I buy them lunch," explained Mr. Sanford.

Producers want "stable and responsible" markets, said Martin P. Hughes, executive vp at Mack & Parker Inc., a Chicago brokerage.

In fact, most agents and brokers note that movement of business between producers and insurers is now at a minimum, mainly because "it costs the carrier and agent a lot of money to switch," pointed out James H. Davies, president of Davies & Associates in Murray Hill, N.J.

New York-based Fred S. James & Co. Inc. works closely with insurers to guarantee that their markets remain consistent, said Sidney A. Stewart Jr., vice chairman of the nation's fourth-largest brokerage. "We need consistency so we'll be able to understand the type of business insurers want," he added.

'What bothers an underwriter is what they don't know,' says Mr. Maxwell of Corroon & Black.

Another primary way to an agent's heart is through "competitive rates," according to a recent agent survey conducted by The Merritt Co., an insurance industry publishing company in Santa Monica, Calif.

Of the agents responding to the survey, 31% ranked low rates first in a list of 14 insurer attributes.

And, in the current soft market, insurers are delivering.

"It's pretty much a competitive market," though rate reductions are not as substantial as they were a year ago, pointed out Donald G. Weber, chairman and chief executive officer of Financial Guardian Group Inc. in Kansas City, Mo., the nation's 17th largest broker.

Although most agents and brokers see premium rates stabilizing, some cited incidences of extreme rate-cutting.

For example, Mr. Hughes of Mack & Parker noted that he had observed premiums for some risks being written at 30% to 40% less than last year by some large national insurers. He declined to name the lines or the insurers.

The agents surveyed by Merritt ranked service second in importance. Fourteen percent of those agents viewed "30-day service," or paperwork processing within 30 days, as most important.

In addition, 23% cited "poor service" as their primary gripe with their insurers, followed by "erratic service," at 18%.

Indeed, a segment of agents and brokers value service more highly than low premiums.

"We expect our insurers to run a good, tight ship, including doing things in a timely manner," said John Badgley, president of Key Insurance Agency in Mobridge, S.D. This means promptly mailing out policies and endorsements, processing claims and answering customer questions, he explained.

When insurers do not promptly issue policies and process claims, the agents take the heat from clients, Mr. Badgley pointed out.

"Agents can't fight the whole battle," he said. "We have to produce good products in a timely manner."

Respondents to the Merritt survey as well as agents and brokers in general also list good underwriting practices as a valuable insurer service.

"Underwriters are still requiring good underwriting information," said Richard Maxwell, senior vp and director of marketing for Corroon & Black Corp. of New York, the nation's fifth-largest broker. "In the last soft market, a number of insurers were lenient with that. Today, they may cut the price, but they want to understand the exposure."

In the last hard market, "you couldn't get an underwriter to talk to you," said Mr. Alcorn of Bayly, Martin & Fay. "Now it's a more controlled situation because carriers are adhering to basic underwriting guidelines. I don't see it slipping by—going into classes they wouldn't ordinarily go into."

However, most respondents to the Merritt survey rated company underwriters as only "somewhat" helpful, a complaint that some brokers felt was justified.

Mr. Weber of Financial Guardian said he receives frequent complaints from his producers about the lack of good insurance company underwriters, which he attributes to personnel cuts made earlier in the decade.

But agents and brokers have to provide their underwriters with complete information on their applications to help underwriters maintain high standards, noted Corroon & Black's Mr. Maxwell.

This information should include loss experience, type of risk, type of product produced, losses from the product for an extended period of years and any new acquisitions the client has made, he said.

"What bothers an underwriter is what they don't know," Mr. Maxwell said. Underwriters will give "a defensive quote" rather than a competitive quote, he said. And, if a broker holds back information, underwriters "probably won't quote at all," he observed. ■

Preferred agent programs

Continued from page 36A

underwriting services, financial assistance with automation and perpetuation, low guaranteed loans and an array of consultant services.

In return, agents and brokers that accept those privileges take on the responsibility of promising the insurer a larger volume of business, a crack at the agency's best accounts and one of the top three slots among the agency's insurers.

If handled correctly, preferred agent arrangements can provide both financial and personal benefits for producers and insurers, said Don Himes, managing vp-retail division of Poe & Associates, a Tampa, Fla.-based brokerage.

"By the very nature of what's put together (in a preferred agency contract), it's a more personal relationship," said Mr. Himes. "It's a chance to build those people-to-people bridges that make a relationship."

Preferred agent programs make "good business sense in efficiency and in terms of sales and underwriting results," concurred R. Keith Like, executive vp-commercial lines group for Kemper Group of Long Grove, Ill.

Since the total number of agencies in the country is shrinking, "it's our job to be on point to determine who's going to sift out and be a winner," agreed Ray C. Thomas, senior vp of marketing operations for CIGNA Corp. in Philadelphia.

Hartford Insurance Co.'s VIP program offers the insurer a chance to forge an "overall business relationship" with its agents, rather than just an insurance relationship, explained F. Herbert Brantlinger, vp of marketing.

"I think there's a place for them (preferred agency contracts)," agreed Robert H. Hilb, president of Richmond, Va.-based broker Hilb, Rogal & Hamilton Co.

An agent who has preferred status can get faster quote turnaround and more responsive underwriting, even on "a questionable piece of business," which can mean the difference between success and failure in a tight market, said Bruce C. Dunbar, president and chief executive officer of broker McGriff, Seibels & Williams Inc. in Birmingham, Ala.

For example, because of McGriff, Seibels' affiliation with St. Paul Cos. Inc.'s Top Brass program, it placed "a ton" of business with the St. Paul, Minn.-based insurer during the last hard market, said Mr. Dunbar.

Indeed, "the proof of the pudding" on whether preferred programs work

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lies only in a hard market, where insurers can prove themselves by continuing to write business for their preferred agents and brokers, said Conrad Foa, president of Foa & Son, a New York brokerage.

"In a soft market, their importance fades. In the hard market it's the entry that makes the difference of survival or finding a reasonable market," he said.

Even some risk managers see the programs as a plus for insurance buyers.

"It's more of an advantage to have that (guaranteed) market," said Marge P. Layne, risk manager for the California & Hawaiian Sugar Co. in Concord, Calif. "I think, as a buyer, it's a benefit to me unless it's abused to the point where it's very obvious," she added.

"The consumer could benefit from the solid relationship between producer and insurer," agreed Jon Harkavy, director of government affairs for the Risk & Insurance Management Society Inc. in New York.

Kemper's Mr. Like explained that insurance buyers can benefit from preferred agency programs because "in some cases the agent with a preferred agency contract has a little leverage that others don't have," such as the ability to secure a slightly better renewal price or better consideration from insurers on a more difficult account.

But while many view preferred producer arrangements as beneficial, others believe "preferred" is merely a euphemism for "discriminatory," and that insurers are using the programs not simply to reward good producers, but to winnow out the deadwood among their agents.

That strategy presents an ironic Catch-22 for smaller, less profitable agencies that cannot meet the premium requirements set for the programs but that can benefit from them the most.

"The industry is headed toward an era where you have to be a big producer to get the attention of the insurers. . . .If I were a little agent, I'd be upset," said Mr. Hilb of Hilb, Rogal & Hamilton.

"Preferred agency contracts are a smoke screen to the real issue that the smaller agent is in a real squeeze," said Mr. Himes of Poe & Associates. "Insurers can't afford to focus on the little guys when they (insurers) can do it in big chunks."

Although he believes that a preferred producer program is "a good thing for the industry because it recognizes what is necessary for distribution," these programs hurt "the lower 50% of the agency system"—small agencies that can't qualify for preferred agent status, said Gene McCrory, president of Northern American Insurance Agency in Oklahoma City. Mr. McCrory also serves as chairman of the New York-based Independent Insurance Agents of America's agency contracts committee.

"Preferred agent programs? I haven't even been able to talk to an insurer about them in four or five years," said Randy Blaine, owner of Multi-Line Insurance Agency, a one-man operation in Gillette, Wyo.

Most national insurers require an agency to place at least $300,000 in premium volume with them to qualify for preferred status, said Mr. Blaine. Since his agency produces less than $1 million in premiums per year, it is difficult to place that much business with just one insurer.

But smaller agents like Mr. Blaine look in other directions for the capacity they need. Mr. Blaine's agency represents many regional insurers, which he noted can offer him "all the advantages of a preferred agent program," without the small print. His insurers have helped his agency with increased profit-sharing, computer installation and service.

"When I need help with this or that, I go to my companies for individual deals," Mr. Blaine added. And, regionals "don't jump from agent to agent like they do in the big city," he added.

Roger Murphy, vp of marketing for Harleysville Mutual Insurance Co. in Harleysville, Pa., agreed that as a regional insurer, "We're looking to pick up agencies that the big nationals are neglecting." And Harleysville can offer small suburban and rural agents more personal contact than a national insurer, he added.

Most national insurers readily admit that preferred programs are part of their strategy to reduce expenses by concentrating efforts and finances on the most productive agents.

While the Hartford's Mr. Brantlinger does not feel that the insurer's preferred agency program discriminates against other agents who represent Hartford, he did acknowledge that "it's the old adage that those who do more for us are more likely to get the bulk of our resources."

"Like many companies, we discovered a limited number of agents had a lot to do with our results, and we wanted to recognize that," said Jerry W. Haug, vp of marketing for St. Paul.

"There's no question that they (preferred programs) discriminate, but that's the very thing that agents have told us we need to do," he said.

In addition to freezing out the little guy, some industry observers believe preferred producer programs compromise the relationship between insurers and producers.

With a preferred producer arrangement, it can become too easy for an agency to rely predominantly on the lead insurer, said Lyle Roth, vp of Koelbel & Co., a Denver brokerage, and chairman of the National Assn. of Professional Insurance Agents' company relations committee. "In a relatively short span of time, an independent agent can become not-so-independent."

"I don't think they serve the best overall interest of independent agents," said A. William Bailey, president of Bailey Insurance & Financial Services in Waco, Texas. Mr. Bailey is also a senior vp for the IIAA.

"I don't think it's right for a company to give insureds better pricing from one agency or another," said Mr. Bailey. "It's discriminatory against the customer," he said, noting that a client's selection of an agency will be based solely on price "if there's no demonstration of greater professionalism from one agency to another."

But while Kemper's Mr. Like said that there is a potential for agents to lose some freedom of selection if they do not choose their contracts carefully, agents can avoid this conflict by carefully selecting which preferred agent contracts they accept and by finding insurers that do not require right of first refusal on accounts.

"If they choose their companies carefully and do the right job, they will have all the flexibility they need," Mr. Like stressed. "An agent who wants to maintain independence can keep that if he is not tied down to one or two companies."

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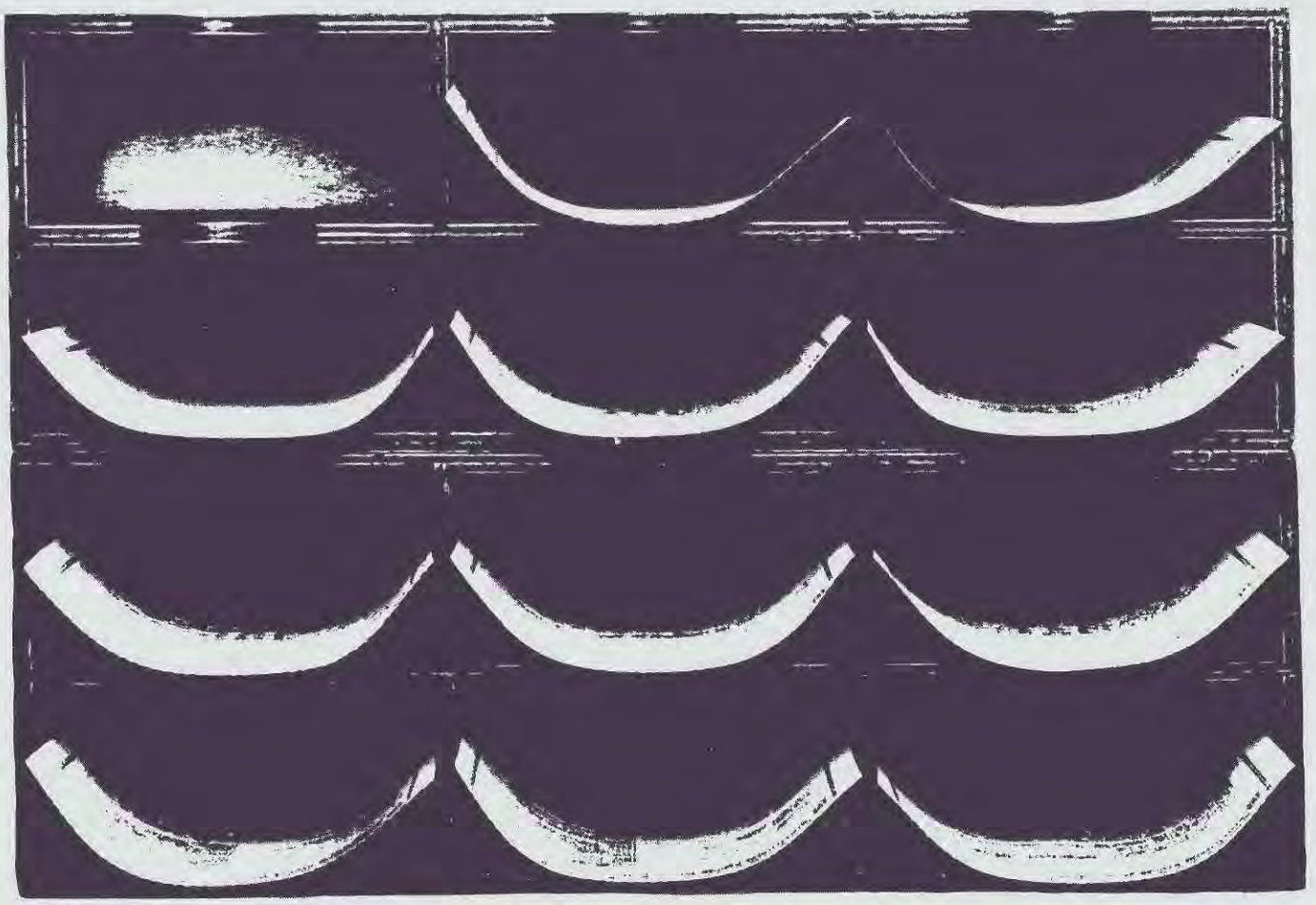

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Insurer topics

Preferred agents

Continued from previous page

The issue has even gone to court. Last March, a small California broker sued CIGNA Corp. claiming that his lack of preferred status caused his company to lose its largest property/casualty account to an agent that belonged to CIGNA's COMPAR preferred agent program (*BI,* March 21, 1988).

A CIGNA spokesman and an attorney for the plaintiff, Stone Insurance Brokers of Pasadena, would not comment because of ongoing settlement negotiations.

But RIMS' Mr. Harkavy points out that "the possibility that a policyholder could be compromised by a producer-insurer relationship exists generically," so preferred status doesn't imply an additional threat.

It's highly unlikely that a knowledgeable risk manager would be taken in by a producer deliberately steering business to an inappropriate insurer, because risk managers know the market and the going commission rates, commented Ms. Layne of C&H.

Still others theorize that preferred agent programs can drive up insurance rates.

For example, if preferred agents are continually paid higher commissions, insurers may eventually have to compensate by passing the expenses to the consumer through rate increases, said J. Robert Hunter, president of the National Insurance Consumer Organization of Alexandria, Va.

Kemper's Mr. Like disagreed. The efficiencies of writing a higher volume of business through fewer agents more than makes up for the costs of any added perks and commissions preferred agents might receive, he observed. In addition, market competition dictates that insurers maintain competitive prices for their clients.

If the existence of preferred status programs has affected the marketplace, the marketplace has also affected the programs.

At first, early in the 1980s when many of the programs were introduced, preferred agent perks were centered around profit-sharing and higher commissions, noted Martin P. Hughes, executive vp at Mack & Parker Inc., a Chicago brokerage.

But as the market softened in the last two years and insurers were forced to cut costs, the emphasis shifted to perks such as consulting services and "management enhancements," though the financial considerations are still important, he said.

"Increased commission is the least significant aspect that makes it attractive," said Robert Nicosia, president of Pilgrim Insurance Agency in Nutley, N.J., which has a preferred agency contract as part of Crum & Forster Inc.'s "Custom Agency" program for commercial lines.

Instead, the most attractive element of preferred agent programs is "how fast they can move" on underwriting, policy processing and other essential services, Mr. Nicosia said.

St. Paul's Mr. Haug acknowledged that the insurer's preferred agents are "subject to the most lenient underwriting" of any of its agents.

And, in addition to more competitive pricing and the ability to get better consideration on more difficult accounts, Kemper's Mr. Like also noted that preferred agents can sometimes have claims adjusted more quickly than other agents.

Other perks may not be essential but can certainly enhance an agency's luster.

The preferred agent programs that Murray Hill, N.J.-based Davies & Associates has joined offer financial assistance for advertising, automation, marketing and consulting services, said James H. Davies, president of the $10 million agency.

Davies & Associates has already financed a new producer and a computer system with the assistance of such programs. "If you ask them, and they won't foot the bill for all of it, they will for part of it," he added.

While there are admitted pitfalls involved in preferred agent programs, most producers agree that, like it or not, such programs are a permanent part of the industry landscape.

