

# Business Insurance

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## Dingell panel circulates draft of federal regulation proposal

WASHINGTON—The House Oversight & Investigations Subcommittee is circulating a discussion draft outlining a possible federal role in insurer solvency regulation.

The "Insurance Legislation Discussion Outline," dated March 14, describes legislation that would:

- Empower a federal agency—possibly the Securities and Exchange Commission—to directly regulate insurers in some cases and to supervise state regulators or self-regulatory groups in others.

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# Businesses' week in court

## Lower courts to review punitive damages

By STACY ADLER

WASHINGTON—There are constitutional boundaries to punitive damage awards, the Supreme Court last week signaled.

By remanding for lower court review seven cases challenging the constitutionality of punitive damages awarded, the justices affirmed Corporate America's claim that it gained ground earlier this month in a high court decision upholding the constitutionality of the procedures Alabama courts use in punitive damage cases.

Despite losing the appeal, busi-

ness groups saw victory in the Supreme Court saying that there is a constitutional "line" which punitive damage awards cannot cross.

By not simply rejecting the seven cases for review, the court signaled that the cases should be reviewed in light of its ruling earlier this month, defense attorneys say.

Consumer groups and plaintiffs' attorneys, who had touted the court's earlier ruling as a victory for the discretion of juries, are cautioning against reading too much into last week's remanding of seven punitive damage cases from other states.

The court last week also refused to review two punitive awards from Alabama.

Defense attorneys, however, say the Supreme Court is sending a message to state courts and state legislatures to reform the system of punitive damages.

They hope the court's actions will light a fire under state judges and legislators. Specifically, defense lawyers want more detailed jury instructions and explicit criteria by which judges can review the awards.

In its earlier decision, the Su-

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## Supreme Court strikes down workplace fetal protection rule

By MEG FLETCHER

WASHINGTON—Last week's Supreme Court ruling that employers may not prohibit all fertile women from holding jobs that pose a significant risk to the health of unborn children could increase liability and other costs for employers with such policies.

The ruling is a defeat for Johnson Controls Inc., a Milwaukee-

based manufacturer that until now had enforced fetal protection policies to prohibit fertile women from working with lead, a known fetal toxin.

For other manufacturers that use fetal toxins, the decision may lead to increased training and operational costs as well as increase their liability to injured offspring in rare third-party lawsuits, employer groups say.

"I think corporate risk managers would be very discouraged by the decision" in this "very significant" case, said Robin Conrad, vp of the National Chamber Litigation Center of the U.S. Chamber of Commerce in Washington, D.C.

The decision creates "a serious problem" for a small segment of manufacturers with fetal protection policies similar to those of

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## Police liability expands

### Appellate decision puts responsibility on municipalities for training officers

By JOANNE WOJCIK

LOS ANGELES—Municipal governments' liability will be expanded under a recent federal appellate court ruling that municipalities and law enforcement agencies are responsible for training officers on the legal limits of the use of force.

The ruling by a panel of the 9th U.S. Circuit Court of Appeals in Seattle also could influence civil litigation filed in connection with the highly publicized Rodney King case in Los Angeles, because California is part of that judicial circuit, attorneys note.

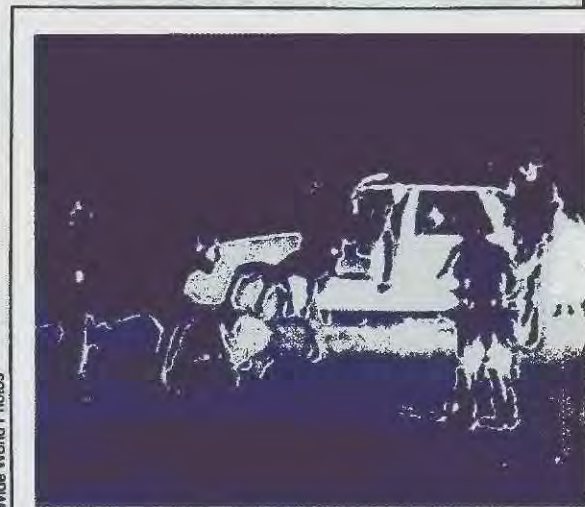
However, municipal risk managers are convinced that police officer training programs are adequate to protect their entities from widening liability exposures.

The March 12 appellate ruling upheld jury verdicts totaling more than \$582,000 against Mason County, Wash., its former sheriff and several deputies for using excessive force in four separate incidents.

One of those incidents, in which a deputy assaulted the operator of a horse-drawn wagon after pulling him over for moving too slowly, "is very similar to what happened to the man down in Los Angeles," observed attorney Timothy K. Ford, who represented several plaintiffs in the Mason County case.

The deputy blew "this case out of proportion," said Mr. Ford, who is with the Seattle firm of MacDonald, Hoague & Bayless.

In the Los Angeles case, Mr. King was assaulted by a group of Los Angeles Police Department of-



The Rodney King incident in Los Angeles was captured on tape by an amateur cameraman.

Officers after being pulled over following a high-speed chase.

Three officers and their supervising sergeant have been indicted by a grand jury assembled to investigate the case. All four were charged with one count of assault with a deadly weapon likely to cause great bodily injury, as well as one count of violating laws that make it a felony for an officer to assault a person unnecessarily.

In addition, U.S. Justice Department lawyers in Washington are considering whether to bring charges against several of the 17 other officers who watched the prolonged beating on the grounds that they had a legal obligation to keep Mr. King free from harm.

Mr. King's attorney, Steve Lerman of Beverly Hills, has announced plans to file a civil suit against the city seeking damages totaling \$56 mil-

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## TPA officials facing charges for MEWA fraud

By DOUGLAS McLEOD

BOSTON—Three officials of a defunct third-party administrator face criminal fraud charges stemming from their operation of multiple employer welfare arrangements that left hundreds of covered employees with \$4.3 million in unpaid medical claims.

A federal grand jury this month indicted three officers of Boston-based Harbor Medical Administrators Inc., charging them with embezzlement from two self-funded MEWAs.

Two of the officials also are accused of paying kickbacks while operating the MEWAs.

Harbor acted as TPA for Omni Medical Health & Welfare Trust—which provided health care coverage to more than 600 employers in Massachusetts and other states—and for Automotive Employee

Benefit Trust—a MEWA sponsored by the Massachusetts State Automobile Dealers Assn.

Together, the two insolvent MEWAs have failed to pay more than \$4.3 million in claims filed by hundreds of covered employees, with individual claims ranging as high as \$250,000, according to Stewart B. Hannon, special agent in charge of the U.S. Labor Department's Office of Labor Racketeering in Boston.

"They thought they had this coverage. They relied on it, and when the time came, it wasn't there," Mr. Hannon said.

Indicted on conspiracy, mail fraud and other charges were Harbor President Richard L. Rowe; Philip W. Carpenter, the firm's executive vp; and Anne B. Dunlop, a Harbor vp.

The three are scheduled to be ar-

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Workers comp self-insurers face tougher eligibility rules

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Federal court's benefit ruling may hurt pension reversions

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New Hampshire overturns cap on non-economic awards

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**Update**

**Federal regulatory plan outlined**

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- Pre-empt state regulation of reinsurers and surplus lines insurers. Solvency regulation in these cases could be taken over by a federal agency or by a self-regulatory group under federal supervision.

- Create federal minimum solvency standards for domestic insurers and provide for federal accreditation of state insurance departments. Insurers licensed in one accredited state could operate nationally.

- Provide for national liquidation of insolvent insurers, administered by a federal agency and handled in federal courts. State and federal regulators would have the power to place insurers in liquidation.

- Create a federal insurance fraud statute modeled after federal bank fraud laws.

Officials of the American Insurance Assn. and Alliance of American Insurers say subcommittee staff members have circulated the outline for comments, though subcommittee counsel John B. Chesson would neither confirm nor deny that proposals have been released.

While noting the subcommittee is trading ideas with various groups, Mr. Chesson said that "it's totally in mid-process. The chairman (Rep. John D. Dingell, D-Mich.) has signed off on nothing."

The subcommittee hopes to have draft legislation finished by June, Mr. Chesson said. Hearings are scheduled for May 2 and May 9.

**Managed care, cost-sharing bill**

WASHINGTON—Legislation introduced in the House last week would impose tax penalties on employers with either insured or self-funded health care plans that do not include managed health care arrangements or require "significant" employee cost-sharing.

And, employers that do not offer group health care coverage would be slapped with a \$200-per-employee tax, not to exceed \$25,000 annually.

Under the Health Equity and Access Reform Today bill, proposed by Reps. Rod Chandler, R-Wash., and Nancy Johnson, R-Conn., employers that do not offer managed care plans or plans that shift costs to employees would face a tax penalty equal to 25% of the employer's cost of each plan not meeting the specified standards.

The bill, H.R. 1565, states a managed care plan must provide explicit standards for selecting providers; has programs for ongoing quality assurance and utilization review; and provides financial incentives to use selected providers. "Significant" employee cost sharing means employees would have to pay at least 30% of the cost of coverage.

Also under the bill, employers with 25 or fewer workers that offer a specified basic health plan—dubbed "MedAccess"—would be exempt from state laws requiring group health insurance policies to cover specified procedures. These employers would be allowed to charge employees for the full cost of coverage.

The legislation does not make clear how the managed care and cost-sharing requirements would be regulated.

**Bo knows insurance**

LONDON—Lloyd's of London underwriter Colin Owen knows Bo is insured for permanent total disability.

The leading sports injury underwriter at Lloyd's says he leads at least three policies that could cover losses resulting from baseball and football star Bo Jackson's potentially career-threatening injury.

Mr. Jackson injured his left hip Jan. 13 during a Los Angeles Raiders football game and it is not clear whether he will be able to resume his athletic careers.

The Kansas City Royals baseball team last week released Mr. Jackson from his contract after the severity of his injury became known. By releasing Mr. Jackson now, the Royals must pay only one-sixth—or about \$400,000—of his non-guaranteed \$2.375 million 1991 salary.

But, under a guaranteed contract, the Raiders reportedly will pay Mr. Jackson more than \$1.6 million for the upcoming season even if he does not suit up.

In addition, Mr. Jackson reportedly receives between \$2 million and \$4 million annually for promoting Nike Inc. athletic products.

Mr. Owen, underwriter for syndicate 718, managed by Oxford Syndicate Management Ltd., would not comment on the limits of the policies, though he said they probably do not cover 100% of the value of Mr. Jackson's contracts with athletic teams and product sponsors. He said the policyholders included Mr. Jackson as well as athletic teams and product sponsors that have contracts with Mr. Jackson.

The policies would be triggered by injuries suffered by Mr. Jackson in either baseball or football games, Mr. Owen said. Product endorsements are protected if an injury "stops him from being a professional athlete, I think," Mr. Owen said.

Mr. Owen stressed that he may not be the only Lloyd's underwriter to lead policies covering Mr. Jackson.

Some of the coverage was placed in London by Windsor Insurance Brokers Ltd., confirmed Windsor Chairman Stan Taylor.

A Royals spokesman said the club had no insurance on Mr. Jackson, while a Raiders spokesman said he did not know about any insurance covering the team or Mr. Jackson.

A spokeswoman for Beaverton, Ore.-based Nike declined to comment on any insurance Nike may have purchased. "Our position on Bo is that Bo will come back to baseball in the spring (of 1992) and will be worth more to Nike than he ever has been," she said.

**Questions raised on BICs bill**

WASHINGTON—Legislation proposed last week by the Bush administration on eliminating "pass-through" Federal Deposit Insurance Corp. coverage for bank investment contracts purchased by pension plans is not clear whether the coverage would be eliminated for all

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**Errors and omissions**

- The insurance reform bill pending in Texas requires regulators to consider investment income when calculating rates. Although consideration of investment income is not mandatory under current law, the State Board of Insurance does consider it when setting rates, contrary to a report in the March 11 issue.

**Antitrust suit appeal**

**Attorneys try to gauge impact of oral arguments**

By JUDY GREENWALD

SAN FRANCISCO—Oral arguments did not shed much light on how an appellate court will rule in the appeal of the 1989 dismissal of the massive antitrust litigation against insurance industry defendants.

Both the state attorneys general who brought the suits and defense attorneys say it is impossible to predict the outcome on the basis of the hour-long March 15 hearing.

Both sides said, based on the questions asked at the hearing, it could be assumed that one of the three judges favored the attorneys general and one favored the industry defendants. The third judge, virtually silent during the arguments, remains a "wild card," the lawyers said.

But they warn against reading too much into the judges' questions. Directing even apparently hostile questions to one attorney does not necessarily mean the judge will rule against that lawyer's position, the attorneys said.

Attorneys general from 19 states are appealing U.S. District Court Judge William Schwarzer's 1989 dismissal of their suit against 31 insurance industry defendants to the 9th U.S. Circuit Court of Appeals (BI, Sept. 25, 1989).

The attorneys general alleged in their original suits that the defendants—including major U.S. insurers and reinsurers, the Insurance Services Office Inc. and several London underwriters—engaged in a boycott involving approval of ISO's commercial general liability policy form.

Specifically, the suits contend the defendants conspired to manipulate the U.S. commercial liability insurance market. ISO, the suits contend, was forced to rewrite its CGL form to exclude coverage for pollution and to include a retroactive date in the claims-made version of the form. The defendants also allegedly conspired to eliminate occurrence-based general liability coverage and to include defense costs within limits.

Attorneys speculate it could take two months to a year for the appellate panel to issue a decision.

Oral arguments on both sides focused on the 1989 decision as well as subsequent friend of the court briefs filed by the British government and the U.S. Justice Department. The British government sup-

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**Court orders payment of unearned benefits**

**Pension reversion threat**

By JERRY GEISEL

RICHMOND, Va.—An appeals court ruling could threaten the ability of employers to recover reversions when terminating overfunded pension plans as well as lead to more litigation involving already terminated plans, experts say.

In a 2-1 decision, the 4th U.S. Circuit Court of Appeals in Richmond ruled that participants in a terminated overfunded pension plan are entitled to special subsidized early retirement benefits even though the participants had not met certain requirements for the benefits at the time the plan

was terminated.

At issue in the case, *B.E. Tilley et. al vs. Mead Corp.*, were so-called early retirement subsidies. Under these subsidies, which are often provided to encourage employees to retire before age 65, pension benefits are not actuarially reduced to reflect the longer period of time over which an early retiree will collect benefits.

The case involved an \$11 million reversion from a 1983 termination of a pension plan by Dayton, Ohio-based Mead.

Workers sued the company following the termination of their pension plan. While the workers

were paid accrued benefits, they claimed they also had a right to benefits for which they would have qualified if they had remained on the job and the plan had not been terminated.

In 1986, the 4th Circuit ruled in the case that a provision of the Employee Retirement Income Security Act of 1974 gives participants rights to additional unearned benefits after a plan termination.

That provision, Section 404(a), provides an allocation schedule detailing the order in which assets of a terminated plan are to be distributed to participants before an

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**29 states now considering regulatory improvements**

By MEG FLETCHER



CHICAGO—Twenty-nine states are considering legislation to improve the ability of state insurance regulators to evaluate and regulate insurer solvency.

"This is an unprecedented level of state activity," said Early Pomeroy, North Dakota insurance commissioner.

Regulators are pushing for adoption of model laws, developed by the National Assn. of Insurance Commissioners, that are needed for NAIC accreditation, Mr. Pomeroy

said during a symposium this month sponsored by The Society of Chartered Property & Casualty Underwriters.

The push to improve state oversight comes as Rep. John Dingell, D-Mich., is drafting federal legislation to accomplish some of the same goals, said a Republican counsel to the House Energy and Commerce Committee.

To be accredited, states have to adopt NAIC model laws or similar measures. Among the subjects of those laws are insurance holding companies, managing general agents, reinsurance intermediaries, producer-controlled insurers,

credit for reinsurance, examination processes, liquidation proceedings and risk retention groups.

A state also must adopt NAIC-specified regulatory practices and procedures as well as organizational and personnel practices (BI, Dec. 3, 1990).

Thus far this year, legislatures in South Carolina and Georgia have passed such measures and sent them to their respective governors for signature. Similar measures are being considered in 27 other states, said Carolyn Johnson, model laws coordinator for the NAIC.

They are: Arizona, Colorado,

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**Inside**

✓ It is time for property/casualty insurers to shed their bunker mentality about changes to the McCarran-Ferguson Act, warns this week's editorial. **PAGE 8**

✓ Consumer ignorance of the details of coverage should not be a license to force companies to pay for things that were never intended to be covered, says benefit consultant Hobson D. Carroll in Speaking Out. **PAGE 23**

✓ Despite a slight market hardening, schools are not having significant problems finding reasonably priced D&O coverage, a new survey shows. **PAGE 26**

✓ Given their recent momentum in the stock market, analyst Leonard Wilson views the long-term potential of brokerage stocks. **PAGE 39**

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# Employers shift health care costs

## Workers pick up more of the tab since 1985: Study

By **DAVE LENCKUS** and **CHRISTINE WOOLSEY**

Hammered by health care cost increases, employers in the past five years have hit workers with a multi-pronged cost-shifting attack, according to a new study.

For example, employers increasingly are eliminating 100% reimbursement for hospital and surgical care.

Deductibles for individual coverage are rising dramatically, with employers generally moving toward \$200 deductibles from \$100 deductibles.

Numerous employers—especially those that offer workers more than one health care plan option—also are requiring employees to contribute to the cost of coverage.

In addition, 75% of the employers surveyed have set employees' annual out-of-pocket maximums in excess of \$1,000.

At the same time, there has been a slight increase in the number of employers with "stop-loss" features in their plans to cap employees' annual health care expenses. However, the size of those out-of-pocket caps has jumped.

Many employers also are offering flexible benefit plans and flex credits to help employees offset their health care costs.

These are among the benefit plan trends highlighted in "Salaried Employee Benefits Provided by Major U.S. Employers in 1985 and 1990," a recent survey by Hewitt Associates of Lincolnshire, Ill.

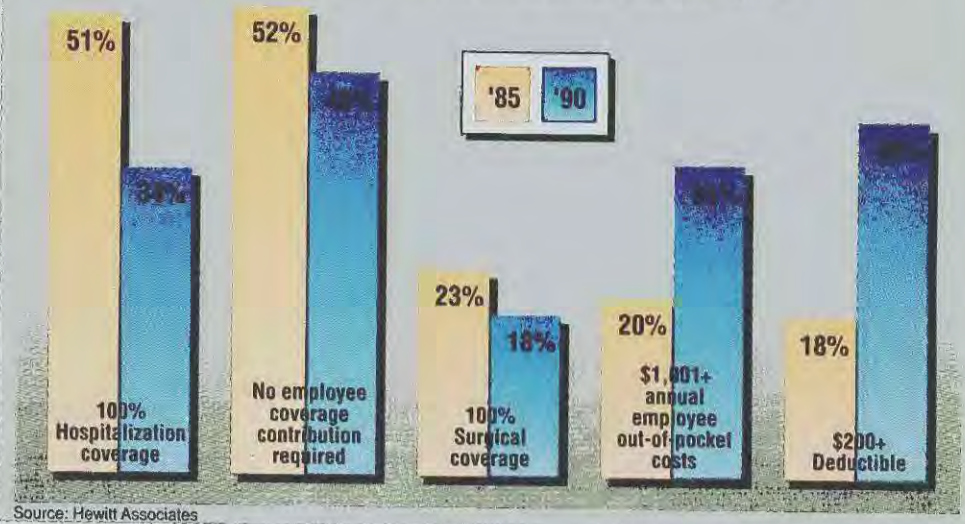
The Hewitt study summarizes benefit plan information provided in 1985 and in 1990 by an identical sample of 560 major U.S. employers.

Among industrial companies, the study included 83% of the Fortune 100 and 42% of the Fortune 500.

In addition to examining trends in employers' health care plans, the Hewitt study pro-

## Shifting health care costs

Many employers that sponsor a single group health care plan took several steps between 1985 and 1990 to shift plan costs to employees.



Source: Hewitt Associates

GRAPHIC BY JOHN HALL

vides information on defined benefit and defined contribution pension plans (see story, page 20), group life insurance plans, long-term disability programs, and dental, vision and hearing care plans.

More employers offered employees multiple medical plan options in 1990 than 1985, according to Hewitt's findings. In 1990, 39% of employers offered multiple plan options—

a 160% increase from 15% of employers in 1985. Last year, 341 employers offered one health plan option and 218 offered multiple options, compared with 474 single options and 86 multiple options in 1985, according to the survey. One employer stopped providing health care coverage since 1985.

The survey also found that companies "are  
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# N.H. overturns non-economic damages cap

By **ADRIENNE C. LOCKE**

CONCORD, N.H.—The New Hampshire Supreme Court used an inappropriate test when it ruled that an \$875,000 statutory cap on non-economic damages in personal injury cases is unconstitutional, defense attorneys say.

The court, in its 5-0 ruling in *Brannigan vs. Usitalo* issued March 13, admits it applied a higher standard of judicial review in determining the constitutionality of the 1986 law limiting non-economic damages in all personal injury cases than courts generally apply. The court applied that same standard in striking down a somewhat similar law in 1980.

But, attorneys do not expect that striking down the New Hampshire cap on non-economic damages will have much impact on liability insurance rates in the state or will influence courts in other states hearing similar challenges to statutory caps on damages.

The latest ruling came in a case in which a personal injury plaintiff awaiting trial challenged the constitutionality of the 1986 New Hampshire law.

In that case, the plaintiff alleges he suffered extreme physical injury and emotional distress because of his urologist's gross negligence after surgery in June 1987.

The plaintiff alleges that the physician failed to recognize the injury the surgery caused either immediately after the operation or in follow-up visits. Eventually, two other operations were required to remove most of the man's penis, said Joan Lukey, the plaintiff's attorney in the Boston office of Hale & Dorr.

In directly accepting the plaintiff's challenge to the 1986 statute, the Supreme Court noted its ruling would "have a substantial effect on the parties' evaluation of the case for purposes of settlement."

"Given the extraordinary character of (plaintiff's) alleged injuries, a jury finding for (the plaintiff) might award non-economic damages in excess of the \$875,000 statutory cap," the court said.

In its ruling, the court relied heavily on its 1980 ruling in *Carson vs. Maurer*, which the court called a "compelling authority."

The court in the Carson decision struck down a \$250,000 cap on pain-and-suffering awards in medical malpractice suits, ruling that the statute did not have a "fair and reasonable relation" to the "legitimate legislative objective" of improving the affordability and availability of liability insurance.

The Legislature in 1986 then passed a law capping non-economic damages in all personal injury suits at \$875,000.