"It's an unavoidable fact that not all agencies are created equal. . . .The old days of business as usual when we all got the same and did the same are gone," said Pilgrim's Mr. Nicosia. "We're talking about entrepreneurial business here, not socialism."

According to a June 1988 national survey conducted by The Merritt Co., an insurance publishing company in Santa Monica, Calif., 60% of the agents polled have a preferred contract with at least one insurer.

A similar survey conducted last year by the Independent Insurance Agents of Texas indicates that of the 750 Texas agents responding, 30% were members of at least one preferred agent program.

Not surprisingly, larger agencies are more likely to have preferred agent agreements.

Only 10% of the respondents to the Texas survey with less than $1 million in annual premium volume had one or more preferred contracts, compared with 35% of those in the $1 million to $3 million category; 70% of those in the $3 million to $5 million category; 78% of those in the $5 million to $10 million category; and 90% in the $10 million and over category.

Preferred agent programs seem to be appreciated by those who have them and are coveted by those who don't.

The Texas survey indicated that nearly 75% of the 358 agents who have never belonged to a preferred agent plan said they would like one, and 83% of those who have lost preferred agent agreements said they are actively seeking a new one.

Agent/Broker Editor Linda J. Collins contributed to this article.

Preferred programs have variety of goals

By LAURA MAZZUCA

Insurers generally structure their preferred agent program to meet different needs and most are willing to work closely with agents and brokers to further customize the arrangement.

"Every one of our programs is custom-designed, agency by agency, by branch managers," explained Jim Carey, senior vp-commercial insurance, underwriting and product management for Fireman's Fund Insurance Cos. of Novato, Calif., referring to the insurer's "MVP" commercial lines preferred agent program.

While most insurers require similar commitments from their preferred agents—such as a minimum premium volume, sound profit history, regional compatibility and that the insurer is one of the agent's top three markets—what an insurer offers its preferred agents depends mainly on what the insurer wants from those producers.

For example, if an insurer is concerned about the perpetuation of the agencies that represent it, it will offer consultation and financing to its preferred agents. Or, if marketing is a big consideration, the insurer could offer marketing assistance.

However, there is a standard "laundry list" of perks generally offered to insurance agents with "preferred" status, including: educational programs and seminars, low-interest guaranteed loans, advertising assistance, higher commission levels, bonuses and underwriting authority.

While many insurers require a preferred agent to maintain a minimum premium volume, others are more concerned with the agency's growth potential or financial stability.

Kemper Group, for example, generally targets established agencies for its preferred agent program but has no minimum premium volume requirement, said R. Keith Like, executive vp-commercial lines group for the Long Grove, Ill.-based insurer. "We simply want enough volume to make it efficient."

Agents in Kemper's "Excel" personal lines program and the "Partner Producer Program" for commercial lines agents are issued a standard Kemper agency contract, said Mr. Like.

However, preferred agents are required to institute a custom-made marketing program, which is negotiated by Kemper and the agency, Mr. Like said. They also must establish a perpetuation plan and be automated.

The emphasis of Continental Corp.'s "Circle" program also is on formulating an annual agency marketing plan and that's one of the major benefits an agency realizes from the program, said Walter Tarver, vp-marketing for the New York-based insurer.

In fact, the Circle program, launched in January 1981, was specifically developed for long-term marketing distribution, "not as a reward for last year's performance," he stressed.

Of Continental's 3,500 agents nationwide, about 1,500 currently are Circle agents.

After the insurer targets an agency for preferred status, the local Continental office dispatches a team of Continental marketing, sales and service personnel to help the agency develop a marketing plan by line of business based on premium volume and policies sold, said Mr. Tarver.

This plan sometimes calls for reduced emphasis on or elimination of some lines of business, he added.

"We're not always seeking to address new business," Mr. Tarver said.

Aetna Life & Casualty Co.'s "Elite" commercial lines program was initiated in 1984 to assist its agents in creating an annual business plan and to develop long-range planning, including automation and perpetuation advice, said Ken May, marketing director-commercial insurance division for the Hartford, Conn.-based insurer.

The insurer initially targeted agents already in the field, "people who had proven over time that they had the same market appetite" as the Aetna home office, said Mr. May.

Today, the basic criteria for joining the program are the same, but Aetna now seeks preferred agencies that generate high revenues per employee and per producer. An Elite agency can produce from $250,000 to $10 million in annual premium volume; no minimums are set, he added.

Aetna's 49 field offices control the preferred agency contracts and manage the program, said Mr. May.

The Elite agreement is a stand-alone and doesn't change the agency's standard contract with Aetna, he said. "It's a relationship-driven contract rather than a contract-driven relationship."

Some insurers' programs stress other concerns.

For example, when The St. Paul Cos. Inc. started its "Top Brass" program in 1984, most of the principals of its candidate agencies were ready for retirement, said Jerry W. Haug, vp of marketing for St. Paul in St. Paul, Minn.

As a result, a formal perpetuation plan became a prerequisite for admittance into the preferred producer program.

To this end, St. Paul consultants help to identify future agency leaders within the company and work with the targeted preferred agency to develop a financial plan.

Continental Corp.'s Circle program, launched in 1981, was specifically developed for long-term marketing distribution, 'not as a reward for last year's performance,' says Walter Tarver.

In addition, the insurer even offers guaranteed loans to buy out the preferred agency if perpetuation isn't feasible, added Mr. Haug.

The agency also must follow a formal marketing plan that requires that it place 30% of its eligible business with St. Paul over the next five years.

Other insurers also want both agency commitment as well as minimum premium volume.

For example, Hartford Insurance Co.'s "VIP" program for personal and standard commercial lines business requires agents to produce a minimum premium volume for the insurer, as well as have a five-year strategic plan specifying goals, resources and annual objectives, said F. Herbert Brantlinger, vp of marketing for the Hartford, Conn.-based insurer.

The volume requirement varies depending on the size, location and expertise of the agency, he added.

Continental's Circle agents must count the insurer as one of their top three insurers, as well as place a minimum of $500,000 in annual premiums with it, said Mr. Tarver.

Some smaller, regional insurers also require minimum premium volume standards from their preferred producer program members.

Harleysville Mutual Insurance Co. of Harleysville, Pa., a mid-Atlantic regional insurer, has developed the "Honors" preferred agent program, with criteria similar to that of national insurers, said Roger Murphy, vp-marketing. However, the minimum premium volume requirement—between $1 million and $1.5 million—is generally lower than that of the nationals, he added.

While insurers require differing premium commitments from preferred agents, CIGNA Corp.'s COMPAR program has a unique requirement: Under the program's "one-company concept," the agent must show virtually all of its business to CIGNA.

"It's an opportunity for us to increase the operating efficiency of an agent" by concentrating efforts and dealing with the agent through automation, said Ray C. Thomas, senior vp-marketing operations for CIGNA Corp. in Philadelphia.

COMPAR, which debuted in 1971, counts 244 agencies as members. These agencies generated $740 million, or 24% of the insurer's business, at year-end 1988, said Mr. Thomas.

However, "In no way do we view our COMPAR agents in any other way than independent," he added, since the agents can place some specialty lines with other insurers.

Premium volume requirements are not as important to some insurers as an indication of strong financial performance and a solid book of business.

For example, under Fireman's Fund's MVP program, the insurer does not require agencies to produce a minimum premium volume, but instead expects agencies to have outperformed the insurer's branch office in that region in terms of profit margin over a three-year period, said Mr. Carey.

And, Aetna's Elite program requires the successful candidate to show three to five years' profit and growth and be operating in a favorable economic and regulatory climate, said Mr. May. "Eventually, an Elite agency is one that will outperform Aetna," he added.

Location is another important consideration when an insurer is appointing a preferred agency.

"We don't want them tripping over other Kemper agents for a piece of the business," said Mr. Like. Rather than saturate a given region with preferred agents, Kemper wants to keep them spread out, he explained.

"You will find us looking a lot more critically at regulation and profitability on where we place our preferred agents," said Mr. Thomas of CIGNA. "It's our job to be on point to determine who's going to sift out and be a winner."

Since Hartford traditionally has concentrated on the East Coast and needs to expand its market penetration, the insurer has targeted the Midwest and Southeast and plans to add about 25 new VIP agents this year, said Mr. Brantlinger.

But, unlike some insurers, Hartford wants to keep the preferred target small: Of the insurer's 6,500 agents, only 154 are VIP agents.

"Our goal is not to have a large number of agents in this program," he said. The insurer plans to have only 300 VIP agents.

For insurers with preferred programs, the rewards can be great.

For example, Harleysville's 181 Honors agents produced 45.3% of its 1988 written premium, said Mr. Murphy. The company has a total of 1,100 agents.

While Elite agencies comprised only 8% of Aetna's total agency force in 1988, they generated almost 33% of the insurer's total commercial lines and bond volume, said Mr. May. Aetna hopes to increase this percentage to as high as 50% in the next five years by adding more Elite agencies.

And, while Mr. Haug concedes that there have been "some disappointments" with St. Paul's Top Brass program—the insurer had to eliminate a handful of preferred agencies because of "operational conflicts"—the results have been satisfactory.

The 217 Top Brass agents generated 22% of the insurer's volume in 1988, a figure St. Paul wants to eventually increase to 35%, he said. Top Brass agencies constitute 4.3% of St. Paul's 5,000 agencies. ■

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Insurer topics

Regional insurers seek small agencies

By LAURA MAZZUCA

While many large, national insurers may not court small insurance agencies with preferred agent programs, regional insurers still give these producers special attention.

Rather than seeking out agencies with large premium volumes as preferred producers, most regionals want to work with smaller agents.

"Many large nationals believe that small agencies are not cost-effective; we don't think this is true," said Robert A. Anker, president and chief operating officer of American States Insurance Co., an Indianapolis-based regional that wrote $796 million in 1987 net premium volume.

"While we have the capacity and ability to write the large stuff, we don't seek it out because we have the distinction of being able to write small business and make money out of it," Mr. Anker said.

Regional insurers often do not burden small producers with minimum premium volume limits and offer a high degree of personal service, insurers and producers report.

And, they provide small agents with markets they can count on.

"What we provide agents with mainly is stability; they know where they're at with us," said Bob J. Smith, vp of marketing for Farmers Alliance Mutual Insurance Co., a 100-year-old multiline mutual based in McPherson, Kan.

For small, rural agencies—especially those with less than $3 million in annual premium volume that operate in sparsely populated areas—regional insurers were "significant lifesavers" in the last hard market and continue to offer stable support, pointed out Lyle Roth, vp of Koelbel & Co. of Denver and chairman of the company relations committee for the National Assn. of Professional Insurance Agents in Alexandria, Va.

Regional insurers' "organizational structure makes them better able to react in these situations," said Herbert G. Treweek, executive vp of the Florida Independent Insurance Agents Assn. and chairman and chief executive officer of Cannon-Treweek Agency Inc. in Gainesville, Fla.

Regionals as a rule do not offer preferred-agent programs. But, preferential treatment is the market stability regional insurers provide.

"By their very decision of geographic limitation, they are committed to a particular area" and are more selective of their agents, said Patricia A. Borowski, the PIA's vp of government and industry affairs.

Thomas C. Mare, president of Tom Mare Insurance Agency, a $1.7 million premium volume agency in Fort Myers, Fla., that specializes in mobile home coverage, praises regional insurers for their market commitment.

Although he lost contracts with five large insurers during the hard market of the mid-1980s, his arrangement with regional insurer American Federation Insurance Co. of Grand Rapids, Mich., has "pretty much doubled the book" of business his agency has written since the contract took effect, he said.

"There is a lot of pulling back" by national insurers in the economically depressed rural areas of states such as Georgia and Louisiana that are victims of the farming and oil crises, said Jerry T. Hargrove, chief executive officer of agency Northside Insurance Services in Atlanta.

In rural regions, national insurers often either will stop writing a line of coverage that may be an agency's lifeblood—such as farm and livestock coverage—or "place such high (premium volume) requirements that small rural agents could never reach that goal," said Darla L. Lyon, deputy director of the South Dakota Division of Insurance in Pierre.

But not all national insurers have erased rural agencies from their marketing picture.

"We don't have a problem with small agencies, only with small agencies that don't want to get bigger," explained Ken May, marketing director of the commercial insurance division of Hartford, Conn.-based Aetna Life & Casualty Co.

And Philadelphia-based CIGNA Corp. did not abandon the Florida market during the recent hard market, pointed out Ray C. Thomas, senior vp of marketing operations.

"Our precedent in this has been very, very excellent," he said. "If there is any type of window (of opportunity) in which we can protect our agents, we will."

"There are all levels of professionalism in our agency plant," said F. Herbert Brantlinger, vp-marketing of Hartford Insurance Group of Hartford, Conn., which appointed 100 various new agents last year and expects to add "that or more" in 1989.

Regional insurers' willingness to use smaller agencies does not mean regionals are not selective in their agency appointments.

For instance, Farmers Alliance requires a minimum written premium volume of only $50,000 from new appointments to qualify for contingency payments if the agency's book of business produces a good loss ratio, Mr. Smith said.

However, the insurer requires its agents to: have a fully funded perpetuation plan, demonstrate that clients need the insurer's products and be professional in all aspects of operations, Mr. Smith said.

Farmers Alliance, which operates in 11 states, mainly in the Midwest, is represented by 864 agents operating mostly in suburban areas and in a region's largest cities. An average agency's annual premium volume is about $500,000, Mr. Smith said.

Milbank Insurance Co. of Milbank, S.D., does not impose a minimum premium volume for its rural and suburban agencies. It is more interested in market penetration.

"If the Aetnas and the others pull out of these towns, we'd like to jump into that vacuum," explained Russel Fischer, branch manager.

Milbank Insurance was acquired by a unit of Royal Group Inc. of Charlotte, N.C., in 1982, which sought to penetrate the South Dakota market and enter the personal lines market.

However, most regional insurers generally impose lower premium volume requirements than national insurers do in appointing an agency.

For example, American Concept Insurance Co. of Rapid City, S.D., is especially geared to servicing small, rural agencies producing between $30,000 and $40,000 in annual premiums for the insurer, said Paul Goyette, vp of marketing.

American Concept, a subsidiary of Providence Washington Insurance Co. of Providence, R.I., writes personal lines business in the Dakotas and Utah. The insurer is represented by about 300 agencies in the three states.

"Most (national insurers) don't want to spend the time with small agencies like these. But, put them all together, and it's good volume," Mr. Goyette said.

But, some larger insurers also recognize that small agents can produce profitable business.

An example is Ohio Casualty Insurance Co., which wrote $1.4 billion as a group in net premiums in 1987, does not require a large premium volume of an agent before paying contingency commissions, said Robert M. Gillespie, agency research and development/marketing for the Hamilton, Ohio-based insurer.

While many national insurers require producers to generate at least $200,000 in premium volume to qualify for contingency commissions, Ohio Casualty's minimum premium volume requirement is $2,500, he said.

The average annual written premium volume of an Ohio Casualty Insurance Co. agency is $250,000, Mr. Gillespie noted.

Regional insurers also deal with fewer producers than national companies do, so producers feel they receive more personal service from regional companies.

And, like the national companies, many regionals also are able to offer their agencies computer interface.

American Federation offers many of the service perks of large national insurers, such as interfacing with agencies to provide underwriting and other services through the insurer's computer system, said Mr. Mare. ■

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Business Insurance

Alleghany proposal

Continued from previous page

healthy financial condition—the company reported net income of $46 million in 1988 and $61.1 million in 1987—and its ready access to capital.

The company also notes the improvements it made in the financial health of the troubled Shelby Insurance Group, which it purchased in December 1986.

"At the time of its acquisition by Alleghany, Shelby was in immediate need of new capital," according to Alleghany's 1987 annual report.

Following its acquisition of Shelby, Alleghany immediately contributed $40 million in cash and about $7 million in other assets to the insurer's surplus, followed by an additional $2 million contribution in 1987, Allegheny reports, adding that Shelby's surplus rose to $45.1 million at year-end 1987 from $7.6 million on Sept. 30, 1986.

Instead of appealing the four commissioners' negative findings to state courts, Alleghany asked federal district courts to declare the state holding company statutes invalid and grant injunctive relief.

Attorneys for regulators and St. Paul, however, argue that Alleghany's appeal to the federal courts is premature and should be dismissed because of the principle of "abstention," which holds that federal courts should abstain from preempting state court deliberations on issues of state interest.

Alleghany, however, turned to the federal courts for its appeals, allowing the deadlines for appeals in the state courts to pass.

Thus far, U.S. district courts in Nebraska and Wisconsin accepted the regulators' arguments and dismissed Alleghany's federal court actions. Alleghany currently is appealing those decisions to the 8th U.S. Circuit Court of Appeals in St. Louis and the 7th Circuit in Chicago, respectively.

However, U.S. District Courts in North Dakota and Indiana have rejected the regulators' abstention requests and sided with Alleghany.

In addition, a U.S. District Court judge in North Dakota, the only jurist so far to consider the constitutionality of the state holding company laws, has sided with Alleghany.

Chief Judge Patrick Conmy of the U.S. District Court for the District of North Dakota Southwestern Division ruled late last year that North Dakota's holding company statute was "purely economic protectionism of those currently in control of the insurance company."

He also found that the state law violates the U.S. Constitution's commerce clause, which prohibits undue interference with interstate commerce.

"Certainly Congress intended the McCarran-Ferguson Act to restore state taxing and regulatory power over the business of insurance, but it did not intend to give the states unlimited power over the business of insurance companies," Judge Conmy said.

"Accordingly, when a state activity is aimed at regulating the business of insurance it is invulnerable to commerce clause challenges, but where the activity regulates in an area other than the 'business of insurance' the McCarran-Ferguson Act does not shield it from the commerce clause despite the fact that the law applies to insurance companies," the judge ruled.

North Dakota's Mr. Pomeroy is appealing Judge Conmy's ruling to the 8th Circuit in St. Louis. This appeal will be consolidated with Allegheny's appeal of the Nebraska decision.

Mr. Pomeroy's rejection of the Alleghany proposal remains in force until a final federal court ruling is issued, an attorney for the North Dakota Insurance Department said.

In related legal action, a state appellate court in Minnesota is considering whether the state's constitution grants a state district court judge the authority to review the state insurance regulators' decisions. ■

Farmers buyout may herald more takeovers

By MEG FLETCHER

Last year's acquisition of Farmers Insurance Group by Batus Inc. likely will have a trailblazing effect, says Ms. Morrissey of Firemark Consultants Inc. The Farmers 'takeover showed it could be done. I think we will see more of them.'

Alleghany Corp.'s efforts to acquire a portion of The St. Paul Cos. Inc. may herald more insurance company mergers and acquisitions, an industry analyst says.

Previously, such acquisitions—especially hostile takeover attempts—were rare because of the regulatory approval process required, some analysts say.

However, last year's acquisition of Farmers Insurance Group by Batus Inc., a unit of British-based B.A.T. Industries P.L.C., likely will have a trailblazing effect, said Joanne Morrissey, president and chief executive officer of Firemark Consultants Inc. in Parsippany, N.J.

"The B.A.T. takeover showed it could be done," Ms. Morrissey said. "I think we will see more of them."

The anticipated increase in insurance company acquisitions and takeovers is "a real regulatory concern," said Earl Pomeroy, the North Dakota insurance commissioner and vp of the National Assn. of Insurance Commissioners.

"The takeover and acquisitions game has wreaked havoc in corporate America," he said, adding that he does not want this "game" to imperil insurance companies' operations or security.

Contributing to the increased interest in insurer acquisitions is an increase in the number of consultants and banks willing to "do deals" as well as an increase in competition among insurers, which hurts small and medium-sized insurers, Ms. Morrissey added.

Generally, "there are more acquisitions and mergers in the industry," Ms. Morrissey said.

In 1988, 21 insurers—13 life-health insurers and eight property/casualty insurers—merged with other operations, she said. That was the highest one-year total since the early 1980s, according to Firemark data.

However, under nearly all states' model holding company statutes, regulators in each state in which an insurance company's affiliates are domiciled must approve a pending acquisition (see story, page 3).

Observers have noted that most regulators often are reluctant to approve a hostile takeover of an insurer.

However, observers disagree about whether that is bad or good for the insurance industry.

Critics contend that regulators have a "parochial" and "xenophobic" orientation that limits their ability to objectively assess the merits of a proposed acquisition.

These observers charge that executives at a hostile takeover target use the insurance regulatory process to protect their companies and their job, especially if the insurer to be acquired is an important local employer.

The Farmers' episode was an "embarrassment" to regulators, one critic said.

Several states opposed Batus' acquisition of Farmers as long as Farmers fought the takeover by emphasizing, for example, that Batus' interest in tobacco companies could potentially conflict with Farmer's non-smoker discounts for life and health insurance (*BI*, Oct. 24, 1988; Aug. 15, 1988).

However, Farmer's executives later agreed to the takeover—after Batus raised its offer—and asked regulators to approve it. The regulators complied.

That series of events made some regulators "look foolish," the critic said.

From a regulatory standpoint, the outcome of the Farmers takeover bid was "absurd," said Michael Hatch, commissioner of the Minnesota Department of Commerce, which regulates insurance companies in the state. "I can find no rational explanation why commissioners should deny Batus and then approve it," he said.

The decision was not made on the basis of what was best for policyholders, Mr. Hatch added.

Regulators need to be wary of being seen as "lapdogs" for hometown insurance company management, Mr. Hatch said. But what often happens is that the insurer's executives "come in and wine and dine you," he said. "It's the old boy network."

However, Mr. Pomeroy disagrees, saying that the fact that Batus and Farmers ultimately reached a mutually agreeable settlement "was not an implication that early regulatory objections weren't wholly legitimate."

The Batus/Farmers affair is similar to Alleghany's bid for St. Paul stock, said Theodore Somerville, Alleghany's vp and general counsel. As a result, states' holding company statutes "look like anti-takeover devices for the benefit of incumbent managements," Mr. Somerville said.

However, other regulators disagree. Regulators' focus is not to protect an insurer's incumbent management but to protect the insurer's policyholders and the insurance buyers in their states, regulators say.

For example, "just because the interests of the Nebraska policyholders coincide with St. Paul's management, it does not follow we are being manipulated as regulators," said Robert Lange, general counsel of the Nebraska Insurance Department.

"Regulators need to confine themselves to a legitimate public policy role in analyzing the appropriateness of an acquiring entity," Mr. Pomeroy said. "We have to avoid being parochial in resisting any acquisition of a local company, if the acquisition is in accord with local statutes," he added.

One reason why an insurance commissioner might worry more about a hostile takeover than an amicable one is that a hostile takeover may result in significant changes at the insurance company, said David Simmons, general counsel of the National Assn. of Insurance Commissioners. "You just don't know what might be changed, for example, management philosophy, investment policy and product mix."

In addition, if an insurer's key managers are replaced, regulators fear that the insurer's surviving managers may become so embroiled in boardroom politics that they will not adequately supervise business operations. That would be disruptive and may create an unstable situation for policyholders, regulators say. ■

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Analysts assess St. Paul as buyout target

The St. Paul Cos. Inc.	
1988 revenues	$3.6 billion
Change from 1987	7.9%
1988 net income	$355.3 million
Change from 1987	-0.4%
Stock price (March 14)	$46.50
52-week range	$48.75-$38.25
Price/earnings multiple	6.3
Average number of outstanding shares (1988)	49.2 million

Alleghany Corp.	
1988 revenues	$1.0 billion
Change from 1987	-0.7%
1988 net income	$46.0 million
Change from 1987	-24.7%
Stock price (March 14)	$84.75
52-week range	$85.50-$69.125
Price/earnings multiple	11.7
Average number of outstanding shares (1988)	6.3 million

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By MEG FLETCHER

The St. Paul Cos. Inc.'s operating results and its reasonably priced stock make it an attractive investment target for Alleghany Corp., stock analysts say.

"Their results have been good and their stock is not expensive," explained Joanne Morrissey, president of Firemark Consultants Inc. in Parsippany, N.J.

Some analysts view St. Paul's acquisition last year of London broker Minet Holdings P.L.C. and its introduction of a new employee stock ownership plan at the end of 1988 as defenses against a hostile takeover. St. Paul officials and some state regulators contend that Alleghany wants to take over St. Paul instead of acquiring 20% of its stock as Alleghany professes.

Acquisitions like the Minet purchase, which one analyst said cost at least seven times the broker's book value, could indicate that St. Paul is loading up on debt to reduce its attractiveness to corporate suitors, some theorize.

The recent increase in St. Paul's debt "may be a more deliberate move" to defend against a hostile takeover, although the level of debt assumed by St. Paul is "not pushing the limits of prudent leverage," said William Anderson, assistant vp and securities analyst with Duff & Phelps Inc. in Chicago.

In addition, one analyst, who asked not to be named, sees the ESOP, for which St. Paul purchased 5% of its shares, as a "sly" way of putting stock in the hands of St. Paul employees who have a stake in the company's current structure. However, others, such as Mr. Anderson, see the percentage of stock held by the ESOP as too little to be significant.

A St. Paul spokeswoman denied that any of these actions were anti-takeover devices.

In addition to its property/casualty insurance company units and Minet, St. Paul's major subsidiaries include Swett & Crawford Group, the nation's largest surplus lines brokerage, and John Nuveen & Co. Inc., an investment banking company specializing in municipal and tax-exempt instruments.

In addition, Minet last year acquired Intere Intermediaries Inc., the ninth-largest U.S.-based reinsurance broker.

Alleghany, which is not linked to Pittsburgh-based Allegheny International Corp., is an insurance and financial services holding company that owns Chicago Title & Trust Co. and The Shelby Insurance Co., a property/casualty insurer, and holds a stake in American Express Co.

New York-based Alleghany wants to acquire 20% of St. Paul's common stock so it "can take into its own earnings not only St. Paul's dividends but Alleghany's entire pro rata share of St. Paul's net income," explained Theodore Somerville, Alleghany's vp and general counsel.

That would result in a "substantial" boost to Alleghany's earnings, he said. For example, Alleghany calculated that its net earnings per common share from continuing operations would have jumped to $12.31 from $8.28 for the nine months ending Sept. 30, 1987, if it had acquired the 20% share on Jan. 1, 1987.

"A factor in Alleghany's acquisition program over the last 20 years has been its desire to avoid the adverse tax consequences of becoming classified by the federal government as an investment company," said James G. Miller, deputy commissioner of the Minnesota Department of Commerce, who evaluated Alleghany's request to purchase St. Paul's stock. The department later approved Alleghany's acquisition of up to 20% of St. Paul's stock. Further purchases of St. Paul stock by Alleghany would require additional department approval.

Alleghany wants to acquire 20% of St. Paul's common stock so it 'can take into its own earnings not only St. Paul's dividends but Alleghany's entire pro rata share of St. Paul's net income,' explains Mr. Somerville, Alleghany's vp and general counsel.

"Since 1984, one of Alleghany's corporate objectives has been to acquire one or more operating companies" to differentiate it from an investment company, Mr. Miller found.

"Alleghany's 1985-89 strategic plan noted that ownership and management of the assets of a (property/casualty) insurance company would mean acquisition of an operating company that, unlike a life insurance company, may invest a large portion of its reserves and surplus in a portfolio of equity securities," Mr. Miller said.

Alleghany unsuccessfully sought to acquire Fireman's Fund Corp. from American Express Co., "but the deal was not completed because Alleghany felt it would have to assume too much debt to close the deal," said Mr. Miller.

American Express in October 1985 spun off Fireman's Fund in what at the time was the largest public stock offering in U.S. history (*BI*, Oct. 28, 1985).

However, the Minnesota department also found that Alleghany's investment practices include periodically acquiring a substantial equity position in a company, holding the stock for a short time and then selling the stock at a profit.

Alleghany has already spent more than $200 million to acquire nearly a 10% interest in St. Paul. However, it currently is stymied from acquiring the full 20% it says it seeks because of opposition from state regulators, many of whom share St. Paul's worry that Alleghany's ultimate aim is to acquire all of St. Paul (see story, page 3).

For example, North Dakota Insurance Commissioner Earl Pomeroy said, "A 20% passive investment in St. Paul by Alleghany is not an impressive or logical investment. It is not a likely long-term position for the company."

In addition, former Indiana Insurance Commissioner Harry Eakin said, "It is not credible that Alleghany would propose this large investment and yet not have any plans or proposals for future action beyond a passive investment of indefinite duration and undefined parameters."

Some of those who fear that the Alleghany proposal could hurt St. Paul policyholders cite a series of internal memos from Alleghany corporate officials and consultants that consider the ramifications of various takeover scenarios.

The memos were released in public hearings before insurance regulators that were studying Alleghany's bid to buy St. Paul stock.

One July 1987 memo contained an analysis that found "St. Paul seems a very vulnerable acquisition candidate because the property/casualty operation can be purchased very cheaply assuming the use of hidden assets," according to the Minnesota report.

"The calculations attached to the analysis assumed the purchase of all of St. Paul's stock and the sale of St. Paul's Nuveen, Swett & Crawford and Minet subsidiaries and the 'extraction of excess statutory capital' from St. Paul's insurance companies," the report said.

Later that same month, Alleghany began to purchase St. Paul stock. It also asked Merrill Lynch Capital Markets, its investment banker, to help prepare an analysis of St. Paul.

A Merrill Lynch staffer dubbed St. Paul "Santa Claus" in accordance with its usual practice of giving a code name to companies that are under scrutiny.

Merrill Lynch subsequently prepared a preliminary leverage buyout analysis that assumed Alleghany would acquire 100% of St. Paul, extract $335 million in excess property/casualty capital and sell Nuveen, Swett & Crawford and Minet, according to the Minnesota report.

However, an Oct. 8, 1987, memo from Alleghany Chairman Fred Kirby describes some of the discussions in previous memos as "quite fanciful." It also emphasizes that the Alleghany board's current intention was to acquire "something less than 10%" of St. Paul.

However, Indiana's Commissioner Eakin noted in his findings that "Kirby's Oct. 8, 1987, memo was prepared with the advice of general counsel Mr. Somerville, who suggested changes to the memorandum."

Contrastingly, Alleghany supporters cite Minnesota's findings that "a leveraged buyout analysis is frequently done as a means of valuing a business and determining its suitability for investment, even though the client does not intend to acquire 100% of a company. Alleghany does such analyses prior to a substantial equity investment. No one at Alleghany ever told Merrill Lynch that it intended to pursue a leveraged buyout."

Mr. Miller also points out that "Merrill Lynch did not contact banks to pursue financing for a leveraged buyout, nor did it solicit interest in the St. Paul subsidiaries proposed to be sold by the analysis."

Mr. Miller concluded that Alleghany Corp. has no plans or proposals at the 20% level of ownership to liquidate the insurer, sell its assets, or consolidate or merge it. Consequently, such a level of ownership "would not jeopardize the financial stability of St. Paul or any of the insurers, or prejudice the interest of their policyholders of the interests of any security holders who are unaffiliated with Alleghany at the 20% level of ownership."

However, Mr. Miller added that Alleghany should seek new approval from the state if it decides to increase its ownership of St. Paul to more than 20% because "the evidence in this record preponderates in favor of a conclusion that it would be unfair and unreasonable to policyholders."

Michael Hatch, Minnesota's commissioner of commerce, said he generally agrees with the findings of Mr. Miller, to whom he delegated the task of evaluating Alleghany's request.

However, he added that he would approve a 100% acquisition of St. Paul by Alleghany if St. Paul agreed to it and if the extent of the debt of the new holding company was not so great that the new holding company would be forced to raid the insurer's surplus. ■

Investigations

Continued from page 2

Both Mr. Helm and agency Chairman Michael A. Rubell also are California-licensed life and disability insurance agents.

In a 13-page formal accusation, the department alleges, among other things, that:

• Rubell Helm in June 1987 failed to renew an aggregate stop-loss policy written by Life Insurance Co. of the Southwest of Dallas for a self-funded health plan operated by Los Angeles-based Longwood Management Corp., despite collecting a $6,000 annual premium from the employer.

The plan covered about 350 employees of Longwood, which operates nursing homes and convalescent centers.

About $400,000 in claims have not been paid because of the lack of stop-loss insurance, according to the department.

• Rubell Helm in May 1988 allegedly collected premiums from but failed to place stop-loss coverage for the Good Health Trust, a multiple employer trust consisting of small employers from Florida and Louisiana that self-fund health care coverage.

The Florida Insurance Department determined that Rubell Helm was operating in the state without a license and issued a cease-and-desist order against the agency on on Feb. 17, said Suzanne Hood, a Florida department attorney.

The order was modified Feb. 24 to permit Rubell Helm to adjust and pay claims on existing business only.

The Louisiana Department has not received any complaints against Rubell Helm from consumers, a spokeswoman said.

• Rubell Helm from late 1987 through 1988 allowed a specific stop-loss policy to lapse and did not place an aggregate stop-loss policy for the California Assn. of Builders Exchanges, a small employer trust.

Fifteen building contractors' groups obtained health and life coverage through a CABE-sponsored plan.

The department alleges that Rubell Helm collected $3.5 million of premiums from CABE for both aggregate and specific stop-loss coverage beginning Oct. 1, 1987, but that the agency placed only a specific stop-loss policy that became effective Dec. 1, 1987 and expired July 1, 1988.

The department charges that the agency failed to place an aggregate stop-loss coverage for this period and failed to renew the specific stop-loss policy.

In July 1988, Rubell Helm informed CABE that the specific stop-loss coverage was terminated and that the plan was covered only by an aggregate policy, the department charges.

About 2,300 employees and dependents were enrolled in the CABE plan in September 1988. However, almost all of the employers that participated in the CABE plan have secured coverage elsewhere, said Hank Muir, president of CABE and president of Continental Electric Inc. of Santa Ana.

• Rubell Helm has transacted health insurance business in the state without a license.

The department charges that between October 1987 and September 1988, the agency paid $1.2 million of claims filed by CABE members from the more than $3.5 million in premiums it collected from CABE.

• Rubell Helm between January and September 1988 allegedly paid fees exceeding $16,500 from the CABE premium account to David Erlandson, chairman of CABE's health trust and a licensed life and disability agent.

The department says these fees constituted a partial premium rebate, a violation of the California Insurance Code.

"We're alleging that Mr. Erlandson was paid this money in his capacity as chairman of CABE, not as an agent," said Mr. Ward.

These fees were paid in an effort to retain the CABE account without the knowledge of the other CABE board members, the department alleges.

Mr. Muir, president of CABE, confirmed the fees were paid without the knowledge of CABE board members.

However, Mr. Helm argued that "Mr. Erlandson is an agent and was CABE's agent, and this was his commission."

• Rubell Helm in May 1988 collected an unspecified amount of premiums from United Auto Workers Local 1797 in Tulare County, Calif., to purchase specific and aggregate stop-loss insurance for the UAW local's self-funded health care plan but failed to place the aggregate coverage.