The state Supreme Court recognized that the 1986 law also was designed in part to stabilize liability insurance rates and improve the availability of liability insurance.

In its *Brannigan* ruling, the court said it addressed the two questions before it: "whether the statute has a fair and substantial relationship to this legitimate legislative objective" and "whether it imposes unreasonable restrictions on private rights."

The statute failed on both points, the judges decided.

The court noted that in the Carson case it found that the \$250,000 cap failed the legislative objective test because courts so seldom awarded damages equal to the cap. Therefore, insurance rates would not be affected by those decisions.

Logically, the same reasoning would apply to the higher cap established by the 1986 law, the court said.

"If the 'fair and reasonable substantive relation' test could  
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# Self-insurance security

## Firms self-funding work comp face tighter scrutiny by states

By **MEG FLETCHER**

Many of the growing number of employers that seek to self-insure their workers compensation risks face tougher eligibility requirements and closer scrutiny by state regulators.

Many self-insurers support the beefed-up regulation. Only financially secure companies should be allowed to self-insure workers comp obligations, they say. This will ensure that other employers will not be assessed to fund unpaid claims if a company goes under, especially in the nearly two dozen states with guaranty funds for workers comp self-insurers.

"States are very much concerned—and I think legitimately concerned—with security," said Jeff Purtell, benefits manager for American Telephone & Telegraph Co. in Newark, N.J.

Other employers, however, question whether some of the new re-

**"We fear there may be some overregulation among states today."**

**— National Council of Self-Insurers**

quirements are necessary and fair.

"We fear there may be some overregulation among states today, perhaps a 'tunnel vision' approach, which forgets the initial premise of regulating—protecting against unpaid claims," said a recent statement by the National Council of Self-Insurers, a Chicago-based association representing large self-

insurers.

Tough security requirements are criticized. States too often demand that self-insurers post expensive surety bonds and other forms of security that go well beyond what is needed to pay workers comp claims if the employer goes bankrupt, the group contends.

In addition, some states are not properly evaluating the risk of an applicant not being able to pay claims, says Alan Strohmaier, director of unemployment and workers compensation for General Motors Corp. in Detroit. Instead, they are applying the same formula to all employers.

That criticism is being leveled in Illinois, where security standards were raised dramatically for many workers comp self-insurers in 1990 (see story, page 13).

Georgia and Massachusetts in recent years also have toughened security standards. And regulators in Pennsylvania, California, Wisconsin and other states are more closely scrutinizing applications to self-insure.

Three states—Iowa, Florida and  
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# Catastrophe losses force Israel Re into liquidation

By **STACY SHAPIRO**

TEL AVIV, Israel—Israel's only professional reinsurance company is facing liquidation because its losses of more than \$80 million, stemming primarily from major catastrophes like Hurricane Hugo, exceed its assets by about \$15 million.

Israel Reinsurance Co. Ltd., now in provisional liquidation, is expected to be placed in mandatory liquidation on May 30 by a court in Tel Aviv.

Claimants then will have only six months—or until Dec. 30—to submit proof of loss to the company's liquidators or forfeit their right to claims payments, said Zuriel Lavie, assistant to one of Israel Re's provisional liquidators and an attorney with L. Meir & Corp. in Tel Aviv.

However, the provisional liquidators would like claimants to

**More international news starts on page 31**

submit their proofs of loss to Israel Re by May 30 so they will have a clearer picture of the losses incurred by the company, said Mr. Lavie. "We're asking the companies to send their proofs of loss now," he said.

Claimants include many non-Israeli ceding companies in Europe and the United States that purchased reinsurance from Israel Re, says Rachel Levitan, an advocate at law firm R. Levitan & Co. in Tel Aviv, who represents non-Israeli ceding companies.

However, Ms. Levitan believes that claimants should submit their proofs of loss no later than the beginning of September in case the Israeli court decides that they must be submitted within six months of

the time the provisional liquidation became effective, which she says was on March 5.

The six-month period in which to file proof of loss is set by Israeli law, but different court cases have interpreted the time period to begin either from the time of mandatory liquidation or from the time of provisional liquidation, she said.

"The proof of loss has to be put forward regardless of whether the cedant has already notified Israel Re of its claim or not," warns Ms. Levitan.

"Such proof of loss should include an update of the reserve, including all costs which might be incurred in settling the claim. In view of the vast amount of anticipated claims which may be lodged against the cedants, which are not necessarily known to date, the proof of loss should also include a  
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## Fetal protection

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Johnson Controls, said Quentin Riegel, general deputy counsel for the National Assn. of Manufacturers in Washington, D.C.

"It could cause (insurance) premiums to increase" at companies that employ women in hazardous operations, Mr. Riegel added.

It is not known how many firms have fetal protection policies. Among the large companies with such policies are General Motors Corp. of Detroit; The BF Goodrich Co. of Akron, Ohio; and E.I. du Pont de Nemours & Co. of Wilmington, Del.

"It's going to pose a dilemma for employers in situations where they know there is a substantial risk of injury to the fetus yet they cannot exclude that one group—fertile women—through which the risk is transmitted," Mr. Riegel said.

However, the United Auto Workers union, which challenged the Johnson Controls policy, and civil

rights activists herald the ruling as one of the most significant sex discrimination rulings in decades because it affirms the right of all qualified women workers to personally decide whether to seek hazardous—and usually higher paying—jobs.

The Supreme Court decision overturns an earlier split decision by the 7th U.S. Circuit Court of Appeals in Chicago that said Johnson Controls' fetal protection policy was acceptable as a business necessity and could have met the test of being a "bona fide occupational qualification," or BFOQ, permitted under the Civil Rights Act of 1964 (BI, Oct. 16, 1989).

The nine Supreme Court justices unanimously agreed that Johnson Controls' fetal protection policy explicitly discriminates against women in violation of the 1978 Pregnancy Discrimination Act amendments to Title VII of the Civil Rights Act.

However, three justices issued a separate opinion that differed with Associate Justice Harry A. Blackmun's implication in his majority

opinion that the Civil Rights Act would prohibit virtually all fetal protection policies.

In the separate opinion, written by Justice Byron R. White, the three justices said that Justice Blackmun erred by concluding that the "BFOQ defense is so narrow that it could never justify a sex-specific fetal protection policy."

Another justice, Antonin Scalia, wrote a third opinion in which he agreed with much of Justice Blackmun's reasoning but said companies should be allowed to justify exclusion policies if not having such a policy would be "inordinately expensive."

The five-member majority led by Justice Blackmun ruled that Johnson Controls could not justify its policy under the BFOQ provision of the Civil Rights Act because a woman's reproductive potential did not prevent her from performing essential job-related duties.

"No one can disregard the possibility of injury to future children; the BFOQ, however, is not so broad

that it transforms this deep social concern into an essential part of batterymaking," Justice Blackmun wrote.

"Decisions about the welfare of future children must be left to the parents who conceive, bear, support and raise them, rather than to the employers who hire those parents," he wrote.

NAM's Mr. Riegel said he was "quite surprised" that the majority of the justices said that Congress, in adopting the anti-discrimination laws, did not recognize that it was reasonably necessary for businesses to consider fetal health in conducting their operations.

"In a broad sense, I think it is kind of a shame that business continues to be faulted for not taking affirmative steps to avoid having workplace tragedies occur," said the Johnson Controls' spokeswoman. She noted that the company made "a very difficult decision" to implement a fetal protection policy, but the Supreme Court now has said that the

company is not supposed to care about fetal health.

But, Isabelle Katz Pinzler, director of the American Civil Liberties Union's Women's Rights Project in New York, said: "The U.S. Supreme Court has sent an important signal about what employers cannot do."

"There are still a whole range of options for actions they can take to ensure a safe and health workplace as well as a non-discriminatory one," she said.

In light of the decision, representatives of Johnson Controls, GM, Du Pont and Goodrich said they plan to examine their current fetal protection policies and take steps to comply with the ruling.

For example, Johnson Controls will consider reinstating a similar voluntary program, which it had in effect from 1975 to 1982. Under that program, women could elect to transfer to less hazardous jobs.

The company established its mandatory fetal protection policy in 1982 after eight employees became pregnant while maintaining high levels of lead in their blood.

Employers also may want to consider asking fertile female employees in hazardous jobs to sign liability waivers, said NAM's Mr. Riegel. Although such waivers will not prevent lawsuits from injured offspring, the waivers could be used as part of an employer's defense against an injured offspring's allegation that the employer was negligent, he said.

However, the UAW would oppose such waivers as an interference with the bargaining unit's contract, said Jordan Rossen, general counsel of the UAW in Detroit.

In addition, employers may want to increase warnings about the effect of fetal toxins on employees, said Ms. Conrad of the Chamber.

The justices in their various opinions noted the question of employer liability for injuries to the offspring of women exposed to hazardous substances in the workplace.

For example, Justice Blackmun said that employers could take steps to eliminate their liability.

"Without negligence, it would be difficult for a court to find liability on the part of the employer," Justice Blackmun wrote for the majority. "If, under general tort principles, Title VII bans sex-specific fetal-protection policies, the employer fully informs the woman of the risk and the employer has not acted negligently, the basis for holding an employer liable seems remote at best," he said.

However, Justice White's separate opinion noted that "such speculation will be small comfort for employers."

It is "far from clear" that compliance with Title VII of the Civil Rights Act will pre-empt state tort liability, Justice White said. In addition, it will be difficult for employers to determine in advance what would constitute negligence.

Meanwhile, the Chamber's Mr. Conrad observed: "This decision, following closely on the heels of the punitive damage decision, indicates that this court—as conservative as it is—is not necessarily pro-business."

The Supreme Court earlier this month refused to set specific limits on the ability of juries to award punitive damages, as many business and insurance industry leaders had hoped (BI, March 11).

However, the court last week signaled that there are constitutional boundaries to punitive damage awards (see story, page 1).

Justice Blackmun was joined in his majority opinion by Justices Thurgood Marshall, John Paul Stevens, Sandra Day O'Connor and David Souter.

Justice White was joined in his opinion by Chief Justice William Rehnquist and Justice Anthony Kennedy.

International Union, United Automobile, Aerospace and Agricultural Implement Workers of America et al vs. Johnson Controls Inc., U.S. Supreme Court; 89-1215.

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PROPERTY • HPR • SPECIAL RISK

# State adopts managed drug program

By MICHAEL SCHACHNER

A managed prescription drug plan is expected to slash the annual increase in prescription costs this year by more than 50% for the state of Georgia.

And, by fiscal 1992, the plan is expected to reverse the trend of rising costs, leading to an overall 10% decrease.

The plan, which focuses on eliminating unauthorized prescriptions while promoting use of generic equivalents, is managed and administered by Cleveland-based INSURx.

Drug costs in the state's self-insured indemnity plan have been increasing by about 22% annually, said Bobbie Jean Bennett, assistant commissioner of the Georgia State Merit System, the agency that ad-

## Benefit beat

ministers the health and welfare system for more than 210,000 state employees and their dependents.

Following the Sept. 1, 1990, introduction of the INSURx program, the state expects to cut that increase to about 10% in fiscal 1991, Ms. Bennett said.

During its first six months, the plan has virtually eliminated coverage for duplicate and unauthorized prescriptions, which had accounted for about 6% of the state's total drug costs in 1990, or about \$20 per covered employee, according to Jerry Chalfin, senior vp with INSURx.

He explained that INSURx now examines every claim form to en-

sure that only authorized drugs are reimbursed. Some prescriptions, like contraceptives and many over-the-counter drugs, are not covered by the state.

And, on Jan. 1, INSURx began informing state employees every time they filled a prescription with a name-brand drug when a generic substitute would have been equally effective. This awareness-raising program has increased generic drug usage by about 10%, Mr. Chalfin said.

He noted that the average generic prescription costs about \$11.20 to fill, while the average name-brand prescription costs about \$30.30.

Meanwhile, in fiscal 1992, the state and INSURx will implement a prescription drug network that guarantees prices about 10% below market prices, which should lower the state's overall drug costs by about 10%, Ms. Bennett said.

In fiscal 1990, Georgia spent about \$39 million on prescription drugs for people in its self-insured indemnity plan. That figure is expected to rise to \$43 million this year. But next year, following the introduction of the prescription network, costs should drop to below \$40 million, she projected.

While INSURx administers the drug plan, the state's major medical benefits administrator, Blue Cross & Blue Shield of Georgia, pays benefits on behalf of the state to the 190,000 beneficiaries and their dependents covered under the

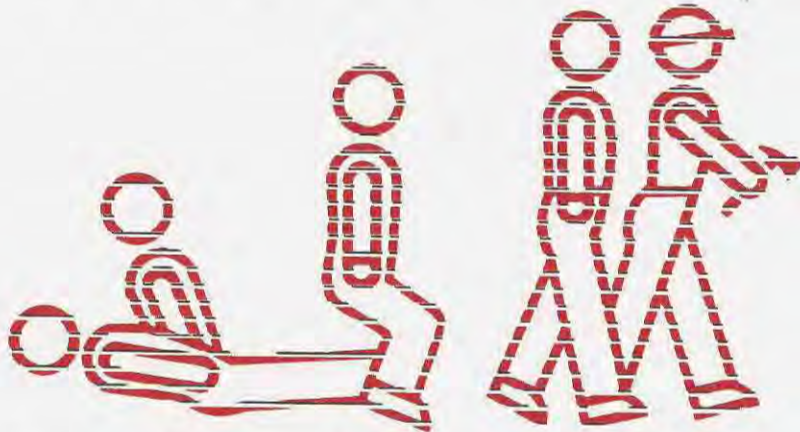
self-insured indemnity plan.

Another 20,000 state workers and their dependents are covered by five health maintenance organizations. They are not affected by the INSURx plan.

"Generally, we're pleased with the new plan," Ms. Bennett said. "We have seen coverage for duplication and fraud almost eliminated and once we get the pharmacy network up and running I think we'll not only be able to control the rate of increases, but actually save money."

Employee drug charges are applied against deductibles and coinsurance under the state's indemnity plan, which were recently increased (BI, Oct. 15, 1990). Deductibles for individual coverage increased to \$250 on Jan. 1 from \$150. Family deductibles climbed to \$750 from \$600. Employees pay 30% of costs up to \$1,300 for individuals and \$3,300 for families.

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## CEBS enrollment up

More than 10,000 registrants in the Certified Employee Benefits Specialist program applied to take exams leading to the professional designation in January, marking a 20% increase over the 8,340 who applied in January 1990.



Nearly 5,300 people enrolled in the program during 1990, up 10% from the 4,800 new registrants in 1989, according to the program's director.

"There was tremendous growth in the CEBS program during 1990. Not only did the number of exams taken increase, but so did new enrollments in the program," according to Daniel Graham, program director.

Mr. Graham said 17,500 registrants are now actively working toward the individual CEBS designation.

"The benefits industry continues to change and become more complex, requiring individuals in the field to upgrade their skills," said Mr. Graham. "Many who are working in benefits feel compelled to pursue advanced educational training and CEBS provides the in-depth type of study that many benefits professionals are looking for."

Begun in 1977, the program is co-sponsored by the International Foundation of Employee Benefit Plans in Brookfield, Wis., and the Wharton School of the University of Pennsylvania in Philadelphia. More than 50,000 people to date have registered in the CEBS program, with more than 3,000 earning the designation, Mr. Graham said.

Most of them, he noted, take three to five years to complete the designation program, which entails passing 10 examinations.

Those who enroll in the CEBS program can prepare for exams by taking numerous courses on employee benefit disciplines through home study or by attending classes at local colleges that offer the program.

Exams are administered at 160 U.S. locations.

The CEBS program is also offered in Canada, where it is co-sponsored by Dalhousie University in Halifax, Nova Scotia. To date, nearly 2,000 people have enrolled in the Canadian program, with 29 enrollees receiving their designation.

For more information about the program, contact the CEBS Department of the International Foundation of Employee Benefit Plans, P.O. Box 69, Brookfield, Wis. 53008; 414-786-6700.

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## Opinions

# Don't reject McCarran changes

WE COMMENT the American Insurance Assn. for its commitment to propose amendments to the McCarran-Ferguson Act.

It is about time leaders in the insurance industry shed their bunker mentality on McCarran-Ferguson and opened their minds to possible reform.

As the AIA has rightly recognized, "the debate over McCarran-Ferguson has become increasingly unproductive and interferes with more critical public policy issues facing the industry"—and, we would add, its customers.

The runaway cost of workers compensation around the country and the retroactive liabilities imposed by the Superfund law are two far more pressing issues than the wording of insurers' antitrust exemption under McCarran-Ferguson.

There is no doubt that, due to the nature of the insurance product, insurers must be permitted some joint activities that are not appropriate in other industries. While the current antitrust exemption is in fact limited, it is a political albatross that the insurance industry cannot continue to bear. Some clearer definitions of permitted activities that otherwise might be considered anticompetitive—like development of common policy forms and collection of loss data—would serve the interests of insurers and consumers without exposing the industry to continued characterizations as a business that is free to gouge consumers.

That is what the AIA appears to be seeking. The AIA says its proposal will "protect the industry's essential business interests and also address the concerns of the law's critics."

Unfortunately, the AIA so far is the only property/casualty insurance group that is willing to negotiate with Congress on McCarran-Ferguson, though the American Council of Life Insurance also is rethinking its stance on the law. We feel it is wrong that the AIA is being criticized by others in the property/casualty insurance industry for its bold move.

If insurers do not begin negotiating on reform of the McCarran-Ferguson Act, they could well be saddled with the pending legislation—H.R. 9 and S. 430—which is not in the best interests of insurers or their customers.

The AIA can take heart that the largest group of commercial insurance consumers also has an open mind on reform of McCarran-Ferguson. The Risk & Insurance Management Society Inc. is willing to consider clarifications and modifications of the law as long as insurers can continue to efficiently and effectively serve their customers.

It is important to recognize that the 1945 law is under attack for the antitrust exemptions it embodies and not because it preserves state regulation of insurance. A possible federal role in the regulation of insurance is an entirely different issue being considered by other members of Congress—and the AIA—but they are not nearly as far along in their deliberations as those who want to reform McCarran-Ferguson.

Our endorsement of the AIA's efforts to draft alternative reform legislation in no way reflects a belief that amending McCarran-Ferguson will increase competition among insurers. Amending McCarran-Ferguson



son—and even its outright repeal—would not increase competition in the industry as the proponents of the amendments contend. But, the debate is too far along for that argument to carry any weight.

McCarran-Ferguson can be amended so that insurers can get on with the business of underwriting risk without driving small insurers out of business or decreasing competition in the insurance industry—two concerns professed by those that are committed to the act as it is written.

We anxiously await the AIA's "constructive alternative" to McCarran-Ferguson reform legislation now pending in Congress. And, we suggest that others withhold their criticism of the AIA until they see what the AIA is proposing.

## Women deserve equal job access

WOMEN ACROSS THE United States have cause to cheer that the Supreme Court has protected their right to equal access to jobs.

Women cannot be denied access to jobs just because they are capable of becoming pregnant, the court ruled (see story, page 1).

As we said last summer, fetal protection policies that deny women capable of bearing children access to certain jobs are archaic (*BI*, June 4, 1990). These policies assume that any fertile woman will become pregnant, which is simply wrong.

Employers have a responsibility to make the workplace as safe as possible for all workers and to warn all workers—men and women—of dangers that cannot be completely eliminated. But employers do not have the right to keep women from jobs that endanger a fetus that may not exist.

The court correctly recognized that well-informed employees have the responsibility to protect their unborn children.

payer is the same, though not so simple. Deductibility of premium expense for a policyholder, taxability of premium income for an insurer, and deductibility of loss reserves by the policyholder's insurer (captive or commercial) are completely different sets of numbers, subject to different tax treatment.

**William T. Howard Jr.**  
Director-Risk Management  
Arch Mineral Corp.  
St. Louis

## Letters

### Captives deserve same tax treatment as commercial insurers

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

To the editor: Edward King's Feb. 25 letter, "Economic Family Theory Makes Sense," seems to imply that a company getting a deduction for premiums paid to its captive, together with that captive getting a deduction for its loss reserves, is more "detrimental to the taxpayers" than a company getting a deduction for premiums paid to a commercial insurer, and that insurer getting a deduction for its loss reserves.

In either event, the effect upon the tax-

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## Benefit reversion

Continued from page 2

employer can recover the excess assets from the terminated plan. But Section 4044(a) does not give participants the right to recover unaccrued benefits, the U.S. Supreme Court said in an 8-1 decision that overturned the 4th Circuit's ruling (*BI*, June 12, 1989).

But in that 1989 decision, the Supreme Court remanded the Mead case to the appeals court, saying there might be other ERISA provisions under which the workers could receive subsidized early retirement benefits even if they had not met all requirements for the benefits.

In the latest ruling, the appeals court said the terms of the Mead plan "compel" payment of subsidized benefits.

Mead's benefit plan documents said the company was entitled to any surplus after satisfying all benefit rights or contingent rights accrued under the plan, according to the court papers.

Citing Black's Law Dictionary, the appeals court said a contingent liability is liability that is not yet absolute and fixed but will become so if a future event occurs.

In the Mead case, the plaintiffs had a fixed right upon reaching age 62 to unreduced subsidized benefits, the court noted.

"At times before the attainment of age 62, that right still existed, though future and uncertain. Therefore, the plaintiffs' rights in the unreduced retirement benefit were contingent as the word is commonly used and as it is specifically used under ERISA," the appeals court said.

"The workers are getting what was promised. They were promised an early retirement benefit," said Cliff Harrison, an attorney with Stone, Hamrick, Harrison & Turk, a Radford, Va., law firm representing the plan participants.

But Mead attorney Richard Saylor, a partner with Jones, Day, Reavis & Pogue in Cleveland, said the conditions for earning the benefits were not satisfied.

As a result, the participants were not entitled to unreduced benefits, Mr. Saylor said.

Some benefit experts say it never had been contemplated that participants—at plan termination—would be entitled to benefits they had not accrued or earned.

"Upon termination, you vest in your accrued benefits, not in benefits not yet accrued," said Seth Tievsky, an attorney with The Wyatt Co.'s Research and Information Center in Washington, D.C.

"The court seemed to have strained a lot to reach its decision," said David Blecher, an attorney and consultant with Hewitt Associates in Lincolnshire, Ill.

Mr. Saylor said if the decision is allowed to stand, thousands of other reversions involving billions of dollars could be under attack by plan participants, charging that they should have received additional benefits before their employers could recover surplus assets.

Mead has asked the entire 4th Circuit Court to review the decision.