The agency informed the UAW local that it would obtain a specific stop-loss policy from Boston Mutual Life Insurance Co. and an aggregate stop-loss policy from Fidelity Security Life Insurance Co. of Kansas City, Mo.

Although Rubell Helm collected a total of $26.95 per plan participant per month for both specific and aggregate coverage, it never placed the aggregate coverage, the department says.

• Rubell Helm since mid-1988 has not released claim checks prepared and processed by the agency's claims administrator, Risk Management Resources in San Francisco.

'We are flabbergasted at the charges,' says Rubell Helm President James B. Helm.

The department charges that Rubell Helm has been holding almost $400,000 in claims checks for CABE and about $419,000 in claim checks for participants covered under the American Trust Insurance Plan, another multiple employer trust.

And, in September 1988, Rubell Helm allegedly informed Risk Management Resources not to pay any claims exceeding $100, the department says.

As of November 1988, the CABE and ATIP groups had about $4.3 million in pending claims that had not been paid by Rubell Helm, the department says.

"We have people who haven't had their claims paid and we have some people who have had no problems at all," said CABE's Mr. Muir.

However, Mr. Helm asserts: "We're paying claims, including the ones over $100." He added that he could produce canceled checks.

• Rubell Helm employees attempted to attract new business by falsely representing that they were state deputy insurance commissioners and displaying official-looking shields.

"We understand that people contacted by Rubell Helm were highly influenced by these phony credentials," said Mr. Ward of the Insurance Department.

But, Mr. Helm explained that he and Mr. Rubell are members of the California Senate's Insurance Claims and Corporations Committee's advisory commission, chaired by Sen. Alan Robbins, D-Van Nuys.

Commission members are issued badges that allow them to enter state capitol offices.

"It's an absolute lie that we were using the badge to solicit business," Mr. Helm said.

A spokesman for Sen. Robbins would only say the two men had been members of the committee's advisory commission until recently.

Rubell Helm has 15 days from the date it receives the accusations in which to respond. Mr. Helm said he received a copy of the accusations by regular mail on March 13.

"We are flabbergasted at the charges, because we have already showed the DOI everything we did," Mr. Helm said.

"At some point, we are going to have to sit down in front of an administrative law judge and figure all of this out," the department's Mr. Ward said.

In Illinois, the Insurance Department has been investigating Mr. Jarvis and his operations for about a month, according to Richard Rogers, deputy commissioner.

However, the department has not issued formal charges against Mr. Jarvis or his operations.

According to the department, the four HMOs to which Mr. Jarvis allegedly failed to remit premiums are Choice Health Care Plan, a Chicago-based HMO owned by Aetna Life & Casualty Co. of Hartford, Conn.; Share Health Plan of Itasca, owned by United HealthCare Corp. of Minneapolis; Complete Health Care Corp. of Joliet, Ill.; and MedCare of Oak Park, Ill.

Mr. Jarvis acted on behalf of small employers because the HMOs would not provide coverage directly to the employers, according to Steven Pearson, a Chicago attorney representing the plaintiff who is suing Mr. Jarvis' operations and three of the HMOs: Choice, Share and Complete Health Care.

Employers were instructed by the HMOs to contact Jarvis & Associates and MICA, Mr. Jarvis' operations, to have the agencies place their coverage, Mr. Pearson said.

Then, Mr. Jarvis would arrange for direct access to the employers' bank accounts so he could withdraw funds to pay premiums to the HMOs, Mr. Pearson said.

According to the suit filed by Mr. Pearson, the plaintiff originally had coverage through Choice, but that coverage was canceled in November 1988 because Mr. Jarvis did not pay the premium on behalf of the plaintiff's employer.

Neither the employer nor the employee was told by the HMO or Mr. Jarvis that the coverage had been canceled, Mr. Pearson said. The plaintiff learned of the cancellation in February when she was denied coverage at a hospital for outpatient tests.

Mr. Jarvis allegedly told some employers that their coverage had been transferred to Complete Health Care, Mr. Pearson said. But, although some employers received membership materials from Complete Health Care, no coverage was ever secured from the HMO, Mr. Pearson alleges.

The lawsuit also maintains that some employees' coverage with Share also was canceled and that replacement coverage was not secured.

The suit charges the three HMOs with negligence for failing to notify the plaintiffs in a timely manner that their premiums had not been paid and that their membership was canceled.

The suit also charges the HMOs with negligently and carelessly failing to inquire into the allegedly fraudulent practices of Mr. Jarvis.

The suit asks for $15,000 from Jarvis & Associates and the HMOs to cover legal costs.

Officials at Choice did not return repeated phone calls. A Share official declined to comment.

Both Choice and Share now are providing replacement coverage for employees that originally were enrolled in those plans, Illinois department officials and Mr. Pearson said. ■

NAIC changes hearing date

WASHINGTON—The National Assn. of Insurance Commissioners has rescheduled a public hearing next month to discuss the role of advisory rating organizations (*BI*, March 13).

The Washington, D.C. hearing, which will focus on testimony from consumers, will be held from 9 a.m. to 1 p.m. April 4 in the auditorium at 1775 Massachusetts Ave. N.W.

Persons wishing to testify should contact the NAIC offices in Washington, D.C., at 202-624-7790.

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FHLBB seeks $663 million from auditors

By MICHAEL SCHACHNER

The Federal Home Loan Bank Board is seeking damages ranging from $8 million to $300 million in its litigation against 10 accountants that the board claims did not properly audit several now-insolvent savings and loan institutions.

The board is seeking a total of more than $663 million from the accountants—including three Big Eight firms—over allegedly shoddy audits that the board claims contributed to the thrifts' insolvencies.

The board names the Federal Savings & Loan Insurance Corp. as the plaintiff in the 11 lawsuits filed against the accountants in various federal courts.

The announcement of the FHLBB lawsuits came one week after the General Accounting Office, the auditing and investigative arm of Congress, called for more stringent S&L auditing standards in a study that highly criticized accountants' audits of six of 11 S&Ls that failed in five Southern states between Jan. 1, 1985, and Sept. 30, 1987.

In the FHLBB litigation, the board is seeking:

- $300 million from New York-based Touche Ross & Co. in connection with the firm's 1982 and 1983 audits of the Beverly Hills Savings & Loan Assn. of Mission Viejo, Calif.

In the litigation, filed in March 1987 in U.S. District Court in Los Angeles, the board claims the accounting firm purposefully failed to report BHSL's true financial condition. The lawsuit alleges that Touche Ross did not follow generally accepted accounting principles in its audits of BHSL's financial statements for 1982 and 1983.

BHSL was placed into receivership by the board on April 23, 1985.

A trial in the case, which currently is in discovery, is at least a year away, according to Leon Gold, an in-house counsel for Touche Ross in New York.

- $250 million from New York-based Deloitte Haskins & Sells in connection with the firm's 1983 and 1984 audits of the Sunrise Savings & Loan Assn. of Boynton Beach, Fla., which the board declared insolvent in July 1985.

The board named Deloitte as a defendant in an amended complaint filed Jan. 19 in Philadelphia. The board originally filed suit against Sunrise management and outside counsel, among others, in federal court in Miami Dec. 6, 1988.

The amended complaint claims Deloitte's Miami branch rendered opinions on financial statements for June 30, 1983, and June 30, 1984, that were not in accordance with GAAP.

The lawsuit further alleges that Deloitte knew Sunrise would rely on the financial statements, which contained overstated revenues, inappropriately recognized income, understated losses and expenses, and no reporting of the lack of reserves for $60 million in outstanding loans.

- At least $40 million in a suit filed against the Pasadena, Calif -based Jeffery, Palazzola & Co. in March 1988 in U.S. District Court in Los Angeles over the firm's audits of North American Savings & Loan Assn. of Orange, Calif. The lawsuit claims the firm failed to comply with GAAP in its audits of the S&L in 1983, 1984, 1985 and 1986.

North American was determined to be insolvent by the board in January 1987, and the FSLIC took it over at that time.

- $20 million from the accounting firm of Anderson, Alfred & Ritter over the firm's audits of the 1984 and 1985 financial statements of State Savings of Salt Lake City. The board filed suit against AA&R in U.S. District Court in Los Angeles in May 1987 alleging fraud, negligence and breach of contract. State Savings was placed into receivership in April 1985.

- $15 million from Mike Sage & Co. Inc. of Tustin, Calif., over financial audits performed for Ramona Savings & Loan

Continued on next page

Accountants E&O market

Continued from page 2

the whole situation," explained John J. Adair, director of audit oversight and policy for the Accounting & Financial Division of the General Accounting Office.

For example, he pointed to loans the now-insolvent thrifts had made to companies with oil interests before the oil crisis hit the Southwest as out of the accountants' realm.

"Anytime you have clients handling money rather than widgets there is room for shenanigans," said Peter Christie, chairman and chief executive officer of Montreal-based Minet International Professional Liability Ltd., which places coverage for the Big Eight firms—much of it in the London market.

Sources estimate the largest firms are able to purchase between $50 million and $100 million in primary and excess professional liability coverage worldwide.

"You can't say the accounting industry is responsible," Mr. Christie said. "I don't believe there will be any material effect at all."

A leading professional liability underwriter who wished to remain anonymous agreed. "We are concerned with accountants becoming a lightning rod for what's beyond their control."

The handful of domestic insurers that write accountants professional liability insurance for small accountants also say they do not anticipate that the FHLBB litigation will affect the market.

"We don't anticipate any problems, but only time will tell. Until then we're continuing to offer the coverage," said James Corcoran, vp for Cherry Hill, N.J.-based Admiral Insurance Co., a unit of W.R. Berkley Corp. that writes coverage for accounting firms with fewer than 35 professionals.

Accountants insured by The Homestead Insurance Co. of Hoboken, N.J., also will not be affected by the litigation, according to Eric Aplegren, vp-special operations.

He explained that Homestead does not insure large accounting firms and "big sisters"—large regional firms that are not considered equal to the Big Eight.

A spokesman for Crum & Forster Management Services in Chicago, which sources say writes coverage for the lion's share of "type B" or "second 16" firms, declined to speculate on what effect the lawsuits may have on the accountants liability market.

Walter Primhoff, director of professional programs for the New York State Society of CPAs, a 31,000-member trade group, thinks "it's too early to tell" how the lawsuits may affect the accountants professional liability market.

"But if there are large claims it certainly will affect those companies involved. It could work on capacity, which could dry up in areas, but hopefully all this won't happen."

Prior to the FHLBB's announcement out its lawsuits, rates were falling 10% to 15%, said Ervin Kranberg, president of Des Plaines, Ill.-based broker Professional Liability & Consultants Inc.

But, the FHLBB suits might trigger some rate increases, he agreed.

"Maybe we should try to firm up rates, because the S&L scandal may somewhere along the line filter back; or worse, we may see a severe hiccup with 400% to 500% rate increases. I'd prefer fewer peaks and valleys and maybe the S&L situation will remind people that E&O is volatile," Mr. Kranberg said.

Uneasyness among reinsurers over the litigation also could lead to higher reinsurance rates for insurers that write accountants professional liability insurance, observed Frederick Knauff, executive vp at CAL Accountants Mutual Insurance Co. of San Francisco, which writes coverage for California accounting firms.

"If reinsurers raise rates, so will primary insurers," Mr. Knauff said.

He pointed out that the CAL Accountants Mutual policy excludes coverage for services performed for financial institutions, though such accountants can buy back the coverage for an added premium.

Mr. Knauff acknowledged that CAL Accountants Mutual insures one of the defendants named in the FHLBB litigation, but he declined to name the accountant.

The FHLBB litigation also may have a chilling effect on capacity for large accounting firms, Mr. Kranberg speculated.

Insurers and brokers reported late last year that sufficient capacity, especially for small firms, apparently was available.

"I think this will solidify the stance of companies" such as American Home Assurance Co. of New York, a subsidiary of American International Group Inc., Admiral and Homestead, he said. "They'll continue not to get involved with the big guys. You just can't price them, especially with a softening market." ■

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Accountants lawsuit

Continued from previous page

Assn. of Orange, Calif., which was declared insolvent and placed into receivership on Sept. 12, 1986. The board claims the 1985 audit performed by the accountant did not apply GAAP. The lawsuit was filed in U.S. District Court in Los Angeles in September 1988.

- $10.3 million from the Wytheville, Va., firm of Cole & Armbrister in connection with alleged faulty audits in 1982 and 1983 of Mountain Security Savings Bank, a small Virginia S&L with assets of $23 million in 1982. Mountain was placed into receivership in June 1986. The case has been pending in federal court in Roanoke, Va., since Feb. 24, 1988.
- At least $10 million from Coopers & Lybrand in connection with the accountant's alleged fraudulent audit in 1984 of CB Financial Corp., an investment company based in Oklahoma City.

Coopers & Lybrand originally was sued in June 1987 as a third-party defendant in the U.S. District Court for the Western District of Oklahoma in Oklahoma City by First Federal Savings & Loan Assn. of Shawnee, Okla.

The lawsuit alleges that the accountant knew that CB Financial was insolvent and knew or should have known the company would use the audit to obtain two letters of credit totaling about $7.5 million from First Federal in April 1985. First Federal claims that based on the accountant's audit, it believed the letters would never be drawn upon.

CB Financial then used the LOCs as security for loans it obtained from Freedom Savings & Loan Assn. of Tampa, Fla., which knew CB Financial was insolvent and could not repay the loans, court papers charge.

In 1987, Freedom drew on the letters of credit, but First Federal refused to release the funds.

- At least $10 million from Regier, Carr & Monroe in connection with its audits of the Savings Investment Services Corp., a service corporation whose stockholders are various S&Ls, including OK Federal of El Reno, Okla.

The lawsuit, filed in federal court in Oklahoma City, alleges that in RC&M's audit of SISCorp for the year ended June 30, 1983, the accountant breached its contract with OK Federal—previously called Globe Savings & Loan—by failing to properly examine OK's investment in loans originated and serviced by SISCorp.

- $8 million in a separate suit from Regier, Carr & Monroe in connection with financial audits it performed for Territory Savings & Loan Assn. of Seminole, Okla., which was declared insolvent in January 1988. The lawsuit, originally filed June 29, 1987, moved from federal district court in Oklahoma City to federal court in New York, claims RC&M breached its contract with Territory over audits for the years ended 1984 and 1985.
- Unspecified damages from the New York firm of Vanasco & Resnick over its alleged fraudulent diversion of more than $12 million from Intercapital Savings Bank of Jacksonville Beach, Fla., between April 1984 and May 1985.

The lawsuit, filed Aug. 14, 1987, in U.S. District Court in Manhattan, also charges Vanasco & Resnick of wire, mail and securities fraud.

Intercapital was placed into receivership in February 1986.

- Unspecified damages from Grant Thornton of Dallas, and its predecessor, Alexander Grant, for the firm's 1984, 1985 and 1986 audits of Dallas-based Sunbelt Savings Assn. of Texas. The June 1988 lawsuit filed in U.S. District Court in Dallas charges the accountant with failing to detect numerous accounting irregularities, including the artificial inflation of Sunbelt's net worth by the thrift's chief executive officer.

In its 12-page study, the GAO determined that the accounting firms that audited six of 11 S&Ls that failed in five Southern states between January 1985 and October 1987 did not adequately audit the S&L's financial or internal controls, report problems with the controls, or both, in accordance with professional standards.

The study does not identify the S&Ls or the accountants.

"The point we've made in our study is that the auditors didn't find out enough about the collectibility of loans," said John J. Adair, director of audit oversight and policy for the Accounting & Financial Division of the GAO.

"If they had, there would have been restructuring of loans and reserves built up, and that would have provided a truer position of the S&L's financial status," he said.

The GAO report concluded that "significant improvements are needed in order to ensure that CPA audits of S&Ls are of adequate quality to permit the FHLBB and others to rely on CPA audits to determine whether S&Ls' financial statements are presented fairly and whether effective internal controls are in place."

The GAO recommended that the American Institute of Certified Public Accountants "expeditiously revise the Audit and Accounting Guide for savings and loan associations to include specific steps for ensuring that those audits are performed in a quality manner." ■

Hartford Steam policy shields contractors

An insurance policy that indemnifies contractors and project managers against damages and delay penalties for the technological shortcomings of their projects is now available from The Hartford Steam Boiler Inspection & Insurance Co.

Although only a handful of insurers including Lloyd's of London underwrite this type of coverage, "there is a growing need for sophisticated insurance coverages like contractors performance insurance," said Executive Vp Donald K. Wilson Jr.

A recent survey of brokers conducted by Hartford Steam Boiler pointed out a need for coverage that protects contractors—especially those working simultaneously on several projects—from project performance failures, said David Chapin, a senior underwriter.

And, while surety bonds guarantee contractual performance obligations, the performance policy covers physical technological output failure "of the insured system due solely to deficiencies in the system's design, material or construction," according to a company statement.

Currently, Hartford Steam Boiler is offering $10 million limits on a claims-made basis. But the insurer will offer higher limits on a policy co-written with Lloyd's underwriters.

Premiums, ranging from $25,000 to $1 million, vary according to the project design, said Mr. Chapin.

A 10% deductible is standard, although the company will adjust the deductible for bigger risks, Mr. Chapin said.

Typical policy exclusions include financial default, vandalism, slowdowns or strikes, failure to obtain licenses and/or permits and physical damage.

For more information contact David Chapin, The Hartford Steam Boiler Inspection & Insurance Co., 1 State St., Hartford, Conn. 06102; 203-722-5514.

Verdict software

Jury Verdict Research Inc. has developed a software program that predicts jury verdicts in civil litigation.

Available in IBM-PC compatible diskette, the JVR Case Evaluation Software can be tailored to meet hard disk as well as mainframe specifications, said Scott Agnew, a research associate with the national legal research and publishing firm.

The firm—which has provided statistical evaluations of personal injury cases to attorneys, insurance companies, governmental agencies and self-insurers for the past 30 years—developed a data base through its national network, Mr. Agnew explained.

"Once our data base of over 100,000 cases was computerized, the. . .software was a natural step for our company," said President Virginia Herman.

By simply entering the facts of their case, "attorneys and insurance claims personnel have a simple, consistent and statistically valid method of determining the value of their claims and the chance of the plaintiff prevailing before a jury," she added.

The software provides the user with defendant and plaintiff information such as past legal loss, medical costs, age and sex of the parties involved in the case, type of corporation and other case characteristics, Mr. Agnew said.

In addition, the software will compare verdict expectations in specific counties or states against national statistics. For example, Wayne County, Mich., has an 18% deviation above the national norm, Mr. Agnew noted. This means that a $10,000 award in most other counties nationwide would translate to $11,800 in Wayne County, which includes Detroit.

Version 1.1 of the software, released in January, is priced at $599 for a one-year subscription. This includes an update six months later.

For more information, contact the Software Support Group, Jury Verdict Research Inc., 30700 Bainbridge Road, Suite H, Solon, Ohio 44139; 216-248-7960.

Data coverage

Marine Office of America Corp. has introduced a broadened property policy for commercial data and word processing operations.

The Electronic Data and Word Processing policy will pay actual cash value or replacement cost for the loss of commercial data and word processing equipment and software—whether leased or rented—in every industry, including banks, offices, hospitals, wholesale/retail businesses and manufacturing plants, said Michael Taylor, MOAC assistant vp.

He added that the policy's "simplified language" enables policyholders to better understand the coverage, which includes:

- Data and word processing equipment as well as component parts.
- Property owned, leased or borrowed from others.
- Data (information) and data media (tapes and disks) with a value up to $50,000 (higher limits available).
- Air-conditioning and electrical systems that specifically service the data with a value up to $10,000 (higher limits available).

In addition, the broad EDP policy insures the equipment against water damage (excluding flooding), mechanical breakdown or short circuit costs up to $10,000, transit, installation and debris removal.

MOAC, a subsidiary of Continental Insurance Corp. of New York, also offers optional business interruption coverage under the EDP policy, Mr. Taylor added.

For more information, contact Michael R. Taylor, Marine Office of America Corp., 1 Continental Drive, Cranbury, N.J. 08570-0001; 609-395-2503.

Chiropractic UR

Focus Healthcare Management is now offering chiropractic utilization review services to workers compensation insurers and self-insured employers.

Focus developed its review process for chiropractic claims after discovering—through a company-conducted study—that "in a number of states, 10%-12% of workers compensation dollars go to chiropractic services," said David Iskowe, executive vp and co-founder.

The findings "confirmed that there is need for cost containment of chiropractic claims," he said.

Under ChiroCERT, registered nurses contact chiropractors just after treatment begins to discuss each patient's intended treatment plan, Mr. Iskowe explained.

If the recommended treatment and/or healing periods differ radically from American Chiropractic Assn. guidelines, the chiropractors are asked to fully explain their recommendations, according to Mr. Iskowe.

"In discussing treatment plans and diagnosis, we can identify whether the treatment is related to workplace injury or is a medical necessity unrelated to a workers comp injury, and thus not covered by workers compensation insurance," Mr. Iskowe explained.

For more information contact David Iskowe, Focus Health Management, 7101 Executive Center Drive, Suite 150, Brentwood, Tenn. 37027; 615-377-9936.

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"Retirement Planning Programs," a structured, step-by-step **guide to preparing older workers for life after retirement** is intended to help company morale and recruitment. The program, published by Business & Legal Reports, covers financial planning, lifestyle choice, home sale decisions, moving, relocation, educational and business opportunities, health care, medical insurance and much more. A retiree workbook and a national survey of company retirement planning programs also are included. Send $79.95 to Business & Legal Reports, 64 Wall St., Madison, Conn. 06443-9988; 203-245-7448 in Connecticut, 1-800-553-4569 elsewhere. ■

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Group health results

Continued from page 1

sults are looking better, it's only because they instituted higher increases in rates for group health insurance."

"Our pricing actions really were the key factors in our improvement in our indemnity business in 1988. We've instituted increases in the 30% to 60% range for the better part of a year now," said Chris Doerr, a senior vp and chief financial officer of the employee benefits group of CIGNA Corp. in Hartford, Conn.

CIGNA reported that its group health indemnity business produced 1988 operating income of $172.3 million, up 8.5% from $158.8 million in 1987.

However, losses from CIGNA's HMO operations grew 68% last year to $132.2 million from losses of $78.7 million in 1987. And, the HMO losses caused overall operating earnings for CIGNA's employee benefits division to fall 49.9% to $40.1 million in 1988 from $80.1 million in 1987.

"The bulk of the reason for these continuing losses in our HMOs is inadequate rating. The pricing has just lagged behind the health care inflation rate," Mr. Doerr explained.

However, the insurer is taking action to cut its HMO losses. Premiums for HMOs operated by CIGNA Healthplans Inc. will increase 25% to 35% during the first part of this year. HMO premium increases in late 1989 will be in the 15% to 30% range (*BI*, Dec. 19, 1988).

Other insurers agree that indemnity plan premium increases are fueling improved results.

"The premium increases we and everyone else began to implement in 1987 are the primary reason we all did catch up" with health care cost inflation, noted Charles T. Bell, a vp in the employee benefits department of Aetna Life & Casualty Co. in Hartford, Conn.

"And, catch-up really is the right characterization of the pricing activity. As near as we can tell, health care inflation is running about 20%. That's what we are pricing for right now," he added.

Aetna is increasing group health indemnity plan premiums about 20% to 25% this year, compared with 20% to 30% premium increases in 1988.

While Aetna reported reduced profits in its group insurance business in 1988, earnings rose significantly in the fourth quarter.

Aetna reported that its group insurance business produced operating earnings of $132 million last year, down 23.3% from $172 million in 1987. Total operating earnings for the insurer's entire benefits division stood at $238 million in 1988, down 11.2% from $268 million in 1987.

However, for the fourth quarter, the employee benefits division reported earnings of $80 million, up 31.1% compared with $61 million in the fourth quarter of 1987. This improvement was due mainly to increases in group indemnity plan premiums.

The group insurance division reported earnings of $80.3 million in the fourth quarter of 1988, up 31% from $61.3 million in the fourth quarter of 1987.

While Aetna did not break out results for its HMO operations, Mr. Bell noted that "virtually every insurer that operates HMOs is reporting losses on that part of our business. Our inside numbers for us also represent a loss on HMOs. This has depressed some of the effects of catching up on group health losses for many insurers, including us."

Yet, even though its HMO operations fared poorly last year, Aetna is increasing its HMO commitment.

Aetna announced in December that it would increase to 95% from 50% its share of the profits or losses from PARTNERS National Health Plans, a managed care joint venture between Aetna and VHA Enterprises, a unit of Irving, Texas-based Voluntary Hospitals of America.

At John Hancock Mutual Life Insurance Co. in Boston, group health insurance "deficits have dropped as premium increases begin to catch up some," said David D'Alessandro, president of the Corporate Sector, Hancock's employee benefits division.

"However, we haven't had really a full year of increases yet because different groups renew at different times of the year," so results should continue to improve, Mr. D'Alessandro said.

Hancock expects to report a $10 million profit on its group health insurance business for

Continued on next page

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Vice-Presidents, General Managers and Other Administrative Personnel 3,650
Financial:
Chief Financial Officers and Vice-presidents of Finance . . . 2,745
Secretaries, Treasurers, controllers and other Financial Personnel . 4,446
Risk/Employee Benefits:
Vice-presidents, directors, managers, and other related department personnel of: insurance, risk, employee benefits, personnel, compensation, pension, safety, security, industrial relations, human resources and employee/labor relations 10,687
Sub-total 23,959
Associations 548
Government, Unions and Educational Institutions 1,299
Commercial Consumers
Sub-total 25,806
Insurance Agents and Brokers 10,745
Insurance Companies 7,557
Actuaries, Consultants, Attorneys, Adjusters, Appraisers and Third Party Administrators 3,580
Others Allied to the Field 2,688
TOTAL 50,376
* Source Business/Occupational breakdown of qualified circulation, November 28, 1988 issue, as submitted to BPA for December 1988 BPA Publisher's Statement.

Health insurers

Continued from previous page

1988, compared with a $29 million loss in 1987, he said. Hancock reported 1986 group health insurance earnings of about $4 million to $5 million.

"There's no question that premium increases helped our results. There's been a lot of catch-up played in setting premiums. And, there still is, to some degree, more catching up going on because there is still some business that's running behind health care trend lines," Mr. Moynahan of Metropolitan explained.

Metropolitan is rebounding from 1987 losses of $94 million on its group health business and expects to report 1988 earnings of $80 million on that business, Mr. Moynahan said.

However, the mutual insurer is not releasing results from its HMO business, other than to say it suffered substantial losses mostly related to HMO start-up costs, Mr. Moynahan said.

Premium increases of between 15% and 25% in 1988 also helped the 77 Blue Cross & Blue Shield Assn. non-profit local plans cut their losses.

That strategy indeed helped, said Douglas Peters, a senior vp with the Chicago-based BC/BS Assn. "Our preliminary figures for 1988 show that we had between $1 billion and $1.1 billion in losses. This is about half of the loss we experienced in 1987," said Mr. Peters.

The BC/BS Assn. reported a $1.9 billion loss for all of the plans in 1987.

"For 1988, 20 of the plans will report positive results," Mr. Peters said.

One BC/BS plan, Blue Cross of California, reduced its net loss by 45.5% in 1988 to $9.1 million from $16.7 million in 1987 as a result of several strategies, including indemnity plan premium increases of 20% to 40%, said Alice Rosenblatt, senior vp of HMO and group services.

Fort Wayne, Ind.-based Lincoln National Corp. plans to continue "re-rating premiums to adequate levels" as part of a recovery plan for 1989, said John P. Cole, executive vp and chief operating officer of the insurer's managed health care group.

The insurer increased indemnity plan premiums about 30% for 1989 and about 20% to 25% in 1988.

Lincoln National narrowed the loss at its employee benefits division—which includes group life and health, HMO and corporate pension operations—to $29.1 million in 1988, a 30.2% decrease from a 1987 loss of $41.7 million.

However, the 1988 loss does not include a $61.7 million write-off primarily related to the discontinuation of group health insurance and HMO business in Florida.

Lincoln National lost $31.4 million in 1988 on group life and health indemnity operations, up 47.4% from a $21.3 million loss in 1987.

Its HMO operations lost $35.8 million in 1988 before the write-off, compared with a $50.7 million loss on HMOs in 1987.

Despite Lincoln National's exit from Florida, "we remain absolutely committed to the managed care area," Mr. Cole said. The insurer has HMOs in 11 cities and in January introduced a new HMO product under which 60% of the premium is prepaid by the employer to cover administrative fees. The remaining 40% of the premium is held by the employer, which pays claims only as they occur.

While health insurance executives say they believe group health insurance earnings should continue to improve throughout 1989, they point out that insurers are by no means out of the woods.

"We will see some improvement and we won't be in the red. But, we won't see a $30 million year. If the medical cost inflation trend trails off, we could possibly see better results, but we haven't seen any evidence that this is going to happen," said Mr. D'Alessandro of Hancock, which reported a $10 million profit on group health business last year.

"I think it's dangerous for an insurer to suggest that in the course of one year that you've solved the cost problem," said Mr. Peters of the BC/BS Assn.

"The nature of the health business is just too unpredictable," added Ms. Rosenblatt of BC of California.

Mr. Callaghan of Alex. Brown observed that "the risk here is that if the health care trend factor takes off again and jumps to 40%, all bets would be off." ■

Pollution coverage ruling

Continued from page 1

on many of these issues," said Katrina Veerhusen, a Chicago attorney who represented the policyholder in the litigation.

Ms. Veerhusen, along with Chicago attorney Kevin M. Forde, represented Specialty Coatings Co. and Specialty Chemical Co. of Elk Grove Village, Ill., in their coverage dispute with United States Fidelity & Guaranty Co. of Baltimore.

"Other Midwestern states have been favoring insurers," Ms. Veerhusen pointed out. "Another pro-insurer decision could have forced businesses to leave Illinois."

Policyholder attorney Eugene Anderson of Anderson Russell Kill & Olick in New York agreed.

"Illinois used to be a relatively anti-policyholder jurisdiction," he noted.

Mr. Anderson touted the appellate court decision as the "second Keene decision," referring to the landmark 1981 ruling in *Keene Corp. vs. Insurance Co. of North America* that dramatically changed the face of asbestos bodily injury litigation.

The District of Columbia Court of Appeals ruled in the Keene case that insurable asbestos bodily injury begins from the time a plaintiff is exposed to the deadly substance until the disease manifests itself, what is now known as the triple-trigger theory. Mr. Anderson represented Keene in the case.

Policyholder attorney Judith Roth of Phillips, Nizer, Benjamin, Krim & Ballon in New York observed that "1989 is looking up for policyholders." The Illinois decision "signals a much more hospitable climate for policyholders to litigate in," she said.

Insurer attorneys, however, are quick to point out that the appellate court's most recent ruling is in direct conflict with another Illinois appellate court ruling last year that upheld the pollution exclusion (*BI*, April 4, 1988).

This conflict could encourage the Illinois Supreme Court to review either or both decisions, said USF&G attorney Stephen Frew of Kiesler & Berman in Chicago.

Mr. Frew said USF&G will first seek a rehearing with the appellate court and, failing a satisfactory result, will appeal to the Supreme Court.

"Across the board we object to the rulings," Mr. Frew said. "The court ignored the clear provisions of the policy."

The court's ruling was "an attempt to create coverage for the policyholder," said insurer attorney Thomas Brunner of Wiley, Rein & Fielding in Washington, D.C. Mr. Brunner represented the Insurance Environmental Litigation Assn., which filed an amicus curiae brief in the case.

"The court was straining to get to a result," agreed insurer attorney Stephen Cohen of Robins, Kaplan, Miller & Ciresi in Minneapolis. He called the decision an example of "judicial activism in rewriting the policy."

The ruling stemmed from a dispute between USF&G and Specialty over whether the insurer had a duty to defend Specialty against three environmental claims.

Starting in 1974, USF&G wrote comprehensive general liability coverage for Specialty with annual per-occurrence and aggregate limits of $25,000.

In 1984, USF&G sued Specialty, seeking a declaration from the court that it did not owe a duty to defend the policyholder in the three underlying pollution claims.

Specialty has been cited for violations of state and federal environmental statutes for sending toxic chemicals via a third party to three waste sites—one in Kankakee County, Ill., and two in Gary, Ind.

The estimated cost to clean the three sites could total more $20 million.

Specialty has no excess insurance.

The appellate court ruling marks one of the first times any court has found the pollution exclusion ambiguous because it was not clear whether it applied to a policyholder, like Specialty, that hires a company to dispose of its hazardous wastes.

"It is not clear from the circumstance of this case and from the underwriting history of the exclusionary clause. . .that the parties intended the exclusionary clause to apply whether the insured was an active polluter or not," the court said.

"Certainly those engaged in manufacturing processes would be expected to have sought other or additional insurance had they known that the mere act of engaging an independent agency such as a waste disposer in the ordinary course of having industrial wastes removed from their property would result in the denial of insurance coverage," the court said.

The argument that the pollution exclusion does not apply if the policyholder hires a third party to dispose of its waste has been raised only in a handful of other courts nationwide, attorneys say.

The Illinois appellate court ruling is expected to encourage more policyholders to raise this and other novel arguments in their efforts to garner insurance coverage, attorneys say.

"Policyholders are now doing a good job of digging deep and being as creative as the insurers," said policyholder attorney Ms. Roth.

In fact, Ms. Roth said she will raise this argument when she appeals a 1987 ruling by a New York appellate court that the pollution exclusion bars coverage.

In that case—which pits Powers Chemco of Glen Cove, N.Y., against Federal Insurance Co. of Warren, N.J., a unit of Chubb Corp.—the court said: "The clear and unambiguous language of the pollution exclusion makes no exception for pollution caused by somebody other than the insured where the pollution is not sudden and accidental" (*BI*, Dec. 5, 1988).

'1989 is looking up for policyholders,' says attorney Judith Roth. The Illinois decision 'signals a much more hospitable climate for policyholders to litigate in,' she says.

Insurer attorney Mr. Cohen maintains that the Powers Chemco decision is correct and that the Illinois appellate court "is reading into the policy something that is not there."

"The pollution exclusion applies to the pollution, not the polluter," Mr. Cohen said.

In ruling that the pollution exclusion was ambiguous, the Illinois appellate court also said the term "sudden and accidental" means "unexpected or unintended."

Insurers vigorously argued that the term means to happen quickly.

In reaching this decision, the court looked at the drafting history of the CGL policy and said "that interpreting 'sudden' to mean 'abrupt' and 'instantaneous' contravenes the insurance industry's announced intent in adding the pollution exclusion to the general liability policy" in 1970.