Under the Mead plan, offered by Lynchburg Foundry Co., a Mead subsidiary, participants could opt for early retirement benefits at age 55.

Early retirement benefits were reduced by 5% for each year by which participants' retirement preceded the normal retirement age of 65.

The plan also offered a subsidized or unreduced early retirement benefit to participants who completed 30 years of service and retired after turning 62.

That subsidized benefit would equal the benefit that would have been payable if the participant were 65.

In 1983, Mead sold Lynchburg Foundry Co. and terminated the pension plan. Unreduced early retirement benefits were paid only to employees who met both age and service requirements.

However, several employees completed more than 30 years of service but had not reached age 62 at the time of termination.

Each of those employees, all of whom elected to receive their benefits as a lump sum, would have been entitled to collect an average of \$9,000 more if Mead had paid the present value of an unreduced early retirement benefit.

After Mead completed its distribution of plan assets to participants, it recovered the remaining \$11 million in surplus assets.

In 1984, six former employees first filed suit against Mead, charging that the company's failure to pay the present value of unreduced early retirement benefits for which they had not yet qualified violated ERISA. ■

## At issue

Have you reassessed your company's earthquake risk in the last year?



**John W. Robson**  
Director-  
Corporate Risk  
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Yes. As more information becomes available from seismic engineers, the issue is now more reasonably understood and quantified. A retrofit project is under way at one major facility, and two more are in the design stage. Contingency planning for various non-production disciplines has also been implemented, i.e., financial, treasury, management systems and more.



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Approximately every five years our earthquake risk for high-value properties is evaluated for the entire organization using a computer model to determine probable maximum loss and cost/benefit of our programs. As new facilities are acquired or consolidations occur, an individual assessment is made at renewal based on proximity to fault lines and type of construction.



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Mercantile began reassessing its "earthquake risk" in 1989 by evaluating coverage on owned properties and by taking a survey quantifying coverage carried by customers on properties securing Mercantile's real estate portfolio. As a result, Mercantile increased its coverage by 25% and purchased contingent coverage to partially protect its real estate portfolio.

Compiled by Sara Harty

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## Israel Re

Continued from page 3  
reserve for" incurred-but-not-reported claims, she said.

"A ceding company which does not put forward a proof of loss will be regarded as if it renounced its rights" to have its claims paid, emphasized Ms. Levitan.

Israel Re was established in 1952 and had capital and surplus of 11.3 million shekels (\$7.1 million at applicable exchange rates) as of year-end 1988, according to A.M. Best Co.

Net premium volume that year totaled 65.1 million shekels (\$40.8 million), according to A.M. Best Co.

Israel Re officials and others could not furnish the company's 1989 results.

The 1990 results have not yet been released.

However, one report said that Israel Re's non-life losses increased to 34.5 million shekels (\$15.1 mil-

lion at applicable exchange rates) as of Sept. 30, 1990, from 26.2 million shekels (\$13.1 million at applicable exchange rates) at the corresponding point in 1989.

And net loss non-life reserves increased to 79.3 million shekels (\$34.7 million) from 71.4 million shekels (\$35.6 million) at Sept. 30, 1989.

Altogether, the non-life account showed a loss of 11.1 million shekels (\$4.9 million) as of Sept. 30, 1990, the report said.

Israel Re's operating loss after taxes totaled 8.5 million shekels (\$3.7 million) as of Sept. 30, 1990, compared with a profit of 100,000 shekels (\$49,900) in profit a year earlier, the report said.

Israel Re, which is a publicly held company, has about 50 employees, said Zvi Lazar, current general manager of Israel Re at his office in Tel Aviv.

Israel Re's main shareholder, which has about 60% of total ownership, is Hassneh Insurance Co.

Ltd., one of the five largest insurers in Israel.

Together, Hassneh and Israel Re own Hassneh Insurance Co. (U.K.) Ltd., which still is solvent and is not part of the provisional liquidation, Mr. Lavie said.

On Feb. 21, Hassneh, AVNER—

Rubin, according to court papers translated from Hebrew into English.

The plaintiffs are all owed substantial reinsurance claims from Israel Re, said Mr. Lavie, including AVNER, which is owed about \$8 million.

**Israel Re's claimants include many ceding companies in Europe and the United States, says attorney Rachel Levitan. 'A ceding company which does not put forward a proof of loss will be regarded as if it renounced its rights,' she warns.**

Motor Vehicle Bodily Injury Insurance Assn. Ltd. and Zion Insurance Co. Ltd. petitioned the District Court of Tel Aviv-Jaffa to appoint three provisional liquidators for Israel Re.

The provisional liquidators are attorneys L. Meir, J. Halevi and P.

According to court documents, the provisional liquidators have been given various powers, including:

- The power to seize all of the company's assets in Israel and abroad, "including bank accounts, other accounts, records, bookkeep-

ing records and any other documents of the company (including computer data) wherever situated."

- The power to investigate the company's activities in Israel and abroad.

- The power to investigate claims lodged against the company "in order to settle them according to a plan of operation (runoff) which will be submitted as soon as possible to this court."

Mr. Lavie says it will take three or four months to gather data to obtain a clearer picture of Israel Re's losses.

Hassneh, AVNER and Zion filed the application for a provisional liquidation because it was clear that Israel Re had "encountered financial difficulties, mainly as a result of claims for compensation in respect of large natural catastrophes that have occurred around the world," according to the court papers.

Two letters were sent to the Stock Exchange in Tel Aviv, the Israel Security and Exchange Commission and the nation's Company Registrar in early February. The letters, which explain Israel Re's financial trouble, are the main evidence for the company's financial situation.

The first letter, dated Feb. 14, says that "in view of the negative development of the claims reserves and additional notifications received by the company in respect of catastrophic natural losses, including the Hugo hurricane and other tempests in Europe, the company estimates that these developments may lead to the erosion of the company's capital and can result in a negative capital situation."

In addition, Israel Re states in the letter that its board of directors agreed to an immediate audit and had reported Israel Re's problems to Israel's Commission of Insurance.

"At this stage, in view of the circumstances, the board of directors has decided not to receive any further business," the Feb. 14 letter stated.

Israel Re sent another letter to the financial authorities on Feb. 21 updating them on information given at a meeting on Feb. 20 to the Israeli insurance commissioner.

Israel Re pointed out in the Feb. 21 letter that the company's total liabilities would exceed \$80 million based on claims notifications "recently received" in regard to Hurricane Hugo and the early 1990 windstorms in Europe.

The company's overall loss for 1990, including various outstanding reserves for claims that were notified after the beginning of 1991, "may be in the region of \$20 million to \$25 million," the letter says.

"The total amount of the company's assets is significantly lower than the above obligations," the letter says.

As a result, "it appears that the balance of the company's obligations according to the company's records over its assets may reach an amount of \$15 million," the letter states.

Hassneh and the other two insurers ceded a large amount of reinsurance to Israel Re, according to Mr. Lavie, and they are owed millions of dollars.

"But we'll know the full picture in the next three to four months," he said.

"Israel Re was affected by the natural catastrophes of the last few years," added Mr. Lazar of Israel Re.

There is no provision in the law in Israel to permit the company to continue operating after it has paid or settled its debts, Mr. Lazar commented.

However, the court can give instructions on how the company is to be run off and arrange the commutations, he said. ■



# now, but what about 10 years from now?



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## Self-insurers

Continued from page 3

Pennsylvania—are now considering further tightening regulations.

Regulators have many reasons for wanting to increase security or eligibility requirements.

"Action on preventing and funding the unfunded workers compensation liabilities of self-insured employers is timely because of market trends," said David J. Lyons, the insurance commissioner of Iowa.

In Iowa and elsewhere, regulators are concerned about the ability of self-insurance applicants to pay claims, especially with a recession following an era of corporate restructurings, they say.

Florida officials are recommending doubling the net worth requirement to \$1 million because "in today's times \$500,000 is not a lot of net worth," said Sandy Lazier, assistant chief of the self-in-

surance bureau of the state Department of Labor and Employment Security.

In addition, the number of self-insured employer applicants is increasing in Iowa, and most of them are high-risk. Mr. Lyons told an Iowa self-insurance study group last year.

Indeed, interest in self-insuring workers comp risk is booming nationwide. Johnson & Higgins and The IMR Corp. forecast that the equivalent of \$17 billion in workers comp premiums will be self-insured this year, up 24.1% from \$13.7 million in 1989 (BI, Jan. 28).

In Missouri, the number of self-insurers rose 18.6% between 1989 and 1990, said Victor Waits, the state manager of self-insurance.

Regulators also generally favor raising security requirements to keep pace with inflation in medical and indemnity benefits.

"Benefit rates have gone up, so losses for the same kind of injury in 1982 now cost considerably

**Florida officials are recommending doubling the self-insurance net worth requirement to \$1 million because 'in today's times, \$500,000 is not a lot of net worth,' says Sandy Lazier of the state Department of Labor and Employment Security.**

more," Mr. Waits said. In Missouri weekly maximum benefits for temporary total disability have risen 43.8% to \$397.50, up 43.8% from \$174 in 1982. Maximum weekly permanent partial benefits have risen even more: 52.5% to \$198.75 from \$104.40.

Generally, regulators are tightening rules in response to self-insurer insolvencies dating back to the early 1980s. In some of those cases, the surety bonds did not cover all the losses, said Mark Wilhelm, senior vp-underwriting for Safety Mutual Casualty Corp in St. Louis, which underwrites

surety bonds nationally.

Some 168 companies that self-insured workers compensation risks in a total of 39 states went bankrupt between 1980 and 1984, according to a 1986 NCSI survey. Fifteen of those firms operated in more than one state.

Pennsylvania, for instance, faced about \$100 million in unfunded workers comp liabilities from early-1980s failures. The state has no guaranty fund for self-insurers.

People had felt "steel is king" and that large, established companies would always be around, said George Knehr, chief of the

state self-insurance bureau. "It blew people away how fast those companies went down."

Claimants were ultimately paid from the security that companies had posted, though it was "very close," he said, adding that some companies emerging from bankruptcy voluntarily assumed their workers comp liabilities, though they were not required to.

"It left us a little squeamish," he said.

Chastened, state regulators recently have taken a conservative approach when approving self-insurers, Mr. Knehr said. Tougher security requirements are also being considered.

Under the conservative approach now used in Pennsylvania, a company generally must have surety bonds equal to its outstanding workers comp liabilities. State regulations require only a \$200,000 minimum. The highest surety a company has posted is \$45 million.

And in mining and other industries prone to catastrophic losses, self-insurers are required to purchase specific excess insurance.

Financial difficulties with self-insurers are not a problem of the distant past, as Iowa has learned. Since August 1988, three self-insured employers there have failed and another entered reorganization.

Claims from injured employees have thus far been paid by tapping the security the defunct companies posted or through the state property/casualty guaranty fund. Although that fund is designed to protect claimants of only insured employers, it contributed because no other funding source was available, said Iowa's Mr. Lyons.

Picking up that tab does not sit well with commercial insurers. Regulators should require self-insurers to be self-sufficient, argues Eric Oxfield, counsel with the American Insurance Assn. in Washington, D.C.

Other states like Illinois and California faced similar self-insurer bankruptcies in the 1980s and responded by enhancing regulation and creating guaranty funds, sources said.

Illinois typically required only \$200,000 in security during the 1980s. Until requirements were raised last year for most self-insured employers, that low requirement produced a "grossly, grossly" underfunded system, said Thomas Nyhan, executive secretary of the Illinois Self-Insurers Assn., which supported the increases.

Self-insurers in the state had only \$103 million in security last year when the Industrial Commission sent out renewal letters utilizing a new formula. Security requirements were nearly tripled to \$299 million, the commission says.

To lessen the bite, regulators allowed some employers to make two equal installments 12 months apart.

Of the 295 letters sent to parent companies, 184 requested increases that averaged \$1.07 million each. Jewel Food Stores Inc. was hit the hardest; its requirement rose 7,815% to \$15.6 million from \$200,000, according to an internal Industrial Commission memo.

Jewel officials would not return phone calls.

Two other states in recent years have hiked security requirements:

- Massachusetts increased its minimum surety bond requirements to \$100,000 in 1989. The previous level, \$20,000, was set in 1943.

- And, the state now requires additional security from workers comp self-insurers, including at least \$500,000 in either aggregate or specific excess insurance, said Dick Lundgren, director of insurance for the state Department of Industrial Accidents.

- Georgia increased minimum surety bond requirements to

*Continued on next page*

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Continued from previous page  
\$250,000 from \$100,000 in 1987, said Herman Waits, licensure supervisor with the state Workers Compensation Board.

Legislation effective at the start of 1991—but as yet not implemented due to lack of budget—also will establish a workers comp self-insurer guaranty fund. The law authorizes the state to collect \$3 million in assessments from self-insured employers to pre-fund the guaranty fund. Once \$3 million is in the fund, the security requirement can drop back to \$100,000.

Other states have other ways to better regulate self-insurers.

California has taken a number of steps in the past five years to tighten security requirements, said Ron Dodrill, supervising workers compensation consultant with the state Office of Self-Insurance Plans.

Self-insurers, for example, are now required to have at least \$2.2 million in shareholder equity.

Wisconsin regulators last year began requiring applicants for self-insurance to submit five years—rather than three years—of certified financial data, said Tom Jones, self-insurance coordinator of the state Workers Compensation Division.

However, the state last year eliminated requirements that self-insurers have at least 100 employees

Illinois AFL-CIO, said 1986 legislation with subsequent amendments that enhanced the state's regulatory system and established a guaranty fund for self-insurers was "one of the most important things we have done for our members... in the past 20 years."

Employers' awareness of rising benefit costs and other workers compensation trends also are encouraging them to support limiting workers comp self-insurance only to financially secure companies that post adequate security, according to the 1986 NCSI report on self-insurer bankruptcies and guaranty funds.

However, the report estimated that among the self-insurers that went bankrupt from 1980 through 1984, "less than 1% of all outstanding claims both in number and dollar value would not be paid dollar-for-dollar either by the self-insured security provided by the self-insured or through guaranty funds provided by state law. ■

# Overregulation alleged

## Utilities 'put out' by their inclusion under new Illinois security guidelines

By MEG FLETCHER

New security guidelines for self-insurers in Illinois are under fire because the same financial tests are applied to employers in all industries.

Some self-insured employers, like utilities, for the first time are being required to post financial security.

Last year, the state raised security requirements for most employers (see story, page 3).

Previously, Illinois required security equal to the \$200,000 mini-

mum requirement. However, little or no security had been required from the largest electric and telephone utilities.

"Our first reaction was one of shock," said Frank Smagacz, staff manager-workers compensation/safety for Illinois Bell Telephone Co. of Chicago.

Its security requirement is now \$2.25 million, according to the commission's internal document.

"We were very, very surprised at what was asked and a little put out by the amount of security required" of Illinois Bell, an American Information Technologies Corp. unit with \$5.8 billion in assets, Mr. Smagacz said. "It was a feeling that they must think Illinois Bell and Ameritech were about to declare (bankruptcy)."

Illinois Bell met the requirement by establishing an escrow account.

It generates interest, "but the money could have been used within the corporation more efficiently," he said.

Even the Illinois Bell requirement pales next to that of the state's major utility, Commonwealth Edison Co. of Chicago.

Com Ed, which had never faced a security requirement, must now put up \$7.95 million, according to the internal memo. A company spokesman would not comment.

The Chicago-based National Council of Self-Insurers, which represents large employers that self-insure their workers comp risks, objects to requiring utilities to post security. Rate regulators, the group points out, allow public utilities to include valid operational expenses—like workers comp claims payments—in their

Continued on next page

# This little symbol could spell big trouble.

Ohio regulators now are 'a little more stringent' about security rules, Ms. Nixon says.

and a minimum of \$500,000 in unencumbered property, he said.

Ohio regulators now are "a little more stringent" about requiring that self-insurers meet minimum security requirements, said Lucy Nixon, assistant director of the Self-Insured Department of the Bureau of Workers Compensation.

At least three states are now considering new regulations:

- Iowa. The Insurance Division is drafting a reform package following the recent bankruptcies of three self-insurers.

Regulators want to increase the minimum surety bond requirement for self-insurers to \$300,000 from the \$200,000 standard adopted in 1984.

They also want better financial statements from self-insurers. Regulators favor beefing up civil and criminal penalties for companies that fail to provide timely disclosure of important financial information.

The insurance division also recommends setting up a guaranty fund for self-insurers, but it is unlikely the Legislature will do so, said Daniel Pitts Winegarden, the division's first deputy commissioner.

- Florida. Regulators in the state's Self-Insurance Bureau are recommending doubling the required minimum net worth to \$1 million.

However, the state would not change alternative requirements for self-insurers, based on a formula related to an employer's net worth and aggregate workers comp risk retention.

- Pennsylvania. Regulators want to establish minimum eligibility requirements for self-insurers, including that they must employ at least 100 people and have a minimum size payroll.

An ardent supporter of beefed-up rules for self-insurers is labor unions, which want to ensure that injured workers' claims are paid in full without delay.

Richard Walsh, president of the



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## Utility security

Continued from previous page rate base.

"So there is no likelihood that any workers compensation claimant of a public utility will go unpaid," the NCSI said.

"To demand that the public utility purchase expensive surety bonds is superfluous, simply an added cost which all consumers must pay in their utility rates, with no relation to the workers compensation risk to be covered," the council argued in a recent newsletter.

Regulators in Iowa set security standards based on formulas similar to Illinois'.

They also believe that requiring utilities to post security just increases costs to consumers, says Daniel Pitts Winegarden, first deputy commissioner of the state insurance department.

"Overregulating utilities will not help a (self-insurance) regulator

find where the problems are," he said.

"A state should not impose a security requirement if there is no risk that the applicant can't pay its work comp claims," said Alan Strohmaier, director of unemployment and workers compensation for General Motors Corp. in Detroit.

Officials in Illinois, however, defend the security measures as reasonable.

"I don't think it is prudent to treat (utilities) differently" from other self-insurers, especially since utilities in other states have gone bankrupt, said Robert J. Malooly, chairman of the Illinois Industrial Commission.

"To assume that a utility cannot become bankrupt is erroneous," agreed Allyn C. Tatum, a member of Arkansas Workers' Compensation Commission and president-elect of the International Assn. of Industrial Accident Boards & Commissions.

**Because some utilities have gone bankrupt, 'I don't think it is prudent to treat (them) differently,' says Mr. Malooly of the Illinois Industrial Commission. 'There is no likelihood that any workers comp claimant. . . will go unpaid,' counters the NCSI.**

Arkansas, Tennessee and Louisiana are among the other states that require utilities to post security to self-insure for workers compensation, he added.

Electric utilities with nuclear power plants pose an added problem, he said. A catastrophe at such a plant could produce work comp claims that would require funds to be available immediately.

Mr. Malooly also downplays the burden on utilities. Major power companies and others should be able to buy surety bonds inexpensively if the bond seller perceives that the company is unlikely to de-

fault, Mr. Malooly said.

However, James L. Sandner, president of Brokers' Risk Placement Service Inc. in Chicago and a member of the Illinois Self-Insurers Advisory Board, which recommends security levels, said there is "a strong feeling" that Illinois regulators should review applying the guidelines to entities like utility companies.

Regulators in other states also criticize applying formulas and ratios across-the-board.

"The importance of the ratios varies from industry to industry," said Sandy Lazier, assistant chief

of the Bureau of Self-Insurance for the Florida Department of Labor and Employment Security. "We very much look at the type of industry because a ratio for one type of industry may not be valid for another type of industry."

"Rigid standards would work against qualified non-profit institutions" like teaching hospitals or universities, said Jack Leicher, New York's state director of workers compensation regulatory services. Their financial statements may not look robust, but they are stable and backed by large endowments, he said.

Non-profit entities like hospitals are among those complaining about the Illinois rules being applied to all self-insurers, in part because their finances may be understated.

One non-profit hospital in Illinois had its surety bond requirement increased to \$325,000 from the \$200,000 state minimum last year, even though a financial rating company raised its bond rating to A+ from A just a few months earlier, according to a hospital spokesman.

The higher bond amount "cost us an extra \$1,500 and there is no real reason for it," the spokesman said.

In addition, a Chicago hospital spokesman said notification that its surety bond requirement rose to more than \$1 million from \$200,000 "caused a lot of concern." Even after negotiating the requirement down, the hospital decided to buy commercial insurance rather than a surety bond, especially since the bond seller demanded a letter of credit equal to the bond amount.

Acknowledging that there may be isolated problems for some institutions, "by and large, the guidelines pretty much work for not-for-profits," Mr. Sandner said.

Grocery chains also may face problems with the new guidelines.

Generally high turnover gives them lower equity-to-sales ratios—one common measure of a company's financial strength—than, say, washing machine manufacturers, said Kevin Conley, actuarial administrator with the Iowa Insurance Division. So grocery companies may be required to post more security than is necessary.

Iowa has learned through experience to apply the formula less mechanically, Mr. Winegarden said.

"It was never suggested (in Illinois) that a universal formula would apply to all businesses, but it would cover far more than it would exclude," said Thomas Nyhan, executive secretary of the Illinois Self-Insurers' Assn., which took the lead in drafting the guidelines and endorses them.

The Illinois Industrial Commission's Mr. Malooly said as the state gains experience in working with its self-insurance guidelines it may establish separate criteria for entities like utilities and non-profit institutions. However, that would take "a fair amount of rather technical work," which could take 12 to 18 months.

Some employers are going beyond criticizing how the Illinois guidelines are applied. Two companies are challenging the process by which they were adopted in court.

In separate state court actions, Northwestern Steel & Wire Co. of Sterling and FDL Foods Inc. of Rochelle allege that the Industrial Commission failed to follow the filing and public notice requirements of the state Administrative Procedures Act, said Douglas Stevenson, an attorney with Stevenson, Rusin & Friedman in Chicago and the NCSI's executive director.

Mr. Malooly, the commission chairman, said that although he believes that the earlier action was appropriate, the commission is now taking emergency steps to meet the requirements of the state law.

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# Work comp standards run the gamut

## Self-insurer evaluation ranges from complex to oversimplified

By MEG FLETCHER

In any state an employer wants to self-insure its workers compensation risks, it must demonstrate to state regulators that it is financially stable enough to pay its employees' workers comp claims, both now and in the future.

However, regulators in different states use differing procedures to determine whether a company is eligible to self-insure and how much security the company must post.

The methods states use to evaluate an applicant's ability to self-insure "vary dramatically from highly complex formulas to oversimplified approaches," according to "Self-Insuring Workers Compensation: Weighing the Options," a monograph published by Tillinghast, a risk management consulting division of Towers, Perrin, Forster & Crosby Inc.