Policyholder attorneys nationwide constantly struggle to persuade courts to examine the drafting history of the CGL policy when interpreting its terms and conditions; however, few courts are willing to do so.

However, when courts do look at the drafting history, they often rule that arguments insurers now raise in an effort to void coverage are very different from the statements insurers made when trying to elicit approval of the pollution exclusion in 1970, policyholder attorneys say.

"Only a few courts have looked at (the drafting history)," said Specialty attorney Ms. Veerhusen. "However, those that did have found it very persuasive for policyholders."

The drafting history is "very important and very persuasive," Ms. Roth agreed. She said the drafting history clearly shows that "when insurers are wearing their collection of premium hats they have one line; when they are wearing their claims-paying hats they have another line."

The drafting history shows that when insurers sought approval of the pollution exclusion clause in 1970 they said its was a "clarification" of existing coverage and not a reduction of coverage, Ms. Roth explained.

These drafting history documents "are a weapon policyholders should make every effort to use," she said.

However, insurers vigorously fight any attempt by policyholders to introduce drafting history documents.

They are a "self-serving selection of documents" that "create a one-sided history of the pollution exclusion," said insurer attorney Mr. Brunner.

The Illinois appellate court ruling also is significant because it marks one of the first rulings on whether a letter from the EPA naming a policyholder as a "potentially responsible party" for a polluted site constitutes a lawsuit for the purposes of insurance.

Under the Comprehensive Environmental Response, Compensation & Liability Act, better known as the Superfund Act, the EPA has the power to notify all parties that could be held liable to pay for the cleanup of a polluted site.

USF&G claimed that these so-called PRP letters do not constitute a lawsuit and therefore do not trigger an insurer's duty to defend.

The court, however, found that PRP letters do constitute a lawsuit for purposes of insurance since the EPA has the choice of cleaning a polluted site and suing the polluters to recoup the costs or forcing responsible parties to perform the cleanup themselves through PRP letters.

"The fortuitous choice to first seek voluntary compliance instead of court action does not eliminate the specter of potential liability for cleanup costs and damages to be incurred by defendants," the court ruled. "Indeed, it is the very threat of available formal legal action that is expected to motivate the recipient of the PRP letter into responding acceptably to the government's suggestions."

Because the issue of whether PRP letters create a duty to defend is an emerging area of insurance law, this decision will have substantial impact, attorneys say.

"The Specialty decision will be persuasive at least for the next year or so, while there are so few decisions," predicted Specialty attorney Ms. Veerhusen.

However, insurer attorney Mr. Cohen pointed out that other state courts have held that PRP letters do not constitute a lawsuit.

In finding USF&G had a duty to defend Specialty, the court also ruled that hazardous waste cleanup costs constitute damages.

This issue is one of the hottest issues in insurance coverage litigation nationwide.

Standard CGL policies stipulate they will "pay on behalf of the insurer all sums to which the insured shall become legally obligated to pay as damages."

By ruling that pollution cleanup costs constitute "damages," the Illinois appellate court has joined a growing number of state courts that have held that cleanup costs are insurable damages, according to attorneys.

"If you do a count of the decisions, they are overwhelmingly in favor of policyholders," said policyholder attorney Ms. Roth.

However, insurers are quick to point out that the only two federal appellate courts to rule on this issue—the 8th U.S. Circuit Court of Appeals and the 4th Circuit—have held that cleanup costs are not insurable damages (*BI*, March 7, 1988; July 27, 1987).

In another unusual argument raised in the Illinois case, USF&G said it did not have to defend Specialty because of a policy exclusion that bars coverage for damage to "property used by the insured."

The insurer said Specialty was "using" the hazardous waste sites as places to dispose of its waste.

However, the court said that this interpretation was too narrow.

"To suggest policy language interpretation that defendants 'used' the (polluted) sites by employing the grounds for the purpose of dumping when disposal agencies. . .themselves owned or selected the sites in performing their services is to create an ambiguity and then resolve it against the policyholder instead of the insurer," contrary to established case law regarding policy interpretation, the court said.

Specialty attorney Ms. Veerhusen labeled USF&G's argument "far-fetched." She also noted that although the exclusion is standard, it is rarely litigated in pollution cases.

Insurer results

Continued from page 1

looks like it's continuing through 1989," agreed Barbara Stewart, president of Stewart Economics in New York. "There's no indication, at least so far, anything's going to change."

David P. Wells, vp with Merrill Lynch Pierce Fenner & Smith in New York, said he believes that "1990 is probably the earliest the market will turn." Meanwhile, 1989 combined ratios will deteriorate four to six points from 1988, he predicted.

The property/casualty insurers surveyed by *Business Insurance* also reported that:

- Investment income increased 11.3% in 1988 to $12.1 billion. Investment income had increased 12.3% in 1987.
- Underwriting results continued to deteriorate, with underwriting losses increasing 23.2% in 1988 to $5.1 billion. In 1987, underwriting losses decreased by 34.9%.
- Policyholder surplus among the 23 companies reporting this data increased 12.8% last year to $31.5 billion. Surplus rose only 8.5% in 1987, in part because of the October stock market crash.
- Operating income declined 10.1% in 1988 to $6.8 billion. This is a marked deterioration from the 37.6% increase in operating income reported in 1987. However, insurers' year-end 1988 decline in earnings is an improvement over the 12.8% decline reported at the end of last year's third quarter.

Analysts and insurers are expecting earnings will suffer more in 1989.

"It looks like '87 more or less was the peak of the cycle, and we're now in the downturn, with profits declining quarter by quarter," said Sean F. Mooney, senior vp and economist of the Insurance Information Institute. However, he predicted a "soft landing" in 1990, unlike the rapid price increases that marked the end of the competitive market of the early 1980s.

Novato, Calif.-based Fireman's Fund Insurance Cos. anticipates a three- to five-point deterioration in its combined ratio in 1989, which will be "in line with the rest of the industry," said Jean Baulis, assistant vp-investor relations.

"Our expectation in '89 would be for deterioration in underwriting results in the commercial line operations," said John H. Fitzpatrick, vp-finance for Kemper Corp. in Long Grove, Ill.

He noted that the improvement in Kemper's combined ratio last year—to 103.3% in 1988 from 104.8% in 1987—was attributable to improved automobile insurance results, which offset deterioration in property and workers compensation insurance.

"I'm still looking for earnings to deteriorate for property/casualty companies this year," said Gloria Vogel, associate director with Bear, Stearns & Co. in New York.

Ms. Vogel added that while there is no evidence prices are increasing, neither are they deteriorating more quickly than they had been.

"We do have some stability. Early 1990 looks like the best bet right now" for a turn in the market, although "it's possible it could still come in late 1989," she said.

Dennis Busti, president of Reliance National Insurance Co. in New York, said: "Overall, we think the market will bottom out sometime in 1989. You might see a modest upturn sometime in 1990."

Combined ratios will deteriorate 2½ to three points in 1989 and, at best, will remain level in 1990, predicted Bernard C. Hlavac, vp and treasurer at Sentry Insurance Cos. of Stevens Point, Wis.

"I would think the momentum of price competition in '89 is going to continue on in 1990," Mr. Hlavac said. Any price increases introduced in 1990 will not be sufficient to offset inflation, he added.

Joanne Morrissey, a principal with Firemark Consultants Inc. in Morristown, N.J., said she continues to believe the market will not turn until 1992.

"The more we're seeing, the more we're standing strong on what our original expectations were. We just don't see things as going to get better, at least immediately," she explained.

Insurers blame rate cutting on others, she said, noting that one insurer executive told her straight-faced that the company was not cutting prices but merely "adjusting rates downward."

"Nobody really admits it. It's the competition that's doing it," Ms. Morrissey said.

Many observers note, however, that property/casualty insurers' fourth-quarter results were better than anticipated, despite the ongoing competition.

"If anything, you had to consider it a strong quarter," said Michael A. Lewis, first vp at Dean Witter Reynolds in New York.

"On balance, they (fourth-quarter results) were very good but for a few exceptions," agreed David Anthony, a senior insurance analyst with Fox-Pit, Kelton in New York.

"Overall, I'd say the quarter's numbers were better than expected," Ms. Vogel said.

Major reasons for the better-than-expected fourth-quarter results include:

- A relatively low level of reserve additions.
- Few weather-related losses.
- Improved group health insurance results among multiline insurers (see story, page 1).

However, the lack of fourth-quarter additions to reserves concerns some observers.

The cycle probably is at the point where—with operations pushing down profit margins and the specter of higher taxes—the pressure to report good earnings would affect an insurer's reserving policy "because it's a direct hit on earnings," Ms. Stewart said.

"Overall, for the industry, I think the reserves look very weak," said Shearson's Mr. Ghose. Adequate additions to reserves would have added another two points to the industry's combined ratio, he said.

Ms. Vogel said the question now is whether loss trends have improved or whether companies are "somehow cheating" on reserve additions and must make up for it in the future. She added the latter scenario may be the case.

"They're going to have to make up for" the lack of reserves for "the current book of business, if not the past book of business," she said. "They have to make up for some reserve shortfalls in the future because they didn't do it in the fourth quarter."

Paid losses rose significantly more than incurred losses in 1988, said the III's Mr. Mooney. "That suggests that perhaps going into '89 you'll see some extra reserving, because paid losses are representative of what's really happening."

"I think this is a time in the cycle when companies need to exercise a heavier discipline in monitoring reserve adequacy because this is the time in the cycle when, traditionally, reserve adequacy starts to slip," said Edwin J. Goss, chairman and chief executive officer of Indianapolis-based American States Insurance Co., the principal property/casualty unit of Lincoln National Corp.

However, Mr. Goss said: "I'm satisfied that's not true of us."

"I think '88 will end up looking about right" in regard to reserving, said Michael Frinquelli, an analyst with Salomon Bros. Inc. in New York. But, he warned that insurers could be entering a period where they run a real risk of underreserving.

Continued on next page

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Summary of major property/casualty insurers' 1988 results

(All amounts in thousands of dollars)

(Ranked by change in aftertax operating income)

		Corporate			Property/casualty operations									
Rank 1988		Consolidated revenues 1988	Aftertax[1] operating income 1988	Percent increase (decline) 1987-1988	Combined[1] ratio 1988	Combined[1] ratio 1987	Net premiums written 1988	Percent increase (decrease) 1987-1988	Pretax underwriting income (loss) 1988	Percent increase (decline) 1987-1988	Pretax investment income 1988	Percent increase (decrease) 1987-1988	Policyholders surplus 1988	Percent increase (decrease) 1987-1988
1	Ohio Casualty Corp.	1,431,441	142,088	46.2	100.8[2]	102.9[2]	1,353,241[2]	(0.5)	(16,261)	58.9	169,755	8.2	452,143	2.2
2	American International Group	13,613,213	1,175,145	24.4	99.4	99.5	8,470,589	11.4	85,692	390.7	834,284	22.4	N/A	N/A
3	Hartford Steam Boiler	446,613	62,639	17.3	84.0	85.7	291,016	0.6	46,712	15.5	35,773	6.4	266,476	22.9
4	Crum & Forster Inc.	4,282,900	305,100	13.5	108.8	108.2	3,403,000	(0.4)	(284,200)	0.5	545,800	11.7	1,390,300	16.1
5	General Re Corp.	2,735,801	518,485	13.0	99.1[2]	99.8[2]	1,779,660	(20.9)	2,698	136.3	542,805	12.5	2,319,177	15.4
6	SAFECO Corp.	3,017,718	234,849	11.7	100.3	101.4	1,517,940	5.6	(5,084)	74.2	220,496	22.6	858,557	27.4
7	Chubb Corp.	3,980,500	372,600	8.1	99.8	97.8	2,765,200	3.4	15,900	(76.9)	377,200	35.3	1,343,100	11.0
8	The St. Paul Cos. Inc.	3,630,774	349,261	7.7	104.0[2]	105.3[2]	2,690,536	(0.5)	(90,209)	29.0	548,682	10.1	1,392,583	16.0
9	Kemper Corp.	3,861,414	205,617	5.6	103.3[2]	104.8[2]	783,673	6.1	(42,487)	(20.4)	82,648	7.1	484,314	8.8
10	Hartford Insurance Group	8,512,011	395,078	3.0	103.9	103.7	6,237,663	(1.8)	(299,715)	(12.4)	768,621	11.3	2,626,449	7.6
11	Travelers Corp.	18,986,300	429,600	0.2	106.8	103.0	5,074,200	(3.5)	(289,400)	(142.2)	636,900	16.2	1,824,400	(1.9)
12	CNA Financial Corp.	8,204,000	404,100	(4.1)	108.8[2]	111.1[2]	5,183,000[2]	11.5	(483,700)[2]	10.6	870,100[2]	16.4	2,686,000	41.1
13	Fremont General Corp.	407,573	20,060	(12.8)	105.7	106.7	274,342	2.7	(15,557)	12.7	43,626	21.6	139,732	26.4
14	Sentry Insurance Cos.[2]	1,421,609	45,471	(17.2)	106.0	105.2	1,146,864	5.2	(72,781)	29.3	136,307	14.2	541,997	15.5
15	Fireman's Fund Corp.	3,703,688	247,068	(17.8)	109.2	114.9	2,835,949	(15.7)	(275,872)	46.7	451,125	1.4	1,452,382	18.3
16	USF&G Corp.	5,581,808	305,733	(18.0)	104.8[2]	104.2[2]	3,891,764[2]	1.2	(190,253)[2]	(64.7)	620,942	2.3	1,387,312	11.9
17	Reliance Ins. Co. & subs.	3,665,178	148,730	(19.8)	103.9[2]	101.5[2]	1,676,076	11.3	(59,453)	(111.0)	200,565	8.8	N/A	N/A
18	Lincoln National Corp.	7,312,300	185,300	(21.5)	100.5[2]	98.2[2]	2,255,400	8.4	(8,600)	(121.6)	276,700	13.1	1,288,200	17.8
19	Aetna Life & Casualty Co.	24,296,400	667,700	(23.0)	109.7	106.1	6,791,000	4.2	(656,500)	(77.2)	900,600	6.5	2,393,168	4.4
20	The Home Group Inc.	2,997,800	81,400	(31.7)	108.8	110.4	2,067,600	1.8	(185,900)	11.5	351,100	(3.3)	828,100	7.8
21	CIGNA Corp.	17,889,400	410,200	(34.7)	109.1	105.1	6,001,500	3.0	(542,000)	(80.1)	803,000	6.0	2,083,500	0.4
22	Old Republic Int'l Corp.	1,102,144	47,243	(49.4)	107:9	105.3	594,204	(0.8)	(48,478)	(48.6)	127,362	18.1	636,657	11.7
23	Continental Corp.	5,877,800	124,000	(62.4)	108.1[2]	104.5[2]	5,052,200[2]	(1.8)	(438,000)[2]	(104.6)	602,100	10.1	1,894,800	24.4
24	Royal Group (U.S. subs.)[2]	N/A	(72,200)	(131.8)	117.2	101.4	2,245,600	(0.3)	(340,900)	(1,648.2)	283,500	8.7	N/A	N/A
—	Nationwide Mutual Ins. Co.[2]	N/A	N/A	N/A	106.1	106.6	5,485,017	(3.2)	(276,886)	27.3	625,610	10.2	2,620,017	9.5
—	Commercial Union Ins. (U.S.)[2]	N/A	N/A	N/A	106.7[3]	106.9[3]	1,203,800	8.5	(91,900)	0.8	148,400	(3.1)	557,500	3.6
—	Liberty Mutual Ins. Co.[2]	N/A	N/A	N/A	113.7	111.8	6,628,935	6.1	(552,448)	6.5	915,286	16.6	N/A	N/A
	Cumulative	146,958,385	6,805,267	(10.1)	106.3	105.1	87,699,969	1.6	(5,115,582)	(23.2)	12,119,287	11.3	31,466,864	12.8

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

Insurer results

Continued from previous page

Other observers suggest, though, that reserve levels may be correct.

"Companies are adding less to reserves than they were, all things being equal," said Merrill Lynch's Mr. Wells.

He added that there probably has been a lot of "pothole filling" over the past couple of years and that reserves are probably closer to adequacy now than they have been.

"I think they're in pretty good shape," said Gordon D. Luce, assistant manager at Brown Bros. Harriman & Co. in New York.

"We've had no changes in our reserving philosophy," said Kemper's Mr. Fitzpatrick. "We add to reserves on a regular basis when, as and if required."

"I think that sometimes analysts aren't looking hard enough at the numbers," commented George Yonker, assistant controller at SAFECO Corp. in Seattle. Mr. Yonker said that SAFECO was overreserved at year-end 1988.

"Our reserving is not as high as it as in 1987, but we still put about $56 million in reserve strengthening," said a spokesman for USF&G Corp., adding the insurer continues to add to reserves when needed.

One company that anticipates adding less to reserves in 1989 is Royal Insurance, whose $260 million addition to reserves, primarily for commercial lines, led to a $72.2 million operating loss for 1988.

"We expect '89 to be a better year," said Senior Vp Robert Humphreys.

Meanwhile, observers say insurers have not yet adequately taken into account the impact of the Tax Reform Act of 1986, at least in part because of competitive pressures.

"I think they're quite concerned about it, but there's not a whole lot they can do," Ms. Stewart said. "I'm sure they would be delighted to be charging higher prices to cover the increased tax burden, but the market just won't permit it."

Insurers may have taken their additional tax obligation into account, "but I don't think market conditions permit them to implement it," agreed Fox-Pitt's Mr. Anthony.