An employer applying to self-insure must submit its financial records to state regulators who are charged with the responsibility of overseeing workers comp self-insurance.

In most states, the insurance department, labor department or industrial commission has this responsibility.

The applications and supporting financial documents are typically evaluated by staff members, who refer qualified applicants to their supervisors along with recommendations about appropriate security requirements.

In some states, like Illinois, a board whose members include self-insured employer representatives also makes recommendations (see story, page 16).

The applications are evaluated according to procedures that usually are developed with the help of self-insured employers and other interested parties, like brokers and third-party administrators.

The Illinois self-insurance community, for example, developed a system of weighted financial ratios in 1982 to evaluate self-insurance applicants, although the system was not uniformly adopted for across-the-board use until late 1988.

Iowa regulators adopted a nearly identical formula approach in 1984 and now are considering modifying it.

The formula approach used by the two states primarily relies on calculating three of the applicant's financial ratios: current assets to current liabilities; capital and retained earnings to sales; and capital and retained earnings to long-term debt.

Each ratio result is assigned a point value.

The outcomes are totaled and compared with a predetermined scale used to calculate the amount of security an applicant is required to post.

The formula approach is designed to promote objectivity and uniformity in assessing the ability of an applicant to self-insure, according to regulators in Iowa and Illinois.

Such an approach has the advantage of reducing the personal discretion a regulator must use when approving self-insurers and determining how much security, in the form of surety bonds or other instruments, a self-insuring company must post, said Daniel Pitts Winegarden, first deputy commissioner of the Iowa Insurance Division.

"If you allow discretion to reduce a bond, the political pressure is always to be the nice guy," he explained.

Regulators in both Iowa and Illinois started using the formula by applying it broadly across all industries, though businesses in some fields complained about the fairness of that procedure (see story, page 13).

Iowa is no longer using the across-the-board formula for all companies, and Illinois is beginning to consider whether the same formula should be used for all employers.

In contrast, Florida's rules for self-insurance say that regulators may consider 13 or more ratios based on an employer's finances and that "all financial ratios will be compared to the average ratios in the industry relative to the self-insurer's type of business and for businesses of similar financial size."

In addition, regulators in Connecticut, New Jersey and Pennsylvania also emphasize that they use industry-specific rather than broad general norms in assessing an applicant's ability to self-insure.

Other states use less technical approaches to determine an employer's security level.

"I hate to say we pull it out of the air," said Herman Waits, Georgia's licensure supervisor.

"We try to determine what an employer could live with and what we would feel safe with," though an employer must post a minimum surety bond of \$250,000, said Mr. Waits.

Surety bonds are the most common form of security state regulators allow. Minimum bond requirements technically range from \$100,000 in New Jersey and Massachusetts to \$530,000 in New York, according to a *Business Insurance* survey of 14 major states.

However, some states also allow employers to use escrow or trust accounts and, increasingly, letters of credit as security (*BI*, Jan. 28; Jan. 29, 1990).

Currently, about two-dozen states allow self-insurers to post LOCs as security and at least four states—North Carolina, Pennsyl-

vania, South Carolina and Texas—are considering it, said Russell Guy, workers compensation counsel with Bethlehem Steel Corp. in Bethlehem, Pa.

However, cross-state comparisons of total security requirements are difficult because of the "Byzantine" mix of security options that different states can impose, said Mr. Winegarden of the Iowa insurance department.

For example, in addition to surety bonds or LOCs, many state regulators require—by law or practice—self-insurers to purchase either aggregate or specific excess insurance.

Or, state regulators will give a company credit for voluntarily buying such coverage when setting the company's security requirement. ■

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# Broker under fire from self-insurers

## Role in deciding security issues raises conflict-of-interest debate

By MEG FLETCHER

CHICAGO—Should a broker whose company sells surety bonds help decide how much security a workers compensation self-insurer is required to post with a state?

And, should his company actively solicit self-insurers' surety bond business when the state increases its security requirements?

Those are questions now being asked by some workers compensation self-insurers and others in Illinois.

James L. Sandner, president of Brokers' Risk Placement Service

Inc., a wholesale and reinsurance broker in Chicago, is the only broker on the six-member Illinois Self-Insurers Advisory Board. The board advises Robert Malooly, chairman of the Illinois Industrial Commission, on workers comp self-insurance matters, including security requirements.

Neither Mr. Sandner nor Mr. Malooly sees a conflict of interest in Mr. Sandner's role.

Four of the other five advisory board members are employed by self-insurers, including Caterpillar Inc. of Peoria and Amoco Corp. of Chicago. The fifth member is Ri-

chard Walsh, president of the Illinois AFL-CIO, who is the designated public member required by law. All members are appointed by the industrial commission chairman. They receive expenses but no salary.

A former chairman of the commission—not Mr. Malooly—appointed Mr. Sandner when the panel was first established.

The controversy surrounding Mr. Sandner emerged last year.

Most self-insurers in Illinois were notified by the advisory board that security requirements were being raised. The changes were based on new guidelines, guidelines which Mr. Sandner helped a committee of the Illinois Self-Insurers Assn. devise in 1982.

About the same time they received that notice, Illinois self-in-

**'My gut feeling is it (is) a perception issue,' says Mr. Larsen of the Board of Ethics.**

surers heard from Brokers' Risk. Apparently using a publicly available list, the broker's marketing manager sent out letters soliciting surety bond business.

The letter stated: "In conjunction with recent increases in security being requested by the Illinois Industrial Commission, BRFS has increased its surety bond capacity to \$2 million."

In a recent interview, Mr.

Sandner said he was not sure whether he was told about the letter before it was sent out.

He did say, however, that he neither wrote the letter nor personally managed the broker's surety bond business, which he said generates less than 1% of the firm's revenues.

The Illinois Board of Ethics, which reviews potential conflicts of interest in state government, has taken no action because no case has been referred to the board by a state agency.

"My gut feeling is it seems to be a perception issue" that the Industrial Commission may be able to handle by making internal policy changes, said John Larsen, executive director of the ethics board.

Mr. Larsen said such "perception" issues comprise about 75% of the evaluations by his board.

Other states have internal policies or practices like those to which Mr. Larsen referred.

For example, a self-insured employer serving on a similar advisory board in Wisconsin voluntarily recused himself from voting on an applicant with whom he had personal—but not financial—dealings, said Tom Jones, the state's self-insurance coordinator.

"That's the way it should be," Mr. Jones said.

Making a judgment on whether vendors like brokers should serve on the ISIAB requires understanding how the Illinois system operates.

The Illinois panel reviews applications from potential new self-insurers that have been screened initially by ISIAB staff based on an analysis of applicants' financial information. Security requirements are generally determined through the use of a formula (see story, page 13).

The board reviews staff recommendations and makes a recommendation to the industrial commission chairman, who also heads the ISIAB. The chairman is required to approve the recommendation promptly or explain in writing why he did not.

A new applicant is then told how much security it must post. The information is usually conveyed on ISIAB stationery, which lists all board members, including Mr. Sandner, and their corporate affiliations.

A new applicant that receives conditional approval then arranges for security, which can include surety bonds or an escrow account.

After presenting proof of security, the company is formally approved as a self-insurer.

For renewals, the procedure is slightly different.

In these cases, staff members do not always make recommendations. Instead, renewal applications from companies whose financial status has deteriorated to questionable levels—which comprise slightly less than 10% all firms renewing their self-insured status—are referred to the board for a determination.

Renewal applications typically list the name of the surety bond broker and the amount of surety previously posted.

Mr. Sandner would "normally not" recuse himself from voting in cases where his firm brokered the surety bond, said Bill Sampias, executive director of the advisory board.

But applications bearing the name of Brokers' Risk are "not very often" presented before the ISIAB, Mr. Sampias said.

Some of Mr. Sandner's critics objected only to the letter from Brokers' Risk's marketing manager. Others disapprove of Mr. Sandner even serving on the board.

The letter "seemed to me to be a

Continued on next page

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### An Open Letter to all Independent Agents:

Members of the IIAA and PIA believe **merger** of the two organizations is the number one priority to create the best future possible for the backbone of the insurance industry. **It is in the spirit of merger that this is written!**

It also was in that spirit that we were gratified last July when the PIA reversed its previous position and agreed to meet. Unfortunately, after what we felt was substantial progress, the PIA representatives chose to halt talks, citing issues that could not immediately be resolved. We contend that all issues, when discussed reasonably, can be resolved over time. And both groups have been asked to confer with their respective national boards. **It is now time to reactivate merger talks!**

**THIS IS AN INVITATION TO THE NATIONAL EXECUTIVE COMMITTEE AND AGENT REPRESENTATIVES FROM EVERY PIA STATE/REGIONAL AFFILIATE TO MEET WITH IIAA'S EXECUTIVE COMMITTEE AND STATE REPRESENTATIVES ON APRIL 10th IN DALLAS—AND TO RESUME MERGER DISCUSSIONS.**

We think this expanded group should hear the issues directly. Moreover, we will select a site that can accommodate **individual** members of both groups who might wish to attend. **This is too important an issue to debate in the press!**

Should this date and location be inconvenient for our PIA counterparts, we are willing to meet on May 10th. And if Dallas is not appropriate, let's meet in Chicago or Kansas City or Washington, DC—or another site suitable for easy travel. **But whenever, or wherever—above all, let's meet again!**

To be certain all of our members know of our intentions, IIAA will publish this invitation in the April 1991 issue of **Independent Agent** magazine. We ask that PIA do likewise in **Professional Agent** magazine.

We, at the IIAA, are prepared to speak on every subject—finances, governance, merger funding, membership classes, office locations—whatever is appropriate to bring us all together. Remember: **There is no point in "putting issues on the table" if nobody is sitting around that table!**

Please let me know if you would like to attend—and your opinion—c/o IIAA, 127 South Peyton Street, Alexandria, Virginia 22314

For the IIAA National Board of State Directors and Executive Committee,

*A.W. Bailey Jr.*

A. William Bailey, Jr., CIC  
IIAA President

Continued from previous page  
 conflict of interest," said Frank Smagacz, staff manager-workers compensation/corporate safety for Illinois Bell Telephone Co. in Chicago.

However, Mr. Smagacz said he favors having Mr. Sandner serve on the board because of his expertise.

An official of a third-party administrator, though, criticized Mr. Sandner's presence on the board. Like several others interviewed, he said he would not speak for attribution because he must deal with the board.

"I don't think it is appropriate to be raising people's bonds and selling them at the same time," he said. "If you are self-insured and go before the board—and you've bought your bond from a member of the board—then it is human nature to think that things may go smoother for you."

Even if that is not the case, the perception that it might occur makes people in the self-insurance community "lose confidence in the fairness of the system," added the TPA official.

"Any time you can gain monetarily from a situation, you have a conflict of interest," said Herman Waits, Georgia's self-insurance licensure supervisor, when asked about ethics standards in his state.

Mr. Sandner's activities—if not a technical conflict of interest—are in "a gray area," said Barry Ketter, a member of the Illinois Industrial Commission who has unsuccessfully sought to replace Mr. Malooly as chairman.

Mr. Ketter said that if he were chairman, he would ask the counsel to Illinois Gov. Jim Edgar to evaluate the appropriateness of Mr. Sandner's activities, especially in light of statements by the governor.

Gov. Edgar has said he wants to root out "potential conflicts of interest" and provide heightened public awareness of the vested interests of elected officials and state employees.

To Mr. Sandner and his supporters, however, there has been no breach of ethics.

Asked about the appropriateness of making recommendations on the applications of Brokers' Risk clients, Mr. Sandner emphasized that staff screenings based on established formulas limited discretion of the advisory board members. Mr. Sandner also pointed out that he is only one of six board members.

"There is absolutely no impropriety," said Thomas Nyhan, executive secretary of the Illinois Self-Insurers Assn.

Mr. Malooly said the only time it might be appropriate for Mr. Sandner to excuse himself from a vote would be if his own company, or one in which he had an ownership interest, was applying to self-insure.

"I can see where people would possibly be concerned" about the letter, said Mr. Malooly, who was recently reappointed by Gov. Edgar as Industrial Commission chairman.

However, Mr. Malooly pointed out that Brokers' Risk is providing needed capacity for self-insurers that want to buy surety bonds to meet security requirements.

Mr. Sandner voted for an ISIAB recommendation to broaden security options to include letters of credit beginning April 1, Mr. Malooly noted. LOCs are purchased from banks and other financial institutions, not brokers.

In addition, Mr. Malooly and advisory board member Susan Sauer, manager of employee insurance at Navistar International Transportation Corp. in Chicago, say they can see no conflict of interest in the Brokers' Risk letter because any broker, using the public list, could

have done the same thing.

"I don't know if you can blame Jim Sandner because no other brokers sent out similar letters," Mr. Nyhan concurred.

Mr. Sandner, who has received the Chartered Property & Casualty Underwriter designation, was recommended for the advisory board by the Illinois Self-Insurers Assn. because of the knowledge he gained in helping draft self-insurance guidelines and his willingness to work to implement them, Mr. Nyhan said.

"I think he has brought an unbelievable wealth of knowledge to the board," said Navistar's Ms. Sauer. "We have been able to do a lot of things because of him."

Mr. Sandner should serve on the advisory board because his experience in the insurance industry can provide "valuable input," said Illinois Bell's Mr. Smagacz, who was troubled by the Brokers' Risk solicitation letter. ■

## Five-year study

Continued from page 3

moving rapidly away from 100% reimbursement and are increasing deductibles and co-insurance," said Perry Brandorff, a partner in Hewitt's Irving, Texas, office.

Among employers that offer multiple health plan options, the study found that 37% in 1990 offered 100% reimbursement for hospital room and board, down from 69% of respondents in 1985.

The percentage of single-plan employers providing 100% reimbursement for hospital room and board—depending on length of stay—declined by one-third to 34% in 1990 from 51% in 1985.

Similarly, fewer employers are reimbursing surgical expenses at 100%.

Among multi-plan employers, 27% offered 100% reimbursement for surgical coverage in 1990, a decrease from 35% in 1985.

Among single-plan employers,

the percentage dropped to 18% of employers in 1990 from 23% in 1985.

More employers also are requiring employees to pay deductibles before any health care costs are reimbursed, the survey reported.

Among single-plan employers, 73% in 1990 required employees to pay a deductible, up from 59% of respondents in 1985.

The number of multi-plan employers requiring a deductible also increased, though not as significantly: 94% of employers in 1990 had at least one plan that required a deductible, an increase from 86% of employers in 1985.

The size of those deductibles increased dramatically between 1985 and 1990, the Hewitt survey found.

Annual deductibles for individual coverage generally have moved toward \$200 or more from \$100 in 1985, Mr. Sperling noted.

Twenty-eight percent of single-plan employers required a \$200 deductible for individual coverage in

1990, compared with 14% in 1985. Six percent required a \$250 deductible in 1990, compared with 2% in 1985.

And, 6% also required a deductible of \$300 or more in 1990, up from 2% in 1985.

Nearly a quarter of single-plan employers—23%—required a deductible of \$100 or less for individual coverage in 1990, down from 52% in 1985.

Among multi-plan employers, 42% had a plan with a \$200 deductible for individual coverage in 1990, compared with 31% in 1985. And, 23% had a plan that required a \$250 deductible last year, up from 11% in 1985.

The percentage of multi-plan employers with plans requiring an annual deductible of \$300 or more jumped to 78% in 1990, up from 45% in 1985.

Forty percent of multi-plan employers in 1990 had a plan with a deductible of \$100 or less, a 37.5%

Continued on next page

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## Five-year study

Continued from previous page  
decrease from 64% in 1985.

There was a slight increase in the percentage of employers implementing "stop-loss" features in their medical plans, rising to 94% in 1990 from 89% in 1985, according to Hewitt.

"Employers don't want to leave employees or dependents with a dire situation that would decimate them," Mr. Brandorff said.

However, the maximum amount workers must pay before the plan started covering 100% of expenses increased over the past five years, the study found.

Among single-plan employers, 35% required annual individual employee out-of-pocket maximums of \$1,001 or more in 1990, up from 20% of employers in 1985. The percentage of employers in 1990 that capped employees' annual out-of-pocket maximums at \$1,000 or less dropped to 50% from

69% in 1985. The remainder structured the cap in some other manner.

Fifty percent of multi-plan employers required a \$1,001 to \$1,999 individual out-of-pocket maximum for at least one of their plans in 1990, up from 21% of employers in 1985, the survey found. And, 55% required an out-of-pocket maximum of \$2,000 or more in 1990, an increase from 28% in 1985. Ninety-two percent required an out-of-pocket maximum of \$1,000 or less in 1990, down from 116% in 1985.

In addition to contributing to the cost of care, the survey found that more employers—especially those offering multiple health plan options—are requiring workers to also chip in toward the cost of their coverage.

Among multi-plan employers, only 14% in 1990 did not require a contribution for at least one of their individual coverage plan choices, a drop from 34% in 1985.

The most common monthly contribution for individual coverage in 1990—required by 19% of multi-plan employers—was between \$10.01 and \$20. Another 17% required a contribution of \$10 or less, while 34% required a variety of amounts greater than \$20. The remainder structured contributions in some other manner or did not answer.

Among single-plan employers, 45% did not require employee contributions for individual coverage in 1990, compared with 52% in 1985, the study found. The most common monthly contribution for individual coverage—required by 11% of employers—was \$10 or less, while another 10% required \$10.01 to \$20. Another 13% required a variety of amounts greater than \$20. The remainder structured contributions in some other manner or did not answer.

The Hewitt survey found more employers sought to control employee health plan costs by impos-

ing second surgical opinion requirements in 1990 than 1985.

For example, 54% of all survey respondents in 1990 reported that they provided reduced benefits if a second opinion for inpatient surgery is not obtained, a 38.5% increase from 39% in 1985.

More employers are covering hospice and home health care in 1990 than 1985, the survey found.

For example, only 15% of respondents in 1990 do not cover hospice stays, compared with 40% in 1985.

In 1990, 9% of respondents offered higher coverage for hospice care than for hospital care, compared 4% of respondents in 1985.

And, 33% of employers offered the same coverage for hospice care as for hospital confinement, up from 25% in 1985.

The survey also found that only 7% of respondents did not cover home health care in 1990, down from 18% five years earlier.

Nine percent of employers in

1990 offered greater coverage for home health care than for hospital care, up from 6% in 1985, the survey reported.

Twenty-five percent offered equal home health care and hospital coverage in 1990, down slightly from 27% in 1985.

Hewitt also found that more employers are requiring retirees to shoulder a greater portion of their health care costs in 1990 than five years earlier.

Sixty-one percent of respondents required pre-65 retirees to contribute toward the cost of coverage for themselves and their spouses in 1990, up from 49% of respondents in 1985.

Twenty-one percent did not require retirees to contribute toward the cost of coverage, down from 33% of respondents in 1985.

Eight percent required contributions only for spousal coverage in 1990, down from 12% of respondents in 1985.

For retirees 65 and older, 49% of employers required contributions for retiree and spousal coverage in 1990, up from 39% in 1985.

Thirty-four percent did not require any contributions from retirees 65 and older, down from 47% in 1985.

Seven percent of employers required contributions only for spousal coverage in 1990, down from 9% in 1985.

Hewitt found a significant increase over the past five years in the number of flexible benefit plans, which may be attributable to changing workforce demographics, Mr. Brandorff said.

"Companies are recognizing that one plan does not fit all," he said.

In 1990, 63% of the 560 survey respondents—or 352 employers—allowed employees flexible benefits plans or flexible spending accounts. Only about 16% of respondents—87 employers—offered such plans in 1985.

The growth in flex plans is partly "because of the changing workforce and because flexible benefits are a palatable way to share costs with employees," Mr. Brandorff said.

The types of benefits employers offered in flex plans included:

- Health care spending accounts, offered by 78% of employers with flex plans in 1990, compared with 84% of employers with these plans in 1985.
- Spending accounts for dependent care, offered by 89% in 1990, compared with 61% in 1985.
- Health plan choices other than health maintenance organization options, offered by 56% in 1990, compared with 52% in 1985.
- Death benefit choices, offered by 37% in 1990, compared with 31% in 1985.
- Disability benefit choices, offered by 23% in 1990, compared with 18% in 1985.

By 1990, only 2% of the 352 survey respondents with flex plans fully funded flex plan credits, compared with 28% of the 87 employers with flex plans in 1985, the survey found.

Fifty-six percent of the 1990 survey respondents with flex plans allowed employees to fund flex plan credits through salary reduction, compared with 36% of employers with flex plans in 1985.

In 42% of the flex plans in 1990, both employer and employee contributions funded flex plan credits, compared with 36% of employers with flex plans in 1985.

The survey also reported that 14% of employers in 1990 offered workers more than one group long-term disability plan option, up from 3% in 1985.

A copy of "Salaried Employee Benefits Provided by Major U.S. Employers in 1985 and 1990" can be obtained for \$50 from Saline Leckman or Sally Erickson at Hewitt Associates, 100 Half Day Road, Lincolnshire, Ill. 60069; 708-295-5000.



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# Firms offer pension choices: Survey

By CHRISTINE WOOLSEY

Because of changing workforce demographics, employers are increasingly offering multiple defined contribution pension plans along with defined benefit plans, according to a new study.

However, slightly fewer employers are offering defined benefit plans than five years ago, according to "Salaried Employee Benefits Provided by Major U.S. Employers in 1985 and 1990."

The study was conducted by Hewitt Associates of Lincolnshire, Ill.

Specifically, 89% of the employers surveyed said they had a defined benefit pension plan in place in 1990, compared with 91% in 1985.

Just 1% of employers with defined benefit plans did not also offer at least one defined contribution plan in 1990, down from 4% in 1985.

And nearly every employer that did not offer a defined benefit plan offered a defined contribution plan.

"Companies recognize defined benefit plans are the most important way to provide benefits to employees that stay with them," said Perry Brandorff, a partner in Hewitt's office in Irving, Texas.

However, he noted that "defined contribution plans are better suited to meet the needs of a mobile workforce."

Employers' recognition that today's typical employee will change jobs more frequently may explain the increase in defined contribution plans, Mr. Brandorff said.

Employers now are more likely to offer their employees a choice of defined benefit plans than they were five years ago, the survey points out.

For example, in 1990, 21% of employers reported offering a defined benefit plan plus two defined contribution plans, up from 13% in 1985.

Conversely, only 64% of employers in 1990 offered a defined benefit plan and a single defined contribution plan, down from 72% five years earlier.

The availability of 401(k) salary reduction plans increased over the five-year period with 95% of 554 surveyed employers with defined contribution plans offering such plans in 1990 compared with 82% of 535 employers with defined contribution plans in 1985, according to the study.

"You wouldn't have seen the tremendous increase in employer-sponsored savings programs if it were not for 401(k)," said Mr. Brandorff, noting the tax effectiveness of these plans.

The survey also found that employers increasingly are offering employees savings and thrift plans that include employer matching contributions.

In 1990, 470 of the employers surveyed offered such plans—with varying levels of employee contributions—compared with 425 in 1985, nearly an 11% increase.

According to the Hewitt survey, most employers—51%—in both 1990 and 1985 would match a maximum employee contribution of 6% of pay.

Thirty-four percent would match a lower maximum employee contribution in 1990, compared with 32% in 1985, while 10% would match a greater maximum employee contribution in 1990, the same as in 1985.

The remaining employers either contributed a flat dollar amount or varied the contribution by pay, service or years of contribution, according to the survey.

ers use to determine their matching contributions is a fixed rate formula—reported by 60% of the employers with such plans in 1990 and 64% of employers with matched savings plans in 1985.

Among those savings plans with a fixed rate matching formula, just over half—52%—in 1990 offered a 50% match to employee contributions, up slightly from 51% in 1985. In addition, 25% of employers in 1990 offered a 100% match to employee contributions, an increase from 20% in 1985.

**Slightly fewer firms now offer defined benefit plans than five years ago, a survey says.**

The next most popular basis among employers for determining their matching contribution is discretionary or a formula based on

profits, reported by 12% of respondents in 1990, down slightly from 13% in 1985.

The survey also found that employee stock ownership plans have significantly increased in popularity. The survey noted that 9% of respondents offered an ESOP in 1990, while only 1% offered such a plan in 1985.

However, "the increase in leveraged ESOPs is a direct result of companies trying to get control of a significant portion of their own stock" in an attempt to ward off

unfriendly takeovers that were so prevalent during the 1980s, Mr. Brandorff said, acknowledging that some of his peers may disagree with him.

"There are certainly good financial reasons" to offer ESOPs, including their tax effectiveness, Mr. Brandorff allowed. But, "we wouldn't have seen the dramatic increase in ESOPs if it weren't for the tax leveraging that companies are able to receive because of the deductibility of dividends in an ESOP," he said. ■

## T H E H O M



## O L D P R O S O N

# Keane promoted at Litton Industries

**Michael E. Keane**, 35, has been named director-pensions and insurance at Litton Industries Inc. of Beverly Hills, Calif. He is responsible for the company's pension and insurance programs worldwide. Mr. Keane replaces **Thomas E. Holgate**, who retired. He reports to Joseph T. Casey, vice chairman and chief financial officer. Mr. Keane, who joined Litton in 1981 as Western regional manager in the corporate audit services department, was named assistant treasurer in 1988. Before joining Litton—which makes automation and

electronic systems—he was a senior accountant at Price Waterhouse & Co. in Chicago. He holds a bachelor's degree in accounting from Illinois State University in Normal and a master's degree in business administration from the University of California at Los Angeles. Mr. Keane is a member of the American Institute of Certified Public Accountants and of the Illinois CPA Society.

## Comings & goings: Buyers

\*\*\*  
**Dan Borbas**, 53, has been named senior vp and director of human resources at Zurich-American Insurance Group, a Zurich Insurance Co. unit in Schaumburg, Ill. In this newly created position, Mr. Borbas is responsible for the entire human resources operation including organizational development, employee relations, employee benefit plans, training programs, salary

administration, job evaluation and management information systems. He reports to Vic Vogel, executive vp of corporate development. Mr. Borbas joined Zurich-American Insurance Group in 1975 as secretary and director of human resources, and was promoted to assistant vp of human resources in 1977. In 1980, Mr. Borbas was promoted to vp of human resources. Before joining Zurich-American Insurance Group, Mr. Borbas was the personnel planning manager at Chicago-based Montgomery Ward & Co. Inc. Mr. Borbas holds a

bachelor's degree in business administration from Roosevelt University in Chicago. Mr. Borbas is a member of the Human Resources Management Assn. of Chicago as well as a member of the Society of Human Resources Professionals.

\*\*\*  
**John R. Rath**, 55, has been named risk manager for Milwaukee County in Milwaukee, Wis. He is responsible for property, automobile, general liability, workers compensation and fiduciary liability insurance programs. Mr. Rath replaces **Charyl Burke**, who left the organization. Mr. Rath reports to Sylvan Leabman,



Mr. Rath

fiscal and budget administrator. Before joining Milwaukee County, he was director of insurance and risk management for the Roman Catholic Archdiocese of Los Angeles. Before that, he was senior claims supervisor at Hartford Fire Insurance Co. in Los Angeles. He holds a bachelor's degree in business administration from St. Norbert College in De Pere, Wis. Mr. Rath holds the Associate in Risk Management designation, the Chartered Property & Casualty Underwriter designation, the Associate in Claims designation and is pursuing the Certified Life Underwriter designation. He is a deputy member of the Risk & Insurance Management Society Inc. and is a member of the Public Risk Management Assn.

\*\*\*  
**Sue Schultz**, 41, has been named vp-risk management at The Gary Williams Co. of Denver, Colo. In this newly created position, she is responsible for the energy company's risk management, safety and insurance programs. Ms. Schultz reports to David Younggren, senior vp. She joined Gary Williams in 1986 and most recently was the company's risk manager. Before joining Gary Williams, she was product development director and excess and surplus lines commercial underwriter for Guaranty National Insurance Co. of Englewood, Colo. Before that, she was commercial multi-lines underwriter for Frankenmuth Mutual Insurance Co. of Frankenmuth, Mich. She holds an associate's degree in computer science from Lansing Community College in Lansing, Mich. Ms. Schultz is a member of RIMS' industry liaison committee.

\*\*\*  
**Wayne G. Plazak**, 60, has been named risk manager at San Diego-based Sea World of California. In this newly created position, he is responsible for the amusement park's risk management, loss control and safety programs. Mr. Plazak reports to Penny Masters, director of human resources. Before joining Sea World of California—a subsidiary of St. Louis-based Anheuser-Busch Cos. Inc.—he was senior vp/risk manager at San Diego-based Great American Bank, A Federal Savings Bank. Before that, Mr. Plazak was an officer in the U.S. Navy. He holds a bachelor's degree in business administration from the University of Wisconsin at Madison.

We'd like to report on staff changes in your company's risk management, safety and employee benefits departments. Just drop a note to Nancy Johnson, Copy Editor, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611-2590, or call 312-649-7784. Please send a photograph, too.

# E T O D A Y



## Underwriter, ahoy!

When Steve Weber graduated from Rutgers he flirted briefly with a career as an oceanographer.

"I've always loved fishing and boats," he says. "The sea is in my veins."

It's also in his job description. After 12 years in insurance, Steve's become the Regional Manager of Ocean Marine in our Houston office.

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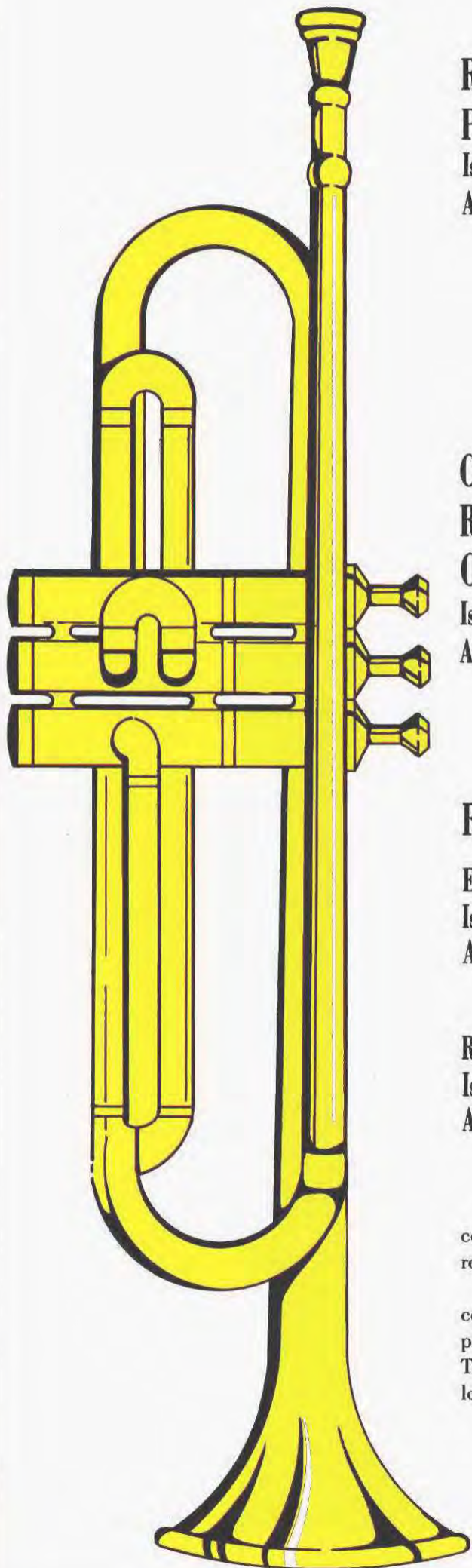
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# A NEW TEAM

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# RIMS NEW ORLEANS



## RIMS PREVIEW Issue: April 22 Ad Closing: April 9

The first note on RIMS '91 will be played by Business Insurance in its annual RIMS Preview 'take-out' section.

Leading with last minute details and updated program and speaker changes, BI's 'take-out' section will contain valuable notes for everyone heading for New Orleans: a floor plan and list of exhibitors; a map of Conference hotels; transportation info; a message center phone number; a New Orleans entertainment and restaurant guide; and weather watch. There will also be highlights on the Spencer Educational Foundation's silent auction, the RIMS softball game, and other major hospitality functions.

Plus — increased exposure — the RIMS Preview 'take-out' section will be distributed from BI's booth #1024-1026.

## CAPTIVES/ RISK MANAGER OF THE YEAR Issue: April 29 Ad Closing: April 16

Business Insurance plays an important role — getting news and information into the hands of decision makers whether they're in their offices or attending the RIMS conference.

BI's feature on Captives will announce the 14th annual Risk Manager of the Year and the Risk Management Honor Roll. This issue also includes BI's exclusive Directory of Captive Managers.

Advertisers in this issue will be listed with their ad page numbers in a special wrap-around for bonus issue distribution at RIMS. BI advertisers who exhibit at RIMS will be listed with their booth number also. It's a once a year opportunity for you from BI ... in concert at RIMS.

## RIMS REPORTS

### Employee Benefits Issue: May 6 Ad Closing: April 23

BI readers responsible for their companies' employee benefits will rely on this issue. From new perspectives to industry insights, BI editors will detail all the vital information covered at the RIMS employee benefits sessions.

### Risk Management Issue: May 13 Ad Closing: April 30

Wrapping up coverage of RIMS '91, BI editors will deliver an information-packed issue on the risk management sessions. Every corporate insurance buyer responsible for risk management will be sure to read this final RIMS feature cover-to-cover.

Business Insurance is the one publication conducting the most timely, comprehensive news coverage before, during and after one of the most important meetings of the year for its readers.

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**Business  
Insurance**  
a publication of Crain Communications Inc

# Insurers must fight bad image

By Hobson D. Carroll

**I**N CASE YOU HADN'T NOTICED, the health insurance industry (along with just about every other segment of the insurance business) has been taking a severe beating lately from a public relations standpoint.

Whether from consumer groups, regulators or the media, there has been a plethora of emotionally hyped anecdotal evidence relating to the "need" to effectively eliminate all those characteristics of the health insurance business that make it insurance and make it a business.

While I hesitate to play the role of an industry apologist, because there are a lot of things I do not like about how our business works, it seems that a great injustice is being done. Given the extent of the one-sided stories being disseminated—such as the "60 Minutes" segment replayed during a recent speech by California Insurance Commissioner John Garamendi (*BI*, Jan. 28)—the moderate response by various industry organizations that I have seen leaves a great deal to be desired.

Stories abound in the media of how innocent people suddenly find themselves, allegedly through no fault of their own, without the health insurance protection for themselves or their dependents that they thought they had. In all of these stories, the impression left to the reader or viewer is that the insurer somehow intentionally manipulated the situation to deprive the "victim" of what was rightfully his. What is almost never done in these stories is to discuss the insurer's side of the story, to acknowledge at least the possibility that insurers were, in fact, within their contractual rights not to pay certain claims presented for payment under their policies.

Purchasers of insurance must have some residual responsibility (though most has been eliminated by the courts or regulators) for understanding not only what the policy covers but for what it does not cover. Clearly, blatant attempts by companies to avoid legitimate claims for which the policyholder is unambiguously protected should always be quickly condemned. But consumer ignorance of the details of coverage should not be a license to force companies to pay for things that were never intended to be covered, and were probably never priced for in the original premium assumptions.

For example, many stories deal with the problems in small group insurance generated by the existence of pre-existing conditions limitations. Often, an employee changes employers and the new insurance coverage imposes a limitation on such pre-existing conditions. The employee may have a dependent who has an existing condition for which he/she is receiving medical treatment, perhaps very expensive treatment, and the employee suddenly discovers that the new insurance will not pay for those expenses.

In most instances the pre-existing conditions limitation in such policies is allowed by state insurance laws and was a part of a policy willingly purchased by the employer sponsoring the plan. However, when a problem arises for an employee, a disturbing new principle appears to be at work in our society, one that says people no longer need to take any responsibility for their own protection. Isn't it possible that people who switch jobs without considering the impact of a change in group health insurance are just as responsible as the limitation practices of a new insurer when a dependent is suddenly without coverage for some pre-existing condition?

I have yet to see in any of these many "horror" stories about someone being without insurance coverage, or about a claim being denied, a discussion of the fact that these situations are but a fraction of the legitimate claims that are paid promptly and with full satisfaction to the policyholder. Also absent is the point that the large majority of the population is in fact covered adequately for medical expenses that may arise in the coming year.

The intangibility of insurance protection as a

## Speaking out

"product" has always made it difficult for consumers to appreciate coverage. It is not something they can drive, wear, eat or play with. If, at the end of a policy year, they are fortunate enough not to have needed the insurance they purchased, they often feel that they didn't get their money's worth. The protection that the industry provides is not long remembered by many of the industry's customers. Unfortunately, it is the absence of such insurance protection that generates the most media interest and, hence, tends to overshadow the immense amount of quiet security being provided by the insurance industry to most of society.

The biggest problem with the rhetoric of the industry's critics is that their statements reflect a lack of knowledge of what constitutes a true insurance risk or what the insurance business is all about. The concept of insurance requires an acknowledgment of the concept of "uninsurability," since true insurance relates to contingent events.

Insurance is protection for an event that has not yet happened and for which, on an individual basis, there is no particular evidence of increased likelihood of that event occurring. People who have conditions generally requiring medical services and who have not already attained coverage for that condition before its onset do not need (nor have a right to) health insurance for that condition. What they need is someone to pay their bills.

Insurers that do not cover people for certain conditions that are known at the outset of the proposed insurance coverage and who make such limitations clear are not guilty of anything devious or immoral. They are just operating according to the principles of insurance, which allow them to keep their premiums down for all their customers.

Especially for small group health insurance, there has also been continued criticism of the industry practices of durational rating, tiered renewal rating and what the newly elected insurance commissioner of California, Mr. Garamendi, has called low "come-on" rates designed to encourage a policyholder to buy initially, while requiring excessive renewal rates. There appears to be little discussion pointing out that such practices have come about largely because the market required it. The "market" in this case is composed of two main components: the buying public and the agent/broker distribution system.

The market told insurers writing small group health insurance that it no longer wished to participate in the more traditional "pooled" concept of insurance. It did so by constantly moving coverage at the smallest hint of a rate increase. At the least, the employers with healthy employees and dependents would leave.

This practice was largely suggested (and certainly encouraged) by agents too lazy or too ignorant to work at educating clients about the realities of the insurance principle as it applies to small group health. (Interestingly, a significant reason that renewal rates have gone up as much as they have is because our friendly agent is typically getting a proportional increase in his commission check every time increasing claims costs drive the required premium up.)

In an effort to keep their blocks of business from deteriorating, insurers had to do something to attract new business and to retain more business that did not have (at least initially) many claims. The response was to price newly underwritten business at premium rates actuarially justified for the anticipated morbidity over the first six to 12 months, but much lower than what the rates would have to be after the underwriting wears off, even ignoring the impact of medical trends on claims cost.

However, as a result, experience rating of the business, to the extent possible for small groups, became a requirement at renewal. The result was the need for larger (in some cases, unrealistically large) premium increases for groups that had the misfortune

of having had claims.

The genesis of these practices is not an attempt to suggest that it is a good way to do business, but an attempt to explain how it has been, from a business point of view, a necessary way to do business. A company failing to meet the market's requirement for low rates for new business would quickly find itself out of the business, or a haven for high-risk, high-loss ratio groups that could never support through premium payments alone the level of claims the groups would generate.

The point is that the market created this situation. The insurers did not get together and decide that this is the way it would be done.

The ironic thing about calls by people like Mr. Garamendi for abolishing "come-on" rate levels is that at the same time they are calling for companies to cover everyone (including uninsurables) at more affordable prices. Doing away with select and ultimate pricing will raise rates for new business, not make it more affordable. In addition, restricting underwriting limitations is not going to lower premiums, either.

While I basically agree with the changes being sought by the National Assn. of Insurance Commissioners and its new model legislation governing small group insurance rating practices (*BI*, Sept. 24, 1990), I wonder how happy the market is going to be when it learns that in order to do away with these "undesirable" practices, the price will be higher for the bulk of employers that consider themselves preferred risks.

The other major problem with both the NAIC and proposed Health Insurance Assn. of America-sponsored plans, is that they only address limitations and restrictions on insurers and do not require that once an employer buys coverage from a certain insurer it should have to stay with the insurer for at least, say, three years. This would go a long way toward addressing the natural deterioration problem by forcing the good risks to subsidize risks that are no longer healthy. Remember, a general dictum of human nature is that the only people who really believe in sharing costs through a pooling arrangement are the ones who can't "swim" and who want everyone else to be in the pool so that they can stand on them.

A movement seems afoot to effectively transform the health insurance industry into a utility. In this version, everyone expects to pay the same flat rate no matter how much they use the system. (Even the gas and electric companies get to bill their higher utilizers more, even if they can only charge the same rate per unit of service.) Such a system would then be a social welfare construction, not insurance.

The term "health insurance" is not synonymous with the phrase "the provision and financing of health care." If society decides to create an administrative utility to pay the medical bills of every citizen, then do not call it insurance (nor a business) and do not attempt to regulate it as such. The world is full of attempts by society to force square pegs into round holes. We do not need another one.

There can be no doubt that the current way that our society has chosen to finance medical care has left some large cracks through which many people have been falling. Many of these cracks are the "collateral damage" of the past decision to use an insurance structure to provide the lion's share of the protection required by the population. Forcing the insurance system to plug those cracks may destroy the principles on which the current structure is based. That is, it will cease to be insurance.

Society must recognize that it cannot make an apple into an orange just by making a law saying it is so. In this particular case, the solution may lie in making fruit salad instead. ■

*Hobson D. Carroll is president of Employee Benefit Specialists Inc., a Minneapolis-based employee benefits and actuarial consulting firm that deals mostly with self-funded plans.*

# Mixing transfer and retention

By The Insurance Institute of America

The following question and answer are drawn from the curriculum for the Associate in Risk Management designation awarded by the Insurance Institute of America. They represent the type of question asked—and the possible answers—in one of the three examinations for the A.R.M. designation.

This month's exercise, taken from a recent national examination in ARM 56, *Essentials of Risk Financing*, focuses on risk financing techniques that are neither clearly risk transfer nor risk retention, but combine elements of each.

**Q:** Risk financing involves either transfer or retention of the financial burden of losses. However, many risk financing mechanisms, such as insurance subject to a substantial deductible, combine elements of both retention and transfer. This is true when the cost of insurance is sensitive to a policyholder's loss experience.

Identify and describe the significance of four factors a manufacturing organization—like a manufacturer of computer mainframes—should consider in selecting the proper amount of the per-loss deductible on the property insurance covering its plant and equipment.

## A.R.M. exercises

Describe how, if at all, each of the following types of insurance rating plans require a policyholder to retain a portion of its workers compensation claims by charging the policyholder a higher premium as its claims become more frequent or more severe:

- Retrospective rating plan.
- Compensating balances plan.
- Discounted (net present value) premium plan.

**A:** Among the many factors that should be considered in selecting a per-loss deductible, four of the most important are:

- The predictability of the losses to be retained, both individually and in the aggregate, which is significant because greater predictability makes losses more budgetable and, therefore, easier to treat as regular expenses.

- The organization's ability to pay retained losses out of its own funds, which is significant because retained losses should not be so large—either individually or in the aggregate—that they deplete funds essential to the organization's normal operations.

- Senior management's tolerance for uncertainty, which is significant because retentions should be small enough that executives do not worry unduly about the organization's ability to pay those portions of losses

that fall within the selected per-loss deductible.

- Premium reductions given for deductibles, which is significant because the insurer should be willing to grant additional premium savings that are in keeping with the added losses (and related loss adjustment and other costs) that the insured agrees to bear under each higher deductible.

An insurance rating plan requires a policyholder to retain some portion of its losses whenever the plan generates a premium for a given period that is higher when the policyholder's losses charged to that period are greater and, conversely, lower when the losses charged to that period are less.

- A retrospective rating plan for workers compensation claims requires an insured employer to retain losses by computing the employer's final premium for a given period as a percentage of that employer's actual loss experience for that period. Therefore, in the long run and subject to the minimum and maximum premium for any given period, the insured employer pays its own losses under such a plan. Only when the workers compensation claims charged to a period exceed this maximum premium are the policyholder's losses actually transferred to the insurer.

- Under a compensating balances plan, an insured employer's actual paid workers compensation claims are met out of the premium deposited in a

bank of the policyholder's choice, where the policyholder must maintain a given compensating balance. If claims are high, the amount of the premium left on deposit is reduced. To the extent the bank then requires the policyholder to deposit additional funds to meet the compensating balance requirement, the policyholder retains a portion of its claims by making additional bank deposits.