"I believe they have taken it into account, yes, but I don't believe they've put it into their rates," said Firemark's Ms. Morrissey.

"I think insurance companies are just beginning to recognize the full impact" of the tax act, said Shearson's Mr. Ghose. Most companies' financial and chief executive officers understand the law theoretically, but field operating employees do not—and insurance is "an industry that's run out in the field."

"These guys have not been made sensitive enough to the '86 tax act, and that's just beginning to happen right now," Mr. Ghose said.

"Communicating how underwriting pricing should change because of the impact of the tax reform act is very difficult," said Kemper's Mr. Fitzpatrick. He added that the insurer plans to put more effort into communicating tax changes this year.

The complexities introduced by the Tax Reform Act of 1986 continue to influence insurers' investment strategies, observers note.

They say a key factor is the alternative minimum tax, which assures that all corporations with income pay some tax.

In light of the AMT, most insurers owned too many municipal bonds at the end of 1987, Mr. Ghose explained. However, through 1988, insurers shifted to taxable instruments. Now, insurers are "pretty much where they want to be," so they can "fine tune" investment strategies in 1989, he said.

Observers also note that while interest rates are increasing, they are not expected to rise high enough to encourage a return to cash-flow underwriting.

"We don't think the rise in interest rates as of now is sufficient to make a major change in market performance," said the III's Mr. Mooney.

"I don't see rising interest rates having an impact on pricing, because I don't think interest rates are going to reach the level that will promote cash-flow underwriting," agreed Robert Branche, of the Morrisville, Pa.-based Branche Research Group.

Meanwhile, investment income will be "helped by higher interest rates, but (insurers) will be hit by lower cash flows" because of reduced premium growth this year, said Fox-Pitt's Mr. Anthony.

Some observers believe that while the problem of reinsurance recoverables has not disappeared for insurers, it no longer is a growing problem.

"I don't think the problem has gotten any worse than it was a year ago," said Shearson's Mr. Ghose.

"I still don't think they're a major problem for the bigger companies," said Brown Bros.' Mr. Luce.

Reinsurance recoverables continue to be problem, though not as bad a problem as in the past, because insurers have become "more and more security conscious," said Firemark's Ms. Morrissey.

"It's of concern, but I think in the last two or three years the quality of reinsurance has vastly improved because lots of the marginal players are out of the business," said the III's Mr. Mooney.

"I think there's still a problem," Ms. Vogel said. "I'm at a loss to quantify it though."

Some observers believe there may be a slowdown in insurers' stock buyback programs this year. Several insurers have introduced and implemented these programs in the past 18 months (*BI*, March 21, 1988; Oct. 26, 1988; Aug. 31, 1987).

Insurers with buyback programs include Fireman's Fund, which received an authorization to buy back 7.5 million shares in last year's third quarter and had repurchased 1.5 million shares as of year-end, Ms. Baulis said, adding that future purchases will be decided by the insurer's chief investment officer.

Aetna purchased 1.5 million shares of its common stock during 1988, of which 177,400 were purchased during the fourth quarter. It received an authorization to buy up to 10 million shares in August, said a spokesman.

Aetna also purchased 584,500 shares of preferred stock during 1988.

SAFECO repurchased 2 million shares, or 3.1% of its outstanding stock, during the fourth quarter and repurchased 4.1 million shares in all of 1988.

In addition, General Re Corp. earlier this year repurchased 480,400 shares of common stock this year.

Insurers' reduced cash flow could have an impact on their ability to buy back shares this year, said David Seifer, a vp with Donaldson, Lufkin & Jenrette in New York.

Noting that the price of insurance stocks has recently improved, Mr. Branche said: "I think we've seen to a large extent the end of stock repurchase programs." Such programs never make sense unless the stock is selling at below book value, he explained.

Stock buyback programs will "not be as hot and heavy as it was before because the stock market obviously has recovered," agreed Firemark's Ms. Morrissey.

Many companies are announcing buyback programs, "but I haven't seen any teeth being put in these programs yet," said Dean Witter's Mr. Lewis. ■

Raytech bankruptcy

Continued from page 3

Edgar Neely, a partner of Neely & Player in Atlanta.

Because of the involuntary bankruptcy petition against Raymark, Raytech cannot recover defense costs it incurs in asbestos litigation under an indemnification agreement it had made with Raymark, Mr. Young said.

"Raymark indemnified Raytech against liabilities under an indemnity clause of the asset purchase agreement, and as long as Raymark was viable, we had indemnity," Mr. Young explained.

While Raytech views the Chapter 11 filing as a temporary move, some plaintiffs' attorneys see it as a death knell for Raytech and Raymark.

"I would be very surprised if the whole corporate scenario were not liquidated. It's very unlikely that these companies will ever emerge from bankruptcy," predicted Fred Baron, a partner with Baron & Budd in Dallas.

"I think the bankruptcy court needs to closely scrutinize the manner in which the assets were transferred from Raymark to Raytech. I think it would find that they are one and the same company and it would be appropriate for the assets of the two companies to be combined," said Timothy E. Eble, a plaintiffs' attorney with Ness, Motley, Loadhoat, Richardson & Poole in Barnwell, S.C.

Mr. Eble views Raytech's Chapter 11 filing "as a last-ditch effort by a company which, in my opinion, has little future."

Paul T. Gillenwater, a partner with Gillenwater, Nichol &

Continued on next page

NRRA unveils its changes to '86 Risk Retention Act

By DEBORAH SHALOWITZ

WASHINGTON—The National Risk Retention Assn. is proposing sweeping revisions to the federal Risk Retention Act, many of which would clarify the regulation of risk purchasing groups.

The NRRA proposal, which is being circulated on Capitol Hill in the form of draft legislation, is similar to Risk Retention Act revisions drafted by U.S. Commerce Department staffers last year (*BI*, Nov. 21, 1988).

The differences between the two proposals "are relatively narrow," said Jon Harkavy, director of governmental affairs for the Risk & Insurance Management Society Inc., which worked with the NRRA on the proposal.

The NRRA proposal "is very close to the discussion draft that we prepared," agreed Edward Barrett, a Commerce Department official.

Under both the NRRA and the Commerce Department proposals:

- An insurer would have to meet objective standards, such as minimum capital and surplus requirements, before it could underwrite coverage for purchasing groups.

However, the NRRA proposal would require insurers to meet several objective standards, while the Commerce Department proposal would require insurers to meet only one of several standards.

Mr. Barrett said this provision of the Commerce Department proposal will be amended, but he declined to specify exactly how the provision will be changed.

The objective standards set forth by both proposals would clarify a confusing provision in the 1986 amendments to the Risk Retention Act that says a purchasing group must buy coverage from an insurer that is admitted or authorized in the state where the purchasing group is located, although the word "located" is not defined.

- The term "located" would be defined so that a purchasing group would have to declare which state is its principal place of business and maintain an office in that state as well as have members in that state.
- Only one state—the state that a purchasing group declares as its principal place of business—would have the power to regulate the rates and policy forms used by a purchasing group insurer.

This provision would negate a 1987 New York federal court decision that some say suggests that purchasing group insurers must submit rates and policy forms to regulators in any state in which a purchasing group has members (*BI*, June 27, 1988; Oct. 5, 1987).

- A purchasing group's insurer would have to provide more information to regulators in each state in which the group has members.

There are a few differences between the NRRA and Commerce Department proposals.

For example, under the Commerce Department proposal, purchasing groups would have to be established and controlled by buyers; insurers or those affiliated with insurers, like managing general agents, could not establish or control a purchasing group.

The NRRA proposal does not contain a similar restriction.

Michael Mullen, an attorney with Crowell & Moring in Washington, D.C., which represents the NRRA, said the association's proposal does not address this issue because it wanted "to make sure that legitimate insurers can provide assistance to (purchasing) groups in their formation."

However, regulators and others have said insurer-organized purchasing groups represent a conflict of interest because the insurer that is setting the rates also controls the fortunes of the group.

Many of the purchasing groups established since enactment of the 1986 amendments have been organized by insurers, some of them thinly capitalized.

Another difference between the two proposals is that the NRRA proposal prohibits any state other than the domiciliary state from imposing a registration fee on a risk retention group or a purchasing group.

Also unlike the Commerce Department proposal, the NRRA calls for the U.S. secretary of commerce or the attorney general to be authorized to file suit to prevent a state from forcing the groups to abide by regulations from which they are specifically exempted under the Risk Retention Act.

The NRRA has not yet found a sponsor for its draft bill, but the proposal is being circulated among members and staffers of the appropriate Senate and House committees, Mr. Mullen said.

"Our hope is that legislation will be introduced in both houses of Congress soon and that hearings will be held at the earliest possible date," said James Anderson, senior director of government relations for the National Assn. of Wholesaler-Distributors in Washington, D.C., and chairman of the NRRA's government affairs committee. ■

Raytech bankruptcy

Continued from previous page

Ames in Knoxville, Tenn., agreed. "I think it's the last resort for them."

Because the filing will protect Raytech's assets until the successor liability issue is resolved, Mr. Baron feels plaintiffs will benefit.

But Mr. Gillenwater said that "few companies have the same value in a forced sale that they do as a going concern, and their creditors suffer."

He and other plaintiffs' attorneys blame Raymark's and Raytech's hard-line settlement approach for driving the companies into bankruptcy court.

"He who lives by the sword dies by the sword, and that's what's happened with Raymark and Raytech," Mr. Baron observed.

"Other asbestos producers have taken a more reasonable approach in working out resolutions. Still others have taken Raymark's tact of defending these cases to the hilt," he said.

Raytech is the latest of several asbestos producers that have filed for Chapter 11 protection, including Manville Corp., UNR Industries Inc. and Nicolet Inc.

Manville has since emerged from reorganization (*BI*, Oct. 10, 1988); UNR has proposed a plan of reorganization (*BI*, Dec. 21, 1987); and Nicolet is being dissolved (*BI*, Sept. 5, 1988).

"Time will tell whether (Raymark and Raytech) were right or not," said attorney Scott Gilbert, who represented asbestos producers that were members of the Asbestos Claims Facility, the predecessor to the Center for Claims Resolution in Princeton, N.J., which represents 21 asbestos producers.

Neither Raymark nor Raytech was a member of either facility.

Mr. Gilbert, a partner with Covington & Burling in Washington, observed that "a number of companies are watching what happens with great interest to see if it provides a road map out of this problem. A lot of others are watching with a great deal of skepticism."

Lawrence Fitzpatrick, president and chief executive officer of the Center for Claims Resolution, does not expect a decision on Raytech's successor liability to have "any impact at all" on that facility's members, none of which has considered restructuring its operations as Raymark did.

"We have a more settlement-oriented philosophy than Raymark and have been settling claims regularly," he said.

"I had serious reservations over their attempts at corporate restructuring and whether it would work, and I think this will cause others to pause before trying to do a similar type of restructuring," Mr. Fitzpatrick added. ■

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Update

New EIL facility forming

DETROIT—Plans are under way for the formation of a syndicate to underwrite environmental impairment liability insurance.

Some 13 of more than 200 property/casualty insurers contacted have responded with interest so far to a Feb. 27 letter proposing the development of an EIL syndicate, said Robert Dinser, vp of Amerisure Insurance Co. of Detroit, which is organizing the effort.

About 20 companies would be needed to form the new facility, he said. He declined to predict when the new facility could begin writing.

The proposed facility would be substantially different from the Pollution Liability Insurance Assn., an EIL reinsurance facility that disbanded as of Jan. 1 (*BI*, Jan. 30; Jan. 16).

For example, PLIA member companies wrote EIL coverage on a joint and several basis. Under the EIL syndicate proposal, each member company would have a specific percentage of participation and thus be responsible for only its share of losses and entitled to only its share of profits, Mr. Dinser explained.

And, while PLIA required that coverage be written through a member company, the new EIL facility would write the coverage on its own paper. The facility probably would write a maximum of $2 million of aggregate limits, Mr. Dinser said.

Air Ontario insured for crash

MONTREAL—Air Ontario has $1 billion of liability insurance for the crash of a $6.5 million Fokker 28 jet that crashed March 10 outside of Dryden, Ontario, killing 24 of 69 people on board and injuring 10 others.

No liability reserve has been set up so far, underwriters say.

The airline has hull insurance to cover the value of the aircraft. The hull and liability coverage, which renews July 1, was placed for Air Ontario's parent company, Montreal-based Air Canada, by Montreal-based broker Dale Parizeau Inc.

Forty percent of the coverage was placed in the Canadian and U.S. markets, led by Canadian Aviation Insurance Group in Toronto, a unit of United States Aircraft Insurance Group in New York.

Another 40% was placed in the London market by Lloyd's of London broker Willis Faber P.L.C. and led in Lloyd's by the Ariel syndicate. The remaining 20% was placed by Dale Parizeau with La Reunion Aerienne in Paris through underwriter Groupe Commerce in Montreal.

The cause of the crash shortly after takeoff remains a mystery because the plane's voice and flight recorders were destroyed.

$7.4 million Delta crash award

AUSTIN, Texas—Delta Air Lines must pay $7.4 million, including interest, to the widow of a passenger killed in a 1985 crash at Dallas-Fort Worth International Airport, a U.S. District Court judge ruled last week.

The victim, Michael Douglass, 41, was a sales vp for Metromedia Inc./Network One.

Delta attorney Jim Guess of San Antonio-based Groce, Locke & Hebdon would not comment on whether the airline plans to appeal.

Delta "did not admit liability but agreed they would not contest liability," Mr. Guess said. The airline has used the same approach in settling most of the approximately 136 suits stemming from the crash to expedite resolution of the cases.

At the time of the crash, Delta had $750 million in aviation liability coverage, and underwriters subsequently reserved $125 million to pay liability claims (*BI*, Aug. 12, 1985).

A federal court jury in New York last year awarded $8 million to survivors of an International Business Machines Corp. executive who was killed in the Dallas crash (*BI*, March 28, 1988).

D&O insurers settle Kaiser suit

RANCHO CUCAMONGA, Calif.—Two directors and officers liability insurers of Kaiser Steel Corp. will contribute $12.3 million to settle two lawsuits against former directors and officers of the company that challenged the legality of certain transactions and property transfers made between 1984 and 1986 after a leveraged buyout of the company.

The settlement is contingent upon resolution of objections non-settling defendants may file. Lawsuits against several more Kaiser Steel defendants will be heard April 11 in U.S. Bankruptcy Court in Denver.

National Union Fire Insurance Co. of Pittsburgh, Pa., an American International Group Inc. unit, will contribute between $1 million and $2 million toward the settlement, and Federal Insurance Co., a unit of Chubb Corp., will contribute the remainder, said Daniel N. Larson, president of Kaiser Steel Resources Inc., the successor company to Kaiser Steel.

Mr. Larson explained that the former officers and directors of Kaiser Steel had $25 million of D&O coverage: a primary layer of $5 million written by Harbor Insurance Co., a Continental Corp. unit; a second layer of $5 million excess of $5 million written by National Union; and a $15 million layer excess of $10 million written by Federal.

Harbor's coverage has been depleted by defense costs, Mr. Larson said.

Briefly noted

Committees representing members of **Lloyd's of London syndicates** managed by four underwriting agencies did not meet as scheduled last week to decide whether to coordinate separate litigation against members' agencies. The members seek to recover millions of dollars in underwriting losses. The committees instead will decide individually whether to accept contingency financing from London Wall Litigation Claims Ltd. . . .The American Insurance Assn. filed a notice of appeal with the New York State Court of Appeals, the state's highest court, seeking the return of at least $87 million that the state Legislature appropriated from **New York's property/casualty guaranty fund** in 1982. A lower court dismissed the AIA's litigation earlier this year (*BI*, Jan. 23).

Brokers hold their own in spite of tough market

By LEONARD M. WILSON

Special to Business Insurance

Overall, brokers' revenues typically rose in the low single-digit area for 1988. This rate of increase reflects the state of the market.

NEITHER THE BEST of years nor the worst of years might be an appropriate description of 1988 for the publicly held insurance brokers. Earnings for the year just about matched those of 1987 despite intensifying competition in the commercial property/casualty insurance market.

Results for the public brokers displayed notable consistency. Marsh & McLennan Cos. Inc. reported earnings of $4.09 per share for 1988 against $4.06 per share in 1987. Alexander & Alexander Services Inc. registered $1.71 per share from continuing operations last year compared with the prior year's $1.77. Corroon & Black Corp.'s fully diluted results were $2.39 in 1988 against 1987's $2.28 per share, while Arthur J. Gallagher & Co. realized $1.41 per share last year vs. $1.34 in 1987.

Mr. Wilson

These rather anemic comparisons were bolstered in several instances by lower rates of tax accrual or share buybacks, which reduced the number of shares on which earnings were calculated. Nonetheless, 1988 results for the public brokers mask a great deal of concerted effort in the realm of new business and expense control.

Overall, brokers' revenues typically rose in the low single-digit area for 1988. This diminished rate of increase reflected the difficult state of the market. Commissions on direct domestic insurance brokerage barely surpassed 1987's performance.

Quantifying the impact of rate reductions on insurance brokerage is never possible with any degree of precision. But we believe that premium rates may have trimmed commissions by as much as 15% across the full book of business. Rates, from our vantage point, seem to have become even softer in the fourth quarter even though the competitive market is now almost 3 years old.