- Under a discounted premium plan, the insured employer pays the insurer at the beginning of a policy period only the discounted premium value of the normal manual premium. This discounting recognizes the time value of money paid at the beginning of a policy period, not loss experience charged to any period. Because neither this manual premium nor the discounting to present value reflects the insured employer's loss experience, the discounted premium plan is not loss-sensitive. Thus, this plan does not require the insured employer to retain a portion of its claims. ■

The sample questions and answers used in this column are taken from the Associate in Risk Management designation curriculum of the IIA. For more information on the content of the A.R.M. program, write Dr. G.L. Head, Vp, Insurance Institute of America, P.O. Box 314, Malvern, Pa. 19355.

## Workers comp claim upheld in shooting

Injuries to a bank president and vp who were shot in the president's home after delivering ransom for release of the president's spouse arose out of and in the course of employment for workers compensation purposes, according to a Missouri appellate court.

James R. Byler, president of Farmers State Bank of Texas County, received a call at work from a man stating he was holding Mr. Byler's wife hostage at the Bylers' home. Mr. Byler, accompanied by Loretta K. Jordan, a bank vp, took the \$100,000 ransom to the house. The assailant made them lie on the garage floor where he shot them. The two applied for and were awarded workers compensation benefits for their injuries. The bank appealed.

On appeal, the bank argued that the assaults were distantly removed in the chain of causation and did not arise out of their employment. "The knowledge that banks often have large amounts of currency and that they are sometimes preyed upon by those seeking money through illegal means makes it a natural and a reasonable incident of employment at a bank that an employee could be shot and that shooting would be a rational consequence of the hazard of such employment," the court said, affirming the award.

*Jordan vs. Farmers State Bank*, Missouri Court of Appeals, June 20, 1990 (BI/02/M. \$10).

### Excess insurer not obliged to drop down

The Supreme Court of Louisiana ruled that an excess insurer's coverage did not drop down to indemnify an insured when the primary insurer became insolvent.

Charles P. Kelly Jr. and Estelle Weil, opposing drivers, were involved in an automobile accident. Mr. Kelly sued Ms. Weil and her employer, Associated Moving & Storage Co. Inc., the alleged owner of the vehicle. Transit Casualty Co. provided

## Legal briefs

automobile liability insurance of \$1 million per accident on the Associated vehicle driven by Ms. Weil. After suit was filed, Transit became insolvent. Mr. Kelly then added as defendants the Louisiana Insurance Guaranty Assn. and U.S. Fire Insurance Co., Associated's excess insurer.

The U.S. Fire policy limited liability to the ultimate net loss in excess of the insured's retained limit. U.S. Fire asked the trial court to remove it from the suit because its policy did not provide coverage until its insured was cast in judgment in excess of the \$1 million limit of the underlying policy. The court ruled that U.S. Fire provided coverage in excess of \$150,000 up to its policy limits.

The state Supreme Court reviewed state and federal decisions on the "drop down" issue and said that the basic consideration is the agreement between the insured and the insurer: the insurance policy. The court said that a simple, logical, common-sense reading of the policy provision here left one conclusion: that the retained limit was the limits of the scheduled underlying policies, supplemented by any other insurance, provided that the other insurance was collectible. The court said the insured's retained limit included the applicable limits of the scheduled underlying policies irrespective of whether those underlying policies were collectible. The court said that U.S. Fire's coverage did not drop down upon the insolvency of Transit, the underlying insurer.

*Kelly vs. Weil*, Supreme Court of Louisiana, June 4, 1990 (BI/01/A. \$10).

### Compensation of attorney's fees

Services of policyholders' attorney were necessary to obtain payment of insurance proceeds from the

policyholders' insurer and, thus, the policyholders were entitled to have the insurer compensate them for the payment of the fees, according to the Supreme Court of Appeals of West Virginia.

In 1986, a fire destroyed the business premises owned by John and Lucille Jordan. The building and its contents were insured by National Grange Mutual Insurance Co. for \$40,000.

The Jordans' claim for \$40,000 was rejected by the insurer because it asserted that the Jordans had willfully concealed and misrepresented material facts. The Jordans retained an attorney to negotiate with the insurer, later filing a civil suit against the insurer.

In 1988 a settlement was reached for \$40,000, but the Jordans refused to cash the check, believing the insurer should be responsible for their reasonable attorneys' fees of one-third of the settlement. The trial court ruled against them.

The appellate court said that allowing the recovery of reasonable attorneys' fees from one's own insurer encourages the prompt payment of valid claims. The court rejected the insurer's argument that recovery of attorneys' fees can occur only when the litigation has ended with a jury verdict favorable to the policyholder. The court said the Jordans substantially prevailed in their suit; thus, the insurer was liable for the reasonable attorneys' fees.

*Jordan vs. National Grange Mutual Insurance Co.*, Supreme Court of Appeals of West Virginia, April 2, 1990, rehearing denied June 7, 1990 (BI/02/A. \$10). ■

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

# Transfer liability for managed care

By MICHAEL SCHACHNER

NEW YORK—Contracts with managed care vendors should contain hold-harmless agreements that protect employers from liability in cases of vendor error or provider malpractice, warns a cost-containment manager at a major corporation.

"As an employer, you should demand that a hold-harmless clause be included as part of your contract with any managed care vendor and ideally this would be a free clause," said Tanya Mayer, manager of cost containment and flexible benefits with Purchase, N.Y.-based PepsiCo Inc.

A managed care vendor should promise to assume all legal responsibility for its actions and the actions of physicians and hospitals with which it contracts, she said.

Ms. Mayer spoke at a conference last month in New York on how to contract for managed care. The meeting was co-sponsored by the New York Chapter of WEB: A Network of Professionals Working in Employee Benefits and the New York Business Group on Health Inc.

"The vendor should be ultimately responsible for the actions of the providers it has under contract," she said.

Employers also must make certain that the managed care firm has liability insurance, she warned. Ms. Mayer suggested that employers request that managed care firms present certificates of insurance during the request for proposal process.

Even when contracting with utilization review firms, employers should make sure the firm is insured for all forms of professional liability and medical malpractice risks, she said.

Employee benefits managers also should check the financial records of any UR firm with which the employer may contract so the employer "can see if the firm will be around for a while," she said. "Don't be afraid to ask for and call upon client references, either," she said.

Employers also should conduct a thorough review of the nurses and doctors that will be performing the UR services, Ms. Mayer said.

She also recommended that employers insist that nurses and doctors—rather than ancillary staff employed by the UR firm—collect all medical information pertaining to patients. "Also, examine the method of review the UR firm uses and make sure all procedures are well documented. You can never have enough documentation," Ms. Mayer advised.

And, under any UR contract, a doctor should be required to issue any final denial of care, she said.

Ms. Mayer pointed out that rather than contract with a managed care network, some larger employers may be interested in setting up their own preferred provider organizations.

For example, PepsiCo has established two PPOs: one for its corporate personnel and another for employees of numerous subsidiaries.

When searching for physicians to participate in a network, employers should determine whether doctors keep solid records, she suggested.

"You also want to see if doctors have privileges with the major hospitals in their area. Also, check to see if the doctors are certified and have clean histories. You don't want to get involved with anybody with a criminal record or suspect past," Ms. Mayer said.

When selecting hospitals for the

PPO, employers should contact with only hospitals that are accredited by the Joint Commission on Accreditation of Healthcare Organizations, Ms. Mayer said.

Employers also should check a hospital's morbidity and mortality statistics as well as its occupancy rates, because "if a hospital is only 15% full, you know something is wrong," she said.

Other speakers included Chip Sharkey, senior vp-employee benefits with CIGNA Corp. in Hartford, Conn., and Alan Koral, an attorney with the New York law firm Vedder, Price, Kaufman, Kammholz & Day. Lee Launer, a partner with Coopers & Lybrand in New York, moderated the session. ■

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# Educators D&O market growing: Survey

By MICHAEL SCHACHNER

CHICAGO—Despite a slight market hardening, schools are not having significant problems finding reasonably priced directors and officers liability coverage, according to a new survey.

Premiums are inching up in many cases but, with at least 20 insurers active in the market, capacity for the coverage remains sizeable, the survey found.

And insurers are renewing current coverage for educators with few changes in limits, deductibles and exclusions, according to "The 1990 Educators Legal Liability Survey," conducted by The Wyatt Co.'s Chicago office.

"The educational institution D&O market is growing as many schools and universities, especially private institutions, are purchas-

ing the coverage," said Phillip N. Norton, the Wyatt consultant who wrote the study.

"Carriers are offering broad-based coverages, availability is rarely a problem, and while premiums are increasing in some cases, the market is expanding amidst competition among insurers," he said.

An earlier Wyatt survey found the corporate D&O market began to harden last year, although the magnitude of premium increases was not severe (BI, Jan. 14).

Of the 558 educational institutions responding to the current survey, 76%, or 424, said they purchase educators D&O.

Among the 344 non-public schools responding, the figure was 90%. However, only about half of the 214 public colleges and universities responding purchased D&O

coverage. Forty-five percent of those cited sovereign immunity/public indemnification as the leading reason for not doing so.

About two-thirds of those surveyed experienced some premium volatility during the period surveyed—the third quarter of 1989 to the third quarter of 1990. Of those, about three in five said premiums increased, though typically not by significant amounts.

For those participants with prior policies, 37% reported higher premiums on renewal. Twenty-six percent said premiums fell and the remaining 37% reported no change.

Breaking down those responses by quarter found the percentage of respondents reporting premium increases was 40% in the third quarter of 1989; 30% in the fourth quarter of 1989; 32% in the first quarter of 1990; 46% in the second quarter;

and 39% in the third quarter.

The percentage reporting decreased premiums by quarter spanned from 23% in the third quarter of 1989; 29% in the fourth quarter of 1989; 30% in the first quarter of 1990; 21% in the second quarter; and 30% in the third quarter. The remainder in each quarter reported no change in premiums.

"Premiums are increasing somewhat. Premium increases are distinctly more popular than premium decreases, but increases are rarely more than 15%," Mr. Norton said.

Very few survey respondents reported difficulty in obtaining adequate coverage. Of the 134 institutions that did not carry the coverage, only 7.5%—or 10—said coverage was too limited or that it was simply unobtainable.

"I think this number is low enough to indicate that coverage is

very available," Mr. Norton said. "For example, corporate D&O's corresponding numbers show that 15% of companies report that coverage is unavailable or too limited. And, because some schools cannot get coverage, (it) may just go to show that there's some underwriting going on. Not every school is going to be risk-free."

Other reasons cited for not purchasing D&O were:

- No need for it, cited by 6%.
- Counsel advised against it, 1.5%.
- Cost was too high, 8.2%.
- Unspecified other reasons (although this usually was self-insurance), 31.3%.

Those educational institutions that opt for the coverage are encountering little trouble in securing adequate limits, the survey found. Among respondents that renewed their policies during the survey period, the majority—89%—reported that limits went unchanged at the last renewal, 10% decreased their limit and only 1% boosted limits.

Respondents reported buying up to \$50 million in D&O limits. But the average limit was \$4 million, and 95% of the respondents purchased limits between \$1 million and \$10 million.

In its overall corporate D&O survey, Wyatt found the average company bought \$26.6 million in primary and excess D&O limits.

Mr. Norton said educational institutions need lower limits than their corporate counterparts.

"The source of claims against universities is normally an employee or a student. Historically, these claims don't reach millions of dollars. Educational institutions aren't facing shareholder claims, which are the ones that really scare corporations," Mr. Norton said.

Wrongful termination damages are another major difference. A chief executive's claim against a big company "can approach \$30 million," said Mr. Norton. "If a professor wins a similar case the award isn't nearly as extreme—usually about \$1 million or \$2 million at most."

According to the survey, public four-year institutions were the most prone to D&O claims. But, the survey found that about 60% of all claims are filed by school employees and most are closed without payment to the claimant, often without legal fees. For those claims that do result in payment, the average loss was about \$50,000, including legal fees.

Mr. Norton pointed out that Wyatt's corporate survey reported a total of 852 claims among 1,442 respondents from 1981 through 1989. Nearly 57% of those were settled by the time participants filled out their surveys. Payments, though, averaged \$1.94 million.

According to the Wyatt survey, the 424 educational institutions with D&O insurance reported paying nearly \$24,000 on average for their coverage. Only 23 schools said they purchase any excess D&O coverage.

In contrast, the corporate D&O study found that respondents paid \$253,649 on average for primary limits and \$425,463 on average for all D&O coverage.

The "1990 Educators Legal Liability Survey" is available for \$85. Companion peer group reports describing the claims and insurance purchasing patterns for segments of the survey participants will also be available in the future. Discounts are available for members of an educational institution. For a copy, contact Donna Juhlin or Mary Maze at The Wyatt Co., Risk Management Services, 303 W. Madison St., Suite 2400, Chicago, Ill. 60606-3308; 312-704-2719.

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## Benefit fraud

Continued from page 1  
rained in U.S. District Court in Boston Thursday.

Ms. Dunlop will plead not guilty, according to her Boston lawyer, Charles Campo. "There was absolutely no intent by Anne Dunlop to defraud anyone of anything in this whole situation," Mr. Campo said.

Lawyers representing Mr. Carpenter and Mr. Rowe could not be reached.

However, Mr. Campo said he was notified by prosecutors last week that Mr. Rowe has agreed to testify against the other defendants at trial, possibly as part of a plea agreement.

Assistant U.S. Attorney Victor A. Wild declined to comment on whether a plea agreement has been reached.

Mr. Rowe has been held in a Massachusetts jail since his extradition last year from Denmark, where he fled after being indicted for embezzlement in a separate MEWA fraud case in Atlanta (BI, Jan. 29, 1990).

Mr. Rowe was one of several people charged in the allegedly fraudulent operation of Harbor Medical Administrators of Georgia Inc. and an Atlanta-based MEWA, Omni Employee Benefit Trust.

Though similarly named, the Georgia and Massachusetts entities were not related, Mr. Wild said.

The Atlanta charge against Mr. Rowe has been transferred to U.S. District Court in Boston under a rule allowing transfers in cases in which the defendant intends to plead guilty, Mr. Hannon said.

Meanwhile, the Labor Department has filed a civil lawsuit against Mr. Rowe, Mr. Carpenter, Ms. Dunlop and Boston-based Harbor seeking to recover losses suffered by participants in Boston-based Omni Medical.

The suit, filed in federal court in Boston, also names accounting firm Coopers & Lybrand and H. James Gorman Jr., former director of the firm's group insurance and welfare plan consulting unit in Boston.

According to the civil complaint, Mr. Gorman advised Harbor officials several times in 1989 that Omni Medical was not a tax-exempt benefit plan under the Employee Retirement Income Security Act of 1974 and that Harbor appeared to be operating as an illegal insurance company.

However, when the New Hampshire Insurance Department inquired about Omni Medical's legal status, Mr. Gorman told Ms. Dunlop she could "try the 'red herring' . . . just to keep them off balance" and wrongly report that Omni was an ERISA-covered plan exempt from state oversight, the complaint charges.

Mr. Gorman also advised that there was little risk of investigation by state regulators, according to the complaint, which says Mr. Rowe adopted Mr. Gorman's suggestions in an October 1989 letter to the New Hampshire department.

The lawsuit also seeks to hold Coopers & Lybrand responsible for Omni Medical participants' losses.

Harris J. Amhowitz, general counsel for Coopers & Lybrand, said in a statement that the firm's "sole involvement in this unfortunate matter is through the actions of its former employee, H. James Gorman Jr. Mr. Gorman was terminated for cause."

Mr. Gorman "expects to be vindicated in this" and will file a motion to dismiss the complaint on the grounds that he and Coopers & Lybrand were not trust fiduciaries and that the Labor Department therefore has no jurisdiction to sue, said his attorney, William Kettlewell of Dwyer, Collora & Gertner in Boston.

Mr. Gorman, who is in his late 50s, took early retirement and was

not dismissed for cause, said attorney Evan Slavitt of Hinckley, Allen, Snyder & Comen in Boston, who is representing Mr. Gorman in a suit against the accounting firm.

The Boston grand jury returned its 27-count indictment March 14, charging the three Harbor officers with conspiring to defraud participants of Omni Medical and AEBT.

Among other things, the indictment charges that:

- Mr. Rowe, Mr. Carpenter and Ms. Dunlop conspired to misrepresent Omni Medical as an ERISA plan operating as a tax-exempt trust under section 501(c)(9) of the Internal Revenue Code.

- The defendants also conspired to misrepresent the cause of overdue claim payments, the insufficiency of funds available to pay claims and the amount of administrative fees and other expenses paid from trust assets, the indictment alleges.

- The defendants embezzled \$249,297 from Omni Medical by transferring the money to AEBT,

**Mr. Rowe has agreed to testify against the other defendants at trial, possibly as part of a plea agreement.**

whose participants were unrelated to Omni Medical's. Mr. Rowe and Mr. Carpenter also transferred \$73,000 of AEBT's funds to Omni, the indictment alleges.

- Ms. Dunlop used \$123,703 of Omni Medical's funds to pay medical benefits to Harbor employees who were not entitled to coverage.

- Mr. Rowe and Mr. Carpenter embezzled \$170,000 from Omni Medical and AEBT in the form of payments to Brahmin International Underwriting Insurance Agency Inc., a Boston firm each of the two men owned at various times after 1985.

- Mr. Rowe and Mr. Carpenter embezzled \$458,460 from AEBT to pay kickbacks to William J. Sweeney & Associates Insurance Agency Inc., an agency that acted on behalf of the auto dealers' association and that received 8% of premiums paid by AEBT participants, the indictment alleges.

Agency President William J. Sweeney Jr. could not be reached.

- Mr. Carpenter solicited and received \$36,676 in kickbacks to choose Lexington Insurance Co. to provide medical stop-loss coverage for Omni Medical and AEBT.

Lexington, which is not a named defendant, was the stop-loss insurer for Omni Medical from 1986 to 1988 and for AEBT from 1987 to 1988, the indictment says.

The alleged kickbacks were deducted by Harbor before premiums were remitted to Lexington, an American International Group Inc. unit, said a source familiar with the case.

Lexington General Counsel Pa-

trick Foley said he hadn't seen the indictment and couldn't comment.

- Mr. Rowe and Mr. Carpenter concealed payments of AEBT assets to Harbor and Sweeney, along with the cause of overdue claim payments, the insufficiency of funds available to pay claims and the receipt by AEBT of funds from the Omni trust.

In addition to the conspiracy and mail fraud allegations, Mr. Rowe and Mr. Carpenter face ERISA-related theft and kickback charges as well as charges of filing false benefit plan descriptions for Omni Medical and failing to file required documents for AEBT. Ms. Dunlop is charged with conspiracy, mail fraud, ERISA-related theft and filing false statements.

If convicted on all charges, Mr. Rowe could face 109 years in prison and \$5.6 million in fines; Mr. Carpenter 113 years in prison and \$6.1 million in fines; and Ms. Dunlop 55 years in prison and \$2.75 million in fines. ■

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## Antitrust hearing

Continued from page 2

ported the defendants, while the Justice Department argued against the case's dismissal (EI, Aug. 13, 1990; May 21, 1990).

In his 1989 decision, Judge Schwarzer had ruled that the states failed to establish that insurance industry defendants violated the McCarran-Ferguson Act by engaging in a boycott. Antitrust exemptions that insurers enjoy under that 1945 law do not extend to boycotts or coercion.

Judge Schwarzer also dismissed foreign defendants from the case on the basis of comity—a reciprocal respect for foreign law—on several grounds, including the difficulty of exercising jurisdiction over the foreign defendants.

The judge also granted the defendants' motion to dismiss the case on the state action doctrine. That doctrine provides immunity from antitrust laws if the anticompetitive restraint of trade reflects a state policy and if the state actively supervises any private anticompetitive product.

Judge Schwarzer also dismissed the attorneys general's global conspiracy charge. They had alleged that U.S. insurers and certain insurance trade groups conspired with foreign reinsurers to restrict coverage available under general liability insurance policies.

He did, however, rule that the attorneys general do have standing to sue.

Frequent questions from the judges punctuated the lawyers' oral presentations.

Particularly vehement was Judge John T. Noonan Jr., who closely questioned the two defense attorneys: John G. Harkins Jr. and Martin F. Evans.

Mr. Harkins, of Philadelphia-based Pepper, Hamilton & Scheetz repre-

sented Astna Casualty & Surety Co. He focused on the McCarran-Ferguson, state action and global conspiracy issues. Mr. Evans of Debevoise & Plimpton in New York represents Continental Reinsurance Corp. (U.K.) Ltd. and Unionamerica Insurance Co. Ltd. He focused on comity and standing.

Judge Noonan, a Reagan appointee and a former professor at Boalt Hall School of Law in Berkeley, questioned whether regulated domestic insurers had used non-regulated foreign defendants to engage in a boycott. He suggested that the defendants were not insulated by McCarran-Ferguson "because your clients use tools prohibited by McCarran."

"When they use an unregulated component, there's no protection," said Judge Noonan.

He also suggested that a refusal to offer reinsurance, as alleged in the suit, constitutes a boycott. "We're talking about boycott. You don't know the ordinary meaning of boycott," he told Mr. Harkins. When a group of people say they will not sell reinsurance, "you've got a boycott."

Mr. Harkins denied the charge.

Judge Noonan's major concerns were whether reinsurance, which is not subject to state regulation and is outside the ISO process, was brought in to use as enforcement muscle against ISO and against consumers," said Thomas M. Alpert, assistant Massachusetts attorney general. "It's our belief it was, and I think he understood that point."

Richard L. Schwartz, assistant New York attorney general, commented that Judge Noonan "is certainly very concerned, I think, with the fact that it was really impossible to say the London companies are subject to state regulation by New York or California, or any other state. He was certainly very struck by that."

"I think, from the questions he asked, Judge Noonan clearly seemed to be sympathetic to the arguments the plaintiffs were making," commented Lisa Tiegel, special assistant Minnesota attorney general.

He understood the allegations and felt, "quite contrary to Judge Schwarzer," that there were sufficient grounds to establish a boycott, added Ms. Tiegel.

**When a group says it will not sell reinsurance, 'you've got a boycott,' Judge Noonan says.**

She said Judge Noonan also was concerned that the defendants argued there was insufficient impact in the United States to justify that the court has jurisdiction over the foreign defendants.

But, on the other hand, the defendants also argued that the states regulated the foreign defendants' conduct and therefore they enjoyed antitrust immunity under McCarran-Ferguson, Ms. Tiegel said. It seems odd, she added, to have state oversight, but no federal jurisdiction.

"I think Judge Noonan's focus is incorrect," commented a defense attorney. "I think his frame of reference appears to be wrong."

The judge appears concerned about whether state law regulates reinsurers and about the applicability of the McCarran-Ferguson antitrust exemption. But instead, the attorney said, the focus should be on whether the conduct is regulated, not on who regulates it.