Reinsurance brokerage in 1988 on an aggregate basis probably declined modestly. Comparisons for most of the year were burdened by the higher retentions of the primary insurers. Late in the year, it had become evident that reinsurance, heretofore exhibiting price discipline, was also responding to the siren song of more competition.

Benefit consulting proved to be 1988's star. Gains ranged above 15% year over year. Marsh & McLennan achieved a 30% advance for the full year, with most of the rise by our estimate from internal progress. The mushrooming cost of benefits and changing regulations have spurred the expansion of benefits activities for insurance brokers.

Investment income increased narrowly as a consequence of the advance in short-term interest rates. Premium volume likely restrained the growth of investible funds.

New business continued to offer the means for creditable performance for brokers over the course of the year. We doubt that new business production, when measured in dollars, surpassed that of 1987 by very much. This was impressive nonetheless in the face of the decline in premium rates and seems to refute the once widespread view that soft markets are not hospitable to new business production for the full-service broker.

Lost business seemed to have escalated in 1987. For 1988 as a whole, the public brokers were able to stem attrition in the existing book of business as a result of efforts aimed at meeting client needs in a soft market.

Prior to the softening of the market in late 1986, we asked each of the public brokers if expense budgeting could be responsive to a slowing of the revenue stream. In our view, a period of duress is the acid test of the budget as an instrument of management control.

Without exception, the public brokers were able to rein in costs during 1988. Expenses increased only slightly in response to premeditated programs of control and expenses shaving. Staff expansion was within nominal bounds and increased productivity became a watchword at all levels of operations.

Notwithstanding strong new business and good cost control, pretax profit margins narrowed in 1988. This was no surprise, since it is almost axiomatic that brokerage margins must shrink when revenue growth slackens to the single-digit area. Our calculations suggest that on average, pretax spreads edged downward by two to three percentage points.

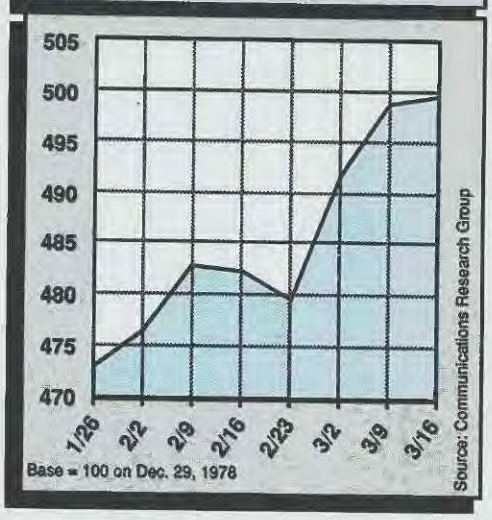
Results in the fourth quarter for the most part adhered to the pattern of the year as a whole. Markets were soft, while new business production and cost restraint prevented earnings comparisons from deteriorating materially.

Performance in the fourth quarter allowed for little optimism about the shape of the first half of 1989 and possibly the full year. Premium rates in the primary segment of the market seemingly deteriorated in the fourth quarter. Now that reinsurance rates are easing, the odds are strongly against any firming in primary rates particularly soon.

We would not be surprised if the public brokers experienced another year of profit margin pressure, given the current outlook for commercial insurance pricing. But the vital signs of insurance brokerage—production and cost control—ought to function as countervailing factors to the continuing soft market. ■

Leonard M. Wilson is a senior vp with Lazard Asset Management Inc. He is a member of the New York Society of Security Analysts.

BI Insurance Index



Insurance industry stocks saw gains last week, as the *Business Insurance Index* rose 0.5 points to 499.6 on March 16, from 499.1 on March 9. Advancing issues were led by SCOR U.S. Corp., up 9.1%; United Medical Corp., up 8.7%; and Seibels Bruce Group Inc., up 6.5%; Decliners followed Maxicare Health Plans, which filed for reorganization, down 69.8%; United Health Services, down 6.7%; and Frank B. Hall & Co. Inc., down 6.4%. The most active issue was Sears, Roebuck & Co. (Allstate), 3.5 million shares traded. The *BI Index* gained a slight 0.1% for the period; the Dow Jones 30 Industrials shot up 2.2%; and both the Standard & Poor's 500 and the NYSE Composite grew by 1.7%

British Issues

March 16 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence	pence
Comml Union	374	12.9	25.3	6.8	381	366
Genl Accident	995	9.2	58.7	5.9	995	971
Gdn Royal Exch	214	11.5	13.1	6.1	217	214
Royal	421	13.1	30.0	7.1	427	420
Sun Alliance	1135	8.7	54.7	4.8	1148	1135
Brokers						
Bradstock	246	13.9	9.0	3.7	246	246
CE Heath	468	14.9	34.5	7.4	471	468
Hogg Robinson	169	15.6	8.0	4.7	173	159
Lloyd Thompson	211	16.6	8.0	3.8	213	211
PWS Holdings	75	20.3	4.6	6.2	78	75
Sedgwick Grp	249	20.6	16.0	6.4	251	248
Steel Brrl Jones	239	21.3	13.3	5.6	240	239
Willis Faber	234	15.9	15.3	6.6	241	234

Source: Philip Olsen/Alan Clifton, Insurance Industry Specialists Kitcat & Aitken Stockbrokers, London

BI Industry Stock Report

MARCH 16, 1989 — 3/10/89 THRU 3/16/89

		Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
BROKERS												
Alexander & Alexander Svcs	NYSE	24.75	4.2	5.3	24.38	22.63	365	1.00	4.0	15.8	3.71	6.67
Corroon & Black Corp	NYSE	32.38	-1.9	4.0	34.50	30.75	605	1.24	3.8	4.8	12.40	2.61
Gallagher Arthur J. & Co	NYSE	18.38	0.7	9.7	18.38	16.13	15	0.48	2.6	13.0	5.46	3.37
Hall Frank B. & Co.	NYSE	3.63	-6.4	26.0	4.63	2.50	101	0.00	0.0	-2.1	0.00	N/A
Hilb, Rogal & Hamilton	OTC	14.50	1.8	-4.9	15.75	13.75	13	0.00	0.0	12.6	4.60	3.15
Marsh & McLennan Cos. Inc.	NYSE	60.50	2.3	7.6	60.38	55.13	650	2.50	4.1	14.8	6.48	9.34
Poe & Assoc Inc.	OTC	8.50	0.0	3.0	8.50	8.25	5	0.40	4.7	7.7	0.27	31.48
BROKERS	AVERAGE		0.2	7.2					2.7	9.5		
CONGLOMERATES & HOLDING COMPANIES												
Berkley W R Corp.	OTC	30.75	0.0	4.2	33.25	29.50	89	0.36	1.2	6.6	17.63	1.74
Berkshire Hathaway Inc.	NYSE	4975.00	3.1	42.5	5050.00	3567.00	74	0.00	0.0	20.0	2492.68	2.00
ITT (Hartford Group)	NYSE	53.88	2.4	7.5	55.75	49.75	966	1.48	2.7	9.0	52.23	1.03
Sears, Roebuck & Co. (Allstate)	NYSE	43.50	3.0	6.4	43.63	40.13	3484	2.00	4.6	18.1	34.74	1.25
CONGLOMERATES	AVERAGE		2.1	15.2					2.1	13.4		
INSURERS & REINSURERS												
Aetna Life & Cas Co.	NYSE	50.13	0.0	6.1	51.38	46.75	687	2.76	5.5	8.6	53.56	0.94
American General Corp	NYSE	34.25	0.7	14.6	34.50	29.50	595	1.50	4.4	10.0	28.04	1.22
Amer Heritage Life Invt	NYSE	27.00	1.9	4.9	27.25	25.00	5	1.08	4.0	11.2	22.47	1.20
Amer Indly Fin'l Corp.	OTC	10.00	0.0	-4.8	11.25	10.00	14	0.56	5.6	6.5	17.06	0.59
American Int'l Group	NYSE	79.50	5.3	17.3	77.88	66.25	1281	0.40	0.5	11.1	33.55	2.37
Aon Corp.	NYSE	29.38	2.2	4.9	29.38	27.00	135	1.28	4.4	9.2	15.13	1.94
Argonaut Group	OTC	54.75	0.5	25.1	56.00	43.50	84	0.00	0.0	8.1	34.94	1.57
AVEMCO Corp	NYSE	23.75	-1.0	-8.2	26.13	23.63	24	0.40	1.7	11.6	9.20	2.58
Baldwin & Lyons Inc.	OTC	16.00	2.4	7.5	16.00	14.50	6	0.20	1.3	6.4	17.57	0.91
Belvedere Corp.	AMEX	5.75	-4.2	27.8	6.50	4.50	17	0.04	0.7	8.3	8.43	0.68
Chandler Insurance	OTC	9.13	-5.2	-1.3	11.25	9.00	10	0.00	0.0	4.4	6.65	1.37
Chubb Corp	NYSE	66.50	-0.4	14.7	66.88	57.63	306	2.32	3.5	7.5	46.13	1.44
CIGNA Corp	NYSE	53.25	0.0	13.0	55.13	45.88	815	2.96	5.6	9.5	51.37	1.04
CNA Fin'l Corp	NYSE	59.50	-0.6	-1.7	61.38	57.63	139	0.00	0.0	9.4	46.40	1.28
Continental Corp.	NYSE	32.75	1.1	1.1	36.00	31.50	764	2.60	7.9	15.7	42.10	0.78
Durham Corp	OTC	31.50	0.0	-4.5	33.75	30.00	25	0.92	2.9	32.8	26.23	1.20
Fireman's Fund Corp.	NYSE	34.00	1.1	16.2	34.00	29.00	524	0.60	1.8	7.2	30.91	1.10
Forum Re (Bermuda)	OTC	1.50	0.0	-8.0	1.75	1.50	9	0.00	0.0	4.2	2.58	0.58
Fremont Gen Corp.	OTC	17.50	2.2	30.8	18.25	12.13	376	0.60	3.4	11.1	16.24	1.08
Frontier Insurance Group	OTC	12.75	2.0	2.0	13.75	12.25	38	0.00	0.0	6.3	5.97	2.14
General Re Corp	NYSE	65.50	4.4	18.0	65.00	54.38	1047	1.36	2.1	13.0	27.10	2.42
Home Group Inc	NYSE	13.75	-0.9	25.0	14.50	11.00	507	0.20	1.5	5.8	18.66	0.74
Hanover Ins Co	OTC	27.75	-1.8	3.7	30.25	26.00	58	0.36	1.3	4.8	25.10	1.11
Harleysville Group Inc.	OTC	21.00	4.3	16.7	21.25	17.75	21	0.48	2.3	7.6	16.65	1.26
Hartford Steam Boiler	OTC	41.75	-1.8	13.6	42.50	34.75	249	1.40	3.4	12.1	10.65	3.92
Kansas City Life	OTC	34.00	-1.4	-1.4	35.00	32.75	12	0.00	0.0	10.8	39.22	0.87
Kemper Corp.	OTC	31.00	-0.8	29.2	32.25	22.75	377	0.84	2.7	8.9	28.91	1.07
Lawrence Ins. Group	AMEX	7.75	-3.1	-1.6	8.50	7.75	3	0.24	3.1	17.2	2.90	2.67
Liberty Corp. S.C.	NYSE	35.25	-1.4	-2.1	38.00	34.75	24	0.80	2.3	13.8	20.76	1.70
Lincoln Nat'l Corp.	NYSE	49.50	0.5	12.5	50.50	42.75	117	2.48	5.0	12.0	37.11	1.33
NAC Re Corp.	OTC	37.25	3.5	17.3	37.50	31.00	327	0.00	0.0	14.8	22.06	1.69
Navigators Group	OTC	21.25	0.0	6.3	22.00	20.50	1	0.00	0.0	10.3	12.88	1.65
Nobel Ins Ltd	OTC	4.88	2.7	2.7	5.00	4.50	38	0.42	8.6	-18.8	7.76	0.63
Northwestern Nat'l Life	OTC	30.38	1.7	-2.4	32.00	26.88	145	1.12	3.7	7.6	35.05	0.87
Ohio Cas Corp.	OTC	40.00	0.6	11.9	45.25	35.50	315	2.08	5.2	6.1	31.53	1.27
Old Rep Int'l Corp.	OTC	26.00	-1.9	8.3	28.88	23.75	121	0.74	2.8	13.0	27.82	0.93
Orion Cap Corp.	NYSE	20.75	5.7	34.9	20.88	15.38	151	0.76	3.7	6.9	9.34	2.22
Phoenix Re Corp.	OTC	10.00	5.3	5.3	11.00	9.50	37	0.00	0.0	5.2	12.49	0.80
Protective Life Corp.	OTC	13.25	0.9	0.0	14.50	12.88	116	0.70	5.3	16.2	17.25	0.77
Re Capital Corp.	AMEX	10.75	1.1	17.7	10.88	9.13	8	0.00	0.0	23.9	11.93	0.90
RLI Corp.	NYSE	9.00	0.0	18.0	9.25	7.50	11	0.36	4.0	7.4	10.59	0.85
Provident Life & Acc Ins Co.	OTC	22.75	1.7	18.2	23.50	19.13	549	0.68	3.0	12.4	21.96	1.04
St. Paul Cos. Inc.	OTC	47.00	1.6	8.0	48.75	43.00	781	2.20	4.7	6.5	30.64	1.53
SAFECO Corp.	OTC	28.38	1.8	20.1	28.38	23.13	897	1.08	3.8	7.9	23.94	1.19
SCOR US Corp.	NYSE	9.00	9.1	-1.4	9.13	7.50	47	0.20	2.2	6.6	9.38	0.96
Seibels Bruce Group Inc.	OTC	12.25	6.5	7.6	13.00	11.25	67	0.80	6.5	7.8	13.42	0.91
Selective Ins Group Inc.	OTC	24.25	1.5	5.4	24.00	21.75	67	1.24	5.1	5.4	22.33	1.09
Statesman Group Inc.	OTC	3.13	4.3	0.0	4.00	2.88	117	0.05	1.6	-313.0	3.48	0.90
Tokio Marine & Fire Ins	OTC	83.50	-3.5	-8.6	95.50	83.25	20	0.22	0.3	50.6	0.00	N/A
Torchmark Corp.	NYSE	33.25	1.5	9.0	33.63	30.00	284	1.20	3.6	10.4	12.24	2.72
Transamerica Corp.	NYSE	34.63	1.1	2.2	35.38	32.75	488	1.88	5.4	8.1	27.36	1.27
Travelers Corp.	NYSE	39.13	1.6	12.6	39.25	34.50	614	2.40	6.1	9.5	45.28	0.86
Trenwick Group Inc.	OTC	13.75	0.0	-5.2	15.25	13.75	355	0.24	1.7	8.5	16.91	0.81
United Fire & Cas Co.	OTC	30.25	0.8	-0.8	30.75	30.00	5	1.08	3.6	5.3	22.56	1.34
United States Fid & Gty	NYSE	32.00	-1.2	12.3	32.88	28.50	3308	2.80	8.8	9.0	22.15	1.44
UNUM Corp	NYSE	29.75	3.0	10.2	29.88	26.63	266	0.48	1.6	10.4	30.64	0.97
USLIFE Corp.	NYSE	39.25	3.3	12.5	40.13	34.13	265	1.36	3.5	10.3	46.77	0.84
Washington Nat'l Corp.	NYSE	27.13	0.0	0.5	27.50	25.25	508	1.08	4.0	-7.9	32.33	0.84
Zenith Nat'l Ins Corp.	NYSE	18.25	-1.4	4.3	19.00	16.75	23	0.80	4.4	8.6	13.61	1.34
INSURERS/REINSURERS	AVERAGE		1.0	8.4					3.1	4.3		
HEALTH MAINTENANCE ORGANIZATIONS												
FHP International Corp	OTC	23.25	1.1	91.7	24.88	11.75	444	0.00	0.0	12.7	3.54	6.57
HMO America Inc.	OTC	1.56	0.0	66.0	1.84	0.94	35	0.00	0.0	-2.5	1.12	1.39
Maxicare Health Plans	OTC	0.19	-69.8	-74.7	0.41	0.19	3000	0.00	0.0	0.0	0.00	N/A
Pacificare Health Systems	OTC	22.75	4.6	85.7	23.00	12.25	145	0.00	0.0	18.2	6.35	3.58
Safeguard Health Ent.	OTC	5.50	2.2	0.0	8.25	4.00	7	0.00	0.0	11.0	2.75	2.00
Sierra Health Services	AMEX	2.38	5.8	46.0	2.63	1.50	45	0.00	0.0	18.3	1.59	1.50
United Health Services	OTC	7.00	-6.7	55.6	7.75	4.13	246	0.00	0.0	3.1	2.59	2.70
United Medical Corp.	AMEX	6.25	8.7	19.0	6.75	5.13	15	0.00	0.0	12.3	3.91	1.60
U S. Healthcare	OTC	9.13	0.8	57.1	4.69	2.63	922	0.20	2.2	76.1	2.87	3.18
Western Health Plans Inc.	AMEX	0.75	0.0	8.7	1.13	0.50	9	0.00	0.0	-0.4	0.82	0.91
HMOs	AVERAGE		-5.3	35.5					0.2	14.8		
ALL COMPANIES	AVERAGE		0.2	12.1					2.6	6.5		

System design: Communications Research Group

Duncanson & Holt.

Aren't they the trail blazers who opened up a new territory in 67?

Unless you're in insurance, you might not know we pioneered accident and health reinsurance in America. Back in 1967, we formed the American Accident Reinsurance Group (AARG), the first facility of its kind in this country.

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