Judge Robert Beezer, also a Reagan appointee, questioned plaintiffs' attorneys about state insurance regulation and the impact of insurers' actions on the market.

Plaintiffs' arguments were delivered by Laurel A. Price, deputy New Jersey attorney general who focused on the McCarran-Ferguson and comity issues, and Laddie Montague of Berger & Montague in Philadelphia, who represented private plaintiffs and discussed the state action and standing issues.

Responding to questions from Judge Beezer, Mr. Price said the defendants agreed to withdraw statistical support and reinsurance for occurrence-based general liability policies during the mid-1980s. "It's the very core of what the McCarran act was intended to attack," he said.

"I think (Judge Beezer) was really focusing on the elaborate regulatory approval process that approved (policy) forms," said

Molly Boast, an attorney with LeBoeuf, Lamb, Leiby & MacRae in New York, which represents Lloyd's of London underwriting agencies in the litigation.

"He—I think, correctly—perceived that the insurance industry engaged in perfectly appropriate activity" with respect to policy forms and did not act either coercively or in violation of antitrust laws, said another defense attorney.

Ms. Tiegel commented, "Judge Beezer's views were less clearly made than Noonan's, but I think he tried to ask more pointed questions" of the plaintiffs. Ms. Tiegel said she is more confident about Judge Noonan's views on the case. "I'm just not sure about Beezer."

Singleton is an Alaskan federal district judge appointed by President Bush who is temporarily serving on the appellate court.

Despite Judge Noonan's apparent sympathy for the plaintiffs and Judge Beezer's for the defendants, lawyers on both sides cautioned against predicting the outcome.

"People say you just can't tell anything from the arguments," said Ms. Boast. "I think the results are just completely unpredictable."

Each judge was interested in different issues, "so I don't think you can draw any conclusion from it," Ms. Boast said.

Judge Noonan asked some questions about McCarran-Ferguson that were not necessarily favorable to the defendants, "but it also seemed Judge Beezer is going our way," said another defense lawyer. With Judge Singleton "impossible to read," the lawyer added, "it's impossible to read as to how it comes out."

Extreme views judges express during oral arguments are sometimes tempered or even changed during the process of reaching a consensus, she explained. "It's very, very difficult to predict."

In explaining why they hesitate to predict Judge Noonan's position, defense attorneys focus on the judge's academic background.

The Socratic method—using a series of questions to test the soundness of a definition—is frequently used in the appeals court, but that does not indicate what the decision will be, said Richard de Saint Phalle of Crosby, Heafey, Roach & May, in Oakland, Calif. He represents Hartford Fire Insurance Co. in the litigation.

"Judge Noonan is an extremely bright person who spent many years following the Socratic method at Boalt Hall, and he knows how to ask the hard questions." But, Mr. de Saint Phalle added, that "doesn't necessarily mean it's where he's going."

Referring to Judge Noonan's com-

ments, David Slaby, an attorney with San Jose-based Pettit & Mari, which represents CNA Re (U.K.) Ltd. in the litigation, said that "you can't and shouldn't assume from the way in which a question is asked where a professor is going."

"Unfortunately, it is impossible to know what the decision is likely to be," agreed New York's Mr. Schwartz. "It certainly did seem that Judge Noonan is very, very receptive to what we had to say, and I think it was particularly gratifying to hear he'd identified kind of the bulk of the defendants' approach as essentially a misrepresentation of the allegations the states made in the complaint," he added.

But, Mr. Schwartz noted, "it's not really possible to get a reading with this case."

"I've learned that you can't discuss votes based on judges' questions. It's just not a reasonable thing to do," said Massachusetts' Mr. Gold.

"It's reading tea leaves," said Richard D. Monkman, former assistant attorney general for Alaska, and now an attorney with Dillon & Findley in Juneau, Alaska, who attended the hearing. "You never know whether a judge is arguing from conviction or simply to understand the party's real position or arguments, so it's really difficult to tell."

Attorneys for both sides said a split decision in which some, but not all, defendants are dismissed from the complex litigation is conceivable. For instance, the foreign defendants could be dismissed from the case, but not the domestic defendants, or vice versa.

## Judge says he'll uphold referendum

ATLANTA—A federal judge has indicated he will rule against consumer groups in a lawsuit charging a 1990 referendum that limits the liability of state entities was misleading.

U.S. District Judge J. Owen Forrester said last month that he would issue a judgment in favor of the state attorney general's office, which has opposed the suit, according to Ken Canfield, an attorney for the plaintiffs with Doffenmyre Shields & Canfield in Atlanta.

Georgia Citizen Action and Common Cause/Georgia last fall sued claiming that the referendum language was misleading.

The groups claimed in their suit that the wording would lead voters to "believe that there is currently no provision for suit or for waiver of sovereign immunity and that the passage of the proposed constitutional amendment can only increase the state's liability to citizens."

The suit noted, however, that the Georgia Constitution already waives the defense of sovereign immunity for a state entity that buys liability insurance, allowing awards up to the limits of the insurance.

During polling hours Nov. 6, Judge Forrester ordered state officials not to release the vote count until he made a final ruling. At that time, the judge agreed that the ballot language could be misleading (EI, Nov. 12, 1990).

The referendum passed with 53.1% of the vote, according to the Georgia secretary of state's office.

At election time, Attorney General Michael Bowers maintained that the purpose of the referendum "to restore good-faith immunity for employees" of the state, even if insurance covered their actions.

Mr. Canfield said he expects the ruling would be appealed.

—By Colleen Johnson

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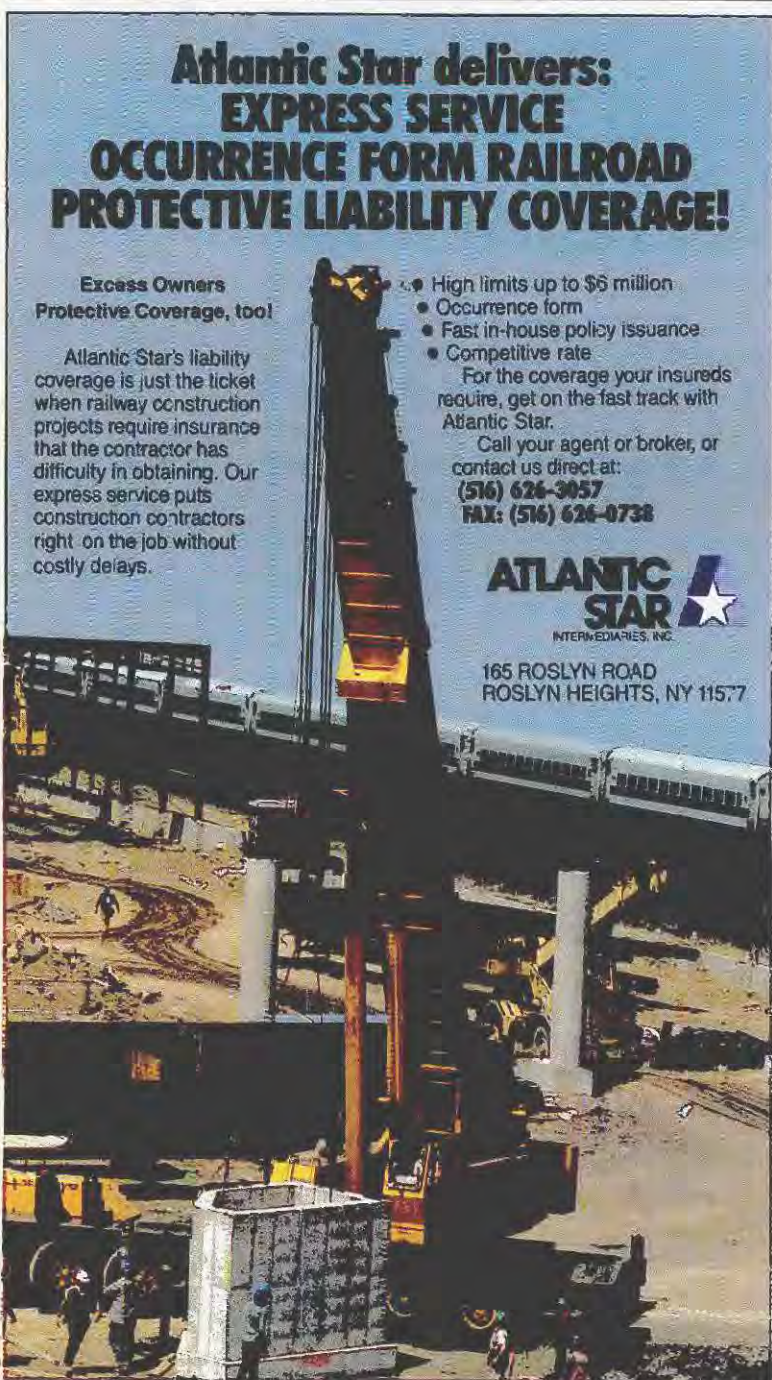
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## New Hampshire

Continued from page 3

not be met because 'few individuals suffer non-economic damages in excess of \$250,000,' we fail to understand how a cap of \$875,000 could meet the test, simply because even fewer individuals would be affected by a higher cap," the court said, quoting its Carson decision.

In addition, the court found—as it did in the Carson case—that it was "simply unfair and unreasonable to impose the burden of supporting the medical care industry solely upon those persons who are most severely injured and therefore most in need of compensation."

And, the court noted, defendants are protected "from the ills" of a runaway jury "that has imposed a disproportionately high award" by the discretion of the trial judge, who can reduce such awards.

However, the New Hampshire Coalition for Affordable & Available Insurance Protection, which filed a brief supporting the defendant, rejected the "protection" provided by trial judge review.

"Presumably, the Legislature enacted the statute because it did not think the 'always available' judicial remedy was adequate to cope with the problem," wrote the Coalition, an organization of employers and other groups that studies tort liability problems and possible solutions.

And, the defense in the Brannigan case contended that since there are discernible differences between the first damage cap and the cap enacted in 1986, the Carson ruling should not be applied. For example, the cap that is applicable in the Brannigan case is much higher than the cap in the Carson case.

However, the court also rejected that argument.

Both the Carson and Brannigan rulings focus on a distinction between plaintiffs with non-economic damages that exceed a cap and those whose damages don't, the court said.

The defense in the Brannigan case also argued that the court should not rely on its decision in the Carson case because the applicable cap in that case applied specifically to medical malpractice awards while the 1986 cap applied to non-economic damages in all personal injury cases.

But, the court again disagreed.

"First, and most important, the language of Carson evinces a rejection of the cap itself, and not merely a concern that medical malpractice victims were subject to a cap while other tort victims were not," the court said.

As the Supreme Court did in the Carson case, it applied a higher level of scrutiny in reviewing the constitutionality of the \$875,000 cap than other state courts typically apply in reviewing state laws.

Scott Goetsch, a defense attorney with Semmes, Bowen & Semmes in Baltimore, explained that state courts traditionally have reviewed the constitutionality of laws using two standards of review: strict scrutiny and rational basis.

Mr. Goetsch explained that the strict scrutiny test—which is more stringent—is reserved for laws that could violate fundamental rights, like race discrimination or restrictions on freedom of speech.

However, other laws typically have to pass the rational basis test. A law passes this test if a court feels the law is consistent with its intended goal.

However, a "middle-tier scrutiny" has evolved, said Martin L. Gross, an attorney with Sulloway, Hollies & Soden in Concord, N.H., who helped draft the Coalition's brief.

Under this test, a court looks at whether the law can accomplish its intended goal.

This new level of scrutiny has been applied in some cases challenging laws that allegedly abridge fundamental rights, Mr. Gross said. But it "has never been applied to the test of the constitutionality of a damage cap before Carson," he said.

The New Hampshire Supreme

Court said it feels that applying this middle-tier standard to the 1986 statute is appropriate.

The court explained its rationale by again referring to its ruling in the Carson case, in which the court said that "although the right to recover for personal injuries is not a 'fundamental right,' it is nevertheless an important substantive right."

In giving a higher priority to personal injury recoveries, the court said "the rights involved herein (were) sufficiently important to require that the restrictions imposed on those rights be subjected to a more rigorous judicial scrutiny than allowed under the rational basis test."

Mr. Gross, who also is counsel for the American Insurance Assn. in New Hampshire, says the court's ruling is an example of "judicial activism."

"When you use the middle tier scrutiny, you are wading right in the middle of tort reform," he said. "You intervene in fundamental legislative decisions."

Continued on next page

### APRIL CLOSINGS

issue: April 15  
closing: April 3  
demographic section:

issue: April 22  
closing: April 9  
editorial feature:

issue: April 29 — Reader Service  
closing: April 16  
editorial feature:

issue: May 6  
closing: April 23  
editorial feature:  
demographic section:

issue: May 13 — Reader Service  
closing: April 30  
editorial feature:

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## New Hampshire

*Continued from previous page*

"I would say that the court is making policy decisions," said Martin Connor, president of the American Tort Reform Assn. in Washington, D.C. "All of us read *Carson* as applying to medical malpractice."

But, according to the court's Brannigan ruling, "if a court were to defer to a legislature's finding that the statute bore a 'fair and substantial relation' to the object of the legislation, it would be abdicating its judicial role." Such power rests with the judicial branch rather than the legislative branch, the court said.

Plaintiffs' attorney Ms. Lukey, said that "we believe it was the correct

decision to uphold *Carson*."

"Once you get into the middle ground, if you don't have a statute that is rational, fair and reasonable, then that statute may be in some trouble," said Bruce W. Felmy, a plaintiff's attorney with McLane, Graf, Raulerson & Middleton P.A. in Manchester, N.H.

The decision should have little effect on liability insurance rates in New Hampshire, said Mr. Gross. "The cap was too high to have a demonstrative affect on insurance availability and affordability in the state" in the first place, he said.

Victor E. Schwartz, a partner at Crowell & Moring in Washington, D.C., said whether liability insurance rates in the state will rise depends on

how many awards insurers think will exceed \$875,000.

Mr. Felmy said the state does not have a history of "runaway" jury awards. "There is no doubt that there are people in New Hampshire who would recover \$875,000 or more, but not that many."

However, Mr. Gross disagreed. "New Hampshire has its share of high—over \$1 million—awards."

But, Mr. Gross does not believe that the ruling will influence courts in other states to overturn statutes limiting non-economic damages.

"The decision will be one more holding for (challengers) to use to argue why caps should not be allowed. But there is no ringing prose in this decision that would change

any minds about whether to challenge a state statute."

"Each state thinks independently, and each state will continue to make its own decision on these caps," Mr. Schwartz said.

Supreme courts in Florida and Washington also have found statutory caps on non-economic damages unconstitutional in all tort cases, according to ATRA.

And, supreme courts in another seven states—Illinois, Montana, New Mexico, North Dakota, Ohio, Oklahoma and Texas—have found caps on all damage awards unconstitutional in certain tort cases.

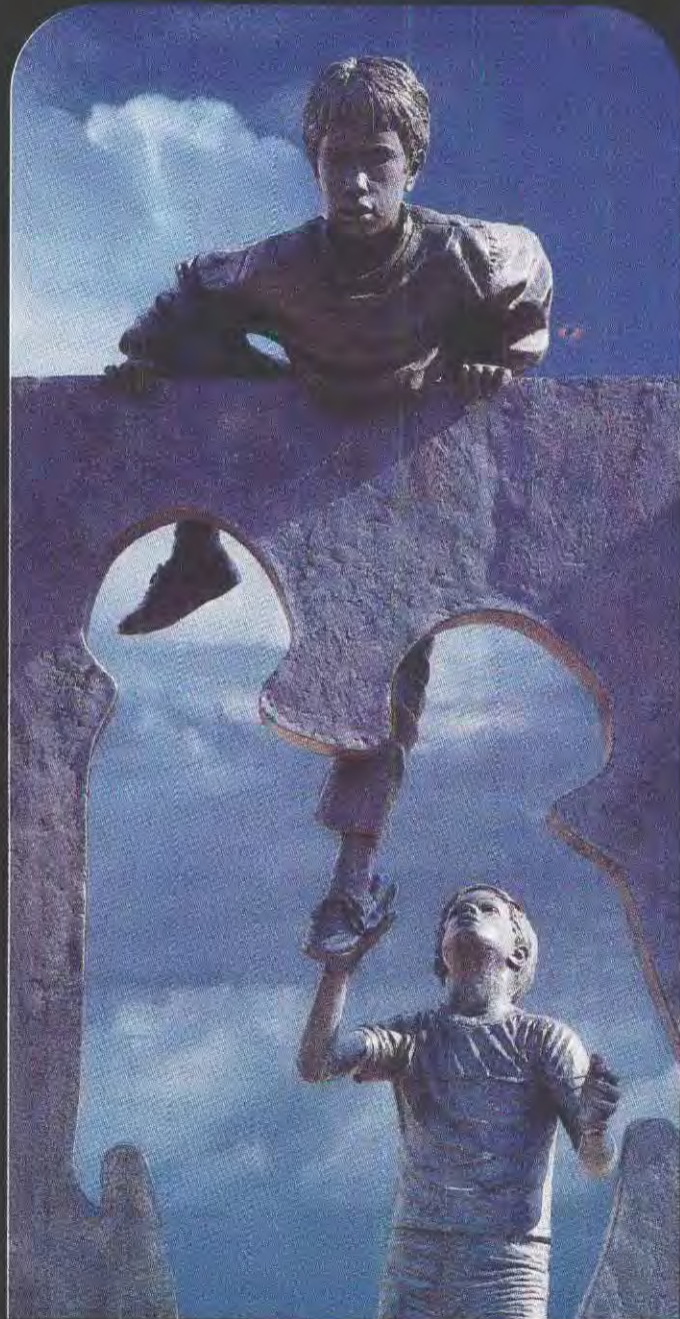
The Kansas Supreme Court has ruled that caps on pain and suffering awards are unconstitutional only in

medical malpractice cases.

The Minnesota Supreme Court has ruled that caps on all damages involving liquor liability are unconstitutional, though caps on all damages in litigation involving public entities are constitutional.

California, Kansas and Maryland supreme courts have ruled that caps on non-economic damages are constitutional for some or all tort cases, according to ATRA. And supreme courts in seven other states—Idaho, Indiana, Louisiana, Massachusetts, Nebraska, Virginia, and Wisconsin—have found caps for all types of damages constitutional, ATRA says.

*Brannigan vs. Usitalo M.D. et al, New Hampshire Supreme Court, 90-377.*



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but in the right use  
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*Henry Ward Beecher*

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# INTERNATIONAL

## House of Lords to rule on tail cover

By STACY SHAPIRO

LONDON—A dispute to be heard in Britain's highest court this summer will determine whether underwriters that withdraw from a line slip must provide "tail coverage" to policyholders, even if the slip continues to provide them with coverage.

The dispute involves a Lloyd's of London syndicate that decided to end its participation in a line slip providing professional liability coverage to the Big Six accountants. Although the syndicate ceased underwriting, the accountants' coverage was renewed by other underwriters on the line slip.

Lloyd's member Colin Baker, representing all members of syndicate 126, formerly underwritten by Ian Posgate, has been given leave to appeal to the House of Lords a recent ruling that would force the syndicate to pay millions of dollars of claims under extended discovery clauses in policies written by the syndicate as part of the slip.

The Court of Appeals on Feb. 28

upheld a High Court ruling that syndicate 126 was liable for claims under the slip's extended discovery—or "tail coverage"—clauses.

Under such clauses in claims-made policies, a policyholder is given additional time beyond the expiration date of the policy to report losses that occurred during the policy period if the underwriter cancels or fails to renew coverage.

The accountants professional liability slip—placed by Minet International Professional Indemnity Ltd. or its predecessor J.H. Minet & Co. Ltd.—provided coverage to six major accounting firms: Touche Ross and Deloitte, Haskins & Sells, which have since merged; Arthur Young & Co. and Ernst & Whinney, which have since merged; Arthur Anderson; and Price Waterhouse.

Although it is not known exactly how much the accountants are seeking under the extended discovery clauses, the firms have notified underwriters of about 1,000 potential losses overall since the end of 1982, with each loss averaging more than \$2 million, said Mi-

**The Minet professional liability line slip provides coverage to the Big Six accounting firms.**

chael Harris, underwriter for syndicates managed by A.J. Archer & Co. Ltd., which is running off syndicate 126.

But, he said, recoveries against syndicate 126 will be limited because the syndicate participated mainly on layers in excess of \$20 million.

Mr. Harris said he hopes the House of Lords will reverse the decision because it "makes commercial nonsense."

The events leading up to the case began in 1982, when Mr. Posgate, one of Lloyd's most successful and flamboyant underwriters, still was writing for syndicate 126, then managed by Alexander Howden

Underwriting Ltd. As underwriter, Mr. Posgate agreed then to participate on the Minet line slip.

The line slip at issue in this case incepted in November 1982, even though Mr. Posgate was forced to leave Lloyd's in September 1982 because of allegations that he misappropriated Howden and syndicate funds. Mr. Posgate was acquitted of criminal charges in 1989 (BI, Aug. 29, 1989).

The line slip that syndicate 126 joined allowed Minet to bind three-year professional liability policies until November 1984, explained Mr. Harris. This means that syndicate 126 could be bound on policies that wouldn't expire until the end of 1987, he said.

The Minet professional liability insurance line slip is one of the most important in the world, covering the world's largest accounting firms. Over the years it has had several underwriters join and leave the slip, said Mr. Harris. The line slip at times could provide up to \$150 million in coverage, he said.

Syndicate 126 normally partici-

pated on the first excess layer, which was for \$20 million excess of \$20 million, as well as the third excess layer, which was for \$20 million in excess of \$50 million, according to court papers.

"Very substantial lines of professional (liability) insurance introduced by Minet were underwritten by syndicate 126," said Lord Justice Neill in his Court of Appeal decision.

The case mainly involves the wordings of three-year claims-made policies that were bought by the six accounting firm plaintiffs in June 1984. The policies all contained a typical provision for extended discovery coverage.

The extension clause said that if the underwriters refused to extend the policy, "the assured firm shall then have the right, upon payment of an additional premium of 100% of the last annual installment of premium, to an extension of the cover granted by this policy in respect of any claim or claims made against the assured firm during the

Continued on page 34

### LONDON

## London insurers standardize rates for Gulf war risks

By GAVIN SOUTER

LONDON—War risk underwriters are again reducing rates in the aftermath of the Persian Gulf War.

The joint Lloyd's of London/Institute of London Underwriters cargo war risk rating committee met last week to set new market-wide rates. As a result, a single rate, described as "all other Gulf ports and places zone" in the market, replaces separate rates for the following areas:

- Iranian Gulf ports, places and offshore islands north of 27 degrees 30 minutes north latitude.
- Iranian ports, places and offshore islands south of 27 degrees 30 minutes north latitude, and north of 26 degrees north latitude.
- Gulf ports and places other than Iran north of 27 degrees 30 minutes north latitude.
- Gulf ports and places south of 27 degrees 30 minutes north latitude and west of 52 degrees east longitude.
- Qatar and Bahrain ports and places.
- Other Gulf ports and places east of 52 degrees east longitude other than Iran.

Marine cargo war risk rates for the "all other Gulf ports and places zone" are set at 0.05% of insured value. This is either lower than or identical to the individual rates it replaces.

The aviation cargo war risk rate of 0.025% for the zone is same as the rate for all of the separate zones it replaces.

In addition to changes in Persian Gulf rates and zones, Colombia is now listed as a separate zone because of strikes and civil commotion currently disrupting industry in the country.

The standard war risk rate of 0.025% of insured value remains for marine cargo bound to and

from Colombia, but other types of coverages set by the committee, including coverage against damage caused by strikes, are now underwritten on a held cover basis, meaning underwriters can set their own rate.

### Springbett steps down

One of the founding triumvirate of PWS Holdings P.L.C. has given up his executive position at the Lloyd's of London reinsurance broker.

David Springbett, who is the "S" in PWS and has served as deputy chairman of the company, will stay on as a non-executive director.

His position was unique and he will not be replaced, said Lord Pearson of Rannoch, the chairman.

Mr. Springbett is considering setting up his own direct broker focusing on health insurance and specializing in insurance for abnormalities in babies, Lord Pearson said.

If Mr. Springbett goes ahead with the new business, PWS may take a stake in it as an investment, he added. "We may invest in the company but it will just be an investment as we want to stick to reinsurance."

Mr. Springbett's decision to step down "is an appropriate move for him and us. He would like to move on to other things and we can allow other to people to move up in the company," Lord Pearson said.

No new deputy chairman will be appointed as the post reflected Mr. Springbett's position as a founder of the company, Lord Pearson added.

Lord Pearson, Mr. Springbett and John Webb left broker C.T. Bowring & Co. in 1964 to set up PWS. Only Lord Pearson remains. Mr. Webb left in 1975.

Mr. Springbett's 1% stake makes  
Continued on page 34

## Power failure damages Brazilian smelting plant

BARCARENA, Brazil—Aluminio do Brasil S.A., an aluminum smelter, incurred millions of dollars in losses when a power outage earlier this month shut down production and solidified much of the aluminum being processed.

The Albras plant lost power for 12 hours on March 8. The outage irreparably damaged a still undetermined number of the plant's 284 smelting pots, where alumina powder was being reduced into aluminum through an electrolysis process.

The plant is 51% owned by the Brazilian government mining concern, CVRD, and 49% by a Japanese consortium.

Albras has \$75 million of coverage for property losses from Sul America Companhia Nacional de Seguros de Rio de Janeiro. However, coverage for damage caused by an electricity blackout is covered under a separate policy with \$50 million in limits.

Representatives from Sul America and its reinsurer, the state-owned Instituto de Resseguros do Brasil, were at the plant last week to evaluate the extent of damage.

Jose Paulo Gils, manager of the IRB's engineering risk department, said damage would probably total between \$15 million and \$50 million.

The damage to the plant was so extensive because the Albras blackout lasted so long, according to aluminum industry sources. It is possible to con-

serve the heat of the liquid aluminum in the smelting pots for about six hours after a blackout, they say. Thereafter, it begins to solidify, expanding and breaking the pots.

Albras Director of Sales and Finance Aroldo Gheren said that at least 40 pots were affected, requiring replacement of the electrolysis mechanism.

The Sul America coverage was 60% reinsured with the IRB, which in turn ceded 40% of the risks to its U.S. subsidiary, United American Insurance Co. of New York, according to Mr. Gils.

One-third of the coverage written by Sul America was reinsured by a group of private Brazilian insurance companies and the other 6.6% was reinsured with Munich Reinsurance Co. of Germany, Mr. Gils said.

—By Rik Turner



GRAPHIC BY CYNTHIA WATSON

## Aussie market tightening

By KATE McILWAINE

Australian property/casualty insurers are predicting rates will rise during the peak renewal season in June.

Although the highly competitive Australian market has been soft for many years with rate cutting the norm, a recent flurry of natural catastrophes, higher reinsurance costs and recession-dampened investment returns are forcing many underwriters to bite the bullet.

In fact, underwriters say they were able to push rates up "a little" during year-end renewals, but most are anticipating at least a 20% rise during June renewals.

A combination of factors is driving the hardening in Australia, according to Felix Zaccar, Sydney-based managing director of Gerling Global Reinsurance Co. Australian insurers are showing bottom-line losses, parent companies are "going through some



pain" and reinsurers are having trouble placing retrocessional covers, he said.

"It's all coming together for the first time.

With disasters on all continents, everyone's been hit," Mr. Zaccar said.

Chris L. Meller, managing director of CIGNA Insurance Australia Ltd. in Sydney, said the long-overdue hardening began with year-end renewals.

"We've really reached the bottom of the barrel," said Mr. Meller.

"I think prices are hardening in a lot of classes. It's been a bad year for property, with fires and natural catastrophes," he said. "The frequency of fire losses was up in relation to previous years."

There has been an "unprecedented frequency of natural disasters, with the Newcastle earthquake in December 1989 (BI, Jan. 1, 1990), and the Sydney hailstorm of March 1990 (BI, April 2, 1990) being the largest and third-largest natural disasters, respectively, to have hit the Australian insurance industry," according to Ron S. Peden, manager of broker insurance operations in Australia for AMP General Insurance Ltd., a Sydney-based unit of the Australian Mutual Provident Society.

Deteriorating claims experience, underpricing and the consequent increase in insurers' expense ratios, combined with the recession, means hardening rates in June, he said.

"The market cannot afford—and we cannot afford—to absorb the financial losses inherent... in the pursuit of market share in spite of increasing claims and expenses.

Continued on next page

## INTERNATIONAL

## Australian market

Continued from previous page

Long overdue action is required to move prices upwards," Mr. Feden said.

Commenting on year-end renewals, Keven J. Kinsella, manager-corporate insurance for GIO Australia in Sydney, which is owned by the government of New South Wales, said there had been no "kamikaze rate reductions."

But now, "a number of underwriters are making a major stance. They will be demanding rate increases and they'll get them," Mr. Kinsella said.

"I just hope the brokers are telling their clients to expect that," he added.

Terry R. Herbert, general manager of Melbourne-based GRE Insurance Ltd., a unit of U.K. insurer Guardian Royal Exchange Assurance P.L.C., agreed that many insurers are issuing clear instructions that underwriters are to get higher prices or lose market share.

"Prices must go up if we want to survive—it's getting to be a question of that now," he said.

Mr. Kinsella said the market will definitely harden in June as a result of heavy losses in Australia and overseas, as well as the increased cost of treaty reinsurance at year-end renewals (BI, Jan. 7).

"Australian companies with London parents will be getting the message. Companies must forsake premium growth in favor of profit," he said.

Mr. Kinsella stressed that the expected hardening of the market is more than wishful thinking on the

part of underwriters. "Rate increases have been suggested in the boardrooms (in the past)," he noted. But this time, he said, the instruction will get down to the underwriters.

There are insurers that have told their underwriters to lift rates by 20% or not write the business, he said, though he did not cite specific examples.

"The disastrous results of some insurance companies are forcing managements to make the hard decisions. There is pressure from parent companies and shareholders," Mr. Kinsella said.

"Brokers are realizing that the market is squeezed, there is nothing left in the kitty and the only way we can go is up. The clients have had a good run for the past five to 10 years. The honeymoon is over," he said.

Contributing to an expected turn in the market, several major Australian insurers reported bad results last year.

At Sydney-based FAI Insurance Ltd., profits were off 69.6% for the year-ended June 30, 1990. And the non-life underwriting loss was \$72.3 million Australian (\$57.3 million at June 30, 1990 exchange rates). Rodney S. Adler, the chief executive, attributed the losses to the Newcastle earthquake, the Sydney hailstorm and floods in Queensland (BI, Feb. 4).

Mercantile Mutual Holdings Ltd. of Sydney reported a \$42 million Australian (\$34.7 million at Sept. 30, 1990, exchange rates) underwriting loss for the year-ending Sept. 30, 1990.

And National Commercial Union Ltd. of Melbourne posted an after-

tax operating loss of \$27.8 million Australian (\$22 million at June 30, 1990 exchange rates) for the year-ended June 30, 1990. Its net underwriting loss for the year was \$105 million Australian (\$83.2 million).

Reduced property and stock market values, as well as lower interest rates, means insurers are getting "no joy in their investment incomes," so companies have to improve performance in the insurance sector, said Hans A.J. Sprangers, chief executive of Sydney-based Lumley General Insurance Ltd.

"Insuring commercial property is, on average, cheaper now than it was 10 years ago. With the storms and earthquakes, that can't last. Rates will have to go up at least 15% to 20% in June," Mr. Sprangers said.

Lumley General had "seen the rot set in years ago," he said. The insurer has not participated in any "unrealistic underwriting," he added.

Ray Kent, insurance manager for Brisbane-based Suncorp Insurance & Finance, the Queensland government-owned insurer, said the market has hit bottom and "things can only get better." He said he anticipates rate increases in June, but as of last month had not yet seen much real evidence of them.

GRE's Mr. Herbert said the market is "hardening a bit." There are still "horror stories about specific cases in which rates are cut to the bone, but the horror stories" are getting fewer, he said.

Rates will rise, but gradually, he said. However, there is a determination among insurers to hold the line that Mr. Herbert said he has not seen in four years.

"There's a lot of pressure from

shareholders, which certainly focuses the minds of chief executives," he said.

In addition, the 1990 demise of two life insurers—Occidental Life Insurance Co. of Australia Ltd. and Regal Life Insurance Ltd.—made non-life insurers more aware of the need for survival, according to Mr. Herbert.

A judicial manager has been appointed to take control of the two companies, while an inquiry is being conducted into their proposed sale by parent company, Battery Group Ltd. of Melbourne. Prompted by the life insurer failures, the Australian government imposed more stringent financial regulations on both life and non-life insurers (BI, Dec. 3, 1990).

A few insurers, though, predict the market will not turn until later in the year.

Bob Wagstaffe, divisional manager of National Commercial Union, said he wanted to see rates rise by 10% to 15% in June, but that those levels are "not necessarily achievable."

He said the premium pool is insufficient to cover the massive property losses seen from the Newcastle quake, hailstorms and industrial fires. Nevertheless, he predicted that it would be November and December 1991 before there was "any real movement" in rates.

Mr. Wagstaffe said his company has set its rates to obtain "a fair and reasonable premium for the risk" and would not be undercutting. "Investment returns can no longer carry poor underwriting returns," he said.

Mike Grossman, regional casualty manager-Australasia in Melbourne with American International Group Inc., said nothing so far suggests a substantial hardening in June. Renewals being negotiated this month will be a better indicator.

Mr. Grossman said that there would be some hardening in the liability lines, but contends there is a lot of capacity in the Australian market to counterbalance the tightening in London.

Given recent indicators like the number of corporate executives "under investigation," the number of companies that had "fallen by the wayside" and the recession, liability underwriters "ought to be a bit concerned," Mr. Grossman said.

Meanwhile, a massive contraction in the Australian reinsurance and retrocessional markets, coupled with reduced capacity, increases the likelihood of rising insurance rates, according to reinsurers.

December 1990 treaty renewals saw minimum increases of 50% in the catastrophe market, with some layers experiencing increases of 300% to 400%, said Alan C. Drake, managing director of Sydney-based Munich Reinsurance Co. of Australia.

"The proportional market is still competitive, but reinsurers are looking at all offers more critically. All reinsurers are looking for insurers to increase rates," he said.

Mr. Drake said insurers were finding that shareholders and overseas head offices were "casting a very discerning eye" on their Australian operations, particularly now that commercial interest rates have dropped.

"Capacity is reducing as reinsurers are seeking a return on capital and are looking very critically at the lines they put down," he said.

Owen F. Roach, GIO's assistant managing director of reinsurance, said retrocessional rate hikes were "very significant" at year-end, with reinsurers paying two to three times last year's rates for their retrocessional covers.

"With the Newcastle earthquake and the wind and hailstorms we have had in Australia, it is clear that we contribute to the worldwide losses and must therefore pay our share of the overseas losses," Mr. Roach said.

The impact of reinsurance rate increases could raise primary premiums in Australia by 10% to 15%, he predicted.

"Many reinsurers haven't got their business fully placed because of a

lack of capacity," Mr. Roach said, noting that GIO had only 60% of the reinsurance protection it had in 1990. However, he added, "that's what we expected."

Most insurers said they paid more for catastrophe cover when renewing their reinsurance. Increases have been 40% to 50% on average, with some companies paying even more for their upper layers, particularly if they were badly hit by the earthquake and storms.

National Commercial Union's Mr. Wagstaffe said catastrophe protection cost "substantially more" and capacity in the property market for some high-exposure risks was drying up.

Gerling's Mr. Zaccar agreed that catastrophe premiums have gone up. He also noted that the direct insurers would have to pass on those increased costs to commercial buyers "because there's no fat left."

"Those (insurers) who need to buy up to \$400 million to \$500 million levels would have trouble. They will need to retain more at the bottom or carry the top layers unplaced," he said.

Retrocessional cover was harder to place and the capacity in the London excess-of-loss market had shrunk by about 50%, Mr. Zaccar said.

"I'm optimistic we have seen the bottom of the market. Rates will go up, although they are not yet hardening" across the board, he said.

Paul Allison, general manager of Copenhagen Reinsurance Co. (Australia) Ltd. a subsidiary of Denmark's Copenhagen Re, said a tightening of retrocessional capacity in London had forced Australian reinsurance rates up and that was placing pressure on direct insurers.

"There are still some silly rates around, but we are seeing improvements. Things will be much tougher in June," he said.

"1990 was a poor year for reinsurers, with negative underwriting results and bottom-line negative results. When we hurt, someone else must, too," he said. ■

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**Business  
Insurance**

# Impact of reinsurance renewals viewed

By GAVIN SOUTER

LONDON—Year-end 1990 reinsurance renewals will have severe repercussions throughout the world reinsurance market, experts predict.

The sudden and violent contraction in retrocessional capacity pushed rates up sharply and forced ceding companies in many nations to seek coverage from new markets, they say.

Worst hit by the capacity meltdown were the London, North European and U.S. reinsurance markets. Southern European markets, which were not affected by winter windstorms, remained more stable.

At a February conference sponsored by Risk & Reinsurance Research Group Ltd., three reinsurance experts reviewed the past year from U.S., London and continental European perspectives.

The shortfall in London retrocessional capacity for U.S. ceding companies did not happen overnight, explained Tom Hancock, executive vp at Willcox Inc., a reinsurance broker based in New York, in a paper delivered at the conference.

"During the first quarter of 1990, we began to notice a hardening of the retro market. This concern carried over to what commitment they might be able to make at year-end," Mr. Hancock said in the paper.

In the meantime, capacity in the U.S. marketplace was contracting throughout 1990, he said. For example, Metropolitan Reinsurance Co.'s book of business was sold to Skandia Insurance Co., U.S. International Reinsurance Co. was placed in runoff by its parent, Home Insurance Co., and several other U.S. reinsurers withdrew from segments of the market (BI, Nov. 12, 1990).

However, problems in the London retrocessional market last year had a more severe effect on U.S. cedants, he said.

"It became quickly evident that most London reinsurers were sitting back waiting to find out what would happen to their own retro programs before they could begin putting down lines on other programs," Mr. Hancock noted.

Problems were compounded when many worldwide reinsurers refused to write programs that contained London market excess-of-loss—or LMX—business, he added.

One of the biggest blows of the renewal season was when CIGNA Corp. closed its London reinsurance operation, Mr. Hancock said.

Due to the lack of capacity, most retrocessional covers were less than 75% placed during midyear 1990 renewals, Mr. Hancock estimated.

That shortfall forced many large U.S. property insurers to cut their Caribbean exposures. They wanted to ensure that they would not be hit on both their domestic and international coverages if another hurricane, like Hurricane Hugo in 1989, hit both the Caribbean and the U.S. mainland, he said.

In addition, U.S. insurers began to look for more proportional cover for U.S. mainland risks that might be hit by hurricanes.

"By year-end, the problems that we had anticipated following mid-year renewals became painfully clear as brokers found it extremely difficult to complete the large property catastrophe programs, say in excess of \$175 million," said Mr. Hancock.

In order to complete programs, brokers looked for new markets in the United States and worldwide.

The problem was partially relieved late in the renewal season when reinsurers re-evaluated their aggregate exposures and took on more risk, Mr. Hancock said.

Not all ceding companies were caught in the crunch, however.

"Property cat covers in respect of regional carriers who buy much

smaller limits were renewed without too much difficulty. There was no general upwards movement in price other than to reflect isolated poor loss experience," Mr. Hancock added.

Medium-sized mutual and stock regional companies had a relatively easy time of it. Reinsurers consider them "preferred business" and property and casualty reinsurance for these insurers was placed at competitive rates, said Mr. Hancock. Directors and officers liability coverages, though, were more difficult to place because of the threat from the savings and loans crisis.

Marine reinsurance programs were renewed at terms that reflected the individual insurers' claims experience, Mr. Hancock said.

The background to the past renewal season in the London market is one of lower profits, said Michael Howard, deputy chairman of broker E.W. Payne Cos. Ltd. For five straight years, the loss ratio on the reinsurance accounts of the 50 largest British general insurers has exceeded 105%, he noted.

One major reason has been increasingly costly natural catastrophes.

The total insured cost of the 1987 European windstorms, Hurricane Gilbert, Hurricane Hugo and the 1990 European windstorms was almost \$20 billion, which represents around 25% of the annual worldwide non-life premium, Mr. Howard said.

"If we assume the reinsurers worked to a premium-to-surplus ratio of 2-to-1 (and) they paid, say, two-thirds of this \$20 billion, then another way of looking at the cumulative effect of these catastrophes is to say that they eroded about 40% of the capital and surplus of the reinsurance industry," Mr. Howard said.

Hard times also have hit aviation reinsurers. Their 1989 losses stand at more than \$1 billion; premiums that

year were only about \$400 million, he said.

However, there still are direct aviation insurers who are making a profit or breaking even, so a disproportionate amount of the losses have been paid by the reinsurance market, Mr. Howard contended.

Finally, the marine market has also been rocked by large losses, like the 1988 Piper Alpha oil rig explosion and the 1989 Exxon Valdez oil spill.

All of these losses forced the sudden tightening of the London excess-of-loss retrocessional market at year-end 1990, Mr. Howard explained.

The difficult 1990 renewal season will force three changes in the London market, Mr. Howard predicted:

- Excess-of-loss retrocessional coverages will be based on far sounder underwriting principles.

- There will be fewer players in the market.

- Financial reinsurance will become more common.

"What has happened has really been no more than a correction in a free market. Its speed of impact has given the impression of something of a roller coaster," Mr. Howard concluded.

Continental European underwrites also have faced an unprecedented series of losses over the past four years, noted Dr. Gianfranco De Giusti, joint general manager of Unione Italiana di Riassicurazione in Rome.

However, loss experience—and rate increases—varied throughout Europe, he said.

"In France, the problem of competition between direct insurance companies, common to many (European Community) markets, has become so strong in the last 10 years that we can consider an under-rating for fire industrial risks of about 50%," said Dr. De Giusti.

Several French mergers have also significantly reduced the amount of business reinsured through pro-rata

treaties, Mr. De Giusti said.

He cites acquisition-minded AXA Midi Assurances S.A. as an example. All the pro-rata treaties formerly purchased by the insurers it has bought out have been replaced by an excess-of-loss program placed through AXA's reinsurance unit, he explained.

Meanwhile, as premiums fell for several years, the 1990 storm losses cost the French reinsurance market 6.5 billion French francs (\$1.27 billion at year-end exchange rates), Dr. De Giusti said. These losses pushed reinsurance rates up an average of 30% at year-end and caused many ceding companies to increase their retentions, he said.

Most programs were eventually placed, but the reinsurers on a program were drastically changed as some major reinsurers tried to set tougher conditions, he said.

Problems in Belgium resembled those in France, he said.

The 1990 storms cost the Belgian market 24 billion Belgian francs (\$775 million at year-end exchange rates), and the market also was hit with several major fire losses, Dr. De Giusti said.

But rates did not increase sufficiently and the main reinsurance programs were placed quickly, he said.

In Germany, too, reinsurance programs were heavily affected by the 1990 European windstorms, but due to pressure from ceding companies, rates were not pushed up to the same extent as in some other European countries, Dr. De Giusti said.

On the other hand, Italy has not been affected by any of the major storms in recent years and consequently excess-of-loss property reinsurance programs were placed easily and at reduced rates, he said.

Italian reinsurers, however, have also frozen "automatic capacities," he added.

## Reinsurer predicts market's future

By GAVIN SOUTER

LONDON—Future demand for reinsurance will be fueled by the need to generate per-risk capacity, the need for catastrophe protection and the need to balance results, says a leading German underwriter.

Consequently, there will be renewed interest in facultative coverage, more information on catastrophe risks and greater use of financial reinsurance, said Christian Baumguertel, board member at Gerling-Konzern Allgemeine Versicherungs A.G.

Cedants' retentions will also rise, said Mr. Baumguertel, attributing the increase to a combination of factors, rather than just increased merger and acquisition activity.

Reinsurers overestimate the effect the current bout of mergers and acquisitions will have on the demand for reinsurance, he said at the Risk & Insurance Research Group's renewal season conference in London.

Increased retentions in merged companies are largely limited to personal lines, auto and small commercial business, he said.

Larger portfolios, which are less exposed to chance, are much more complex. The need for reinsurance depends largely on the structure of the merged portfolio, Mr. Baumguertel said.

Merged insurers often need the same amount of reinsurance as the individual companies did before merging, he asserted.

"Insurance companies acquired remain separate bodies, especially when they form part of an internationally operating group. In these cases, which form the majority of

all acquisitions, there is no significant change in reinsurance demand at all," he said.

Yet, for several reasons, retentions have grown, he added:

- Reinsurance markets have shrunk and more and more markets have reached the saturation point for the traditional classes of insurance.

- Insurers and reinsurers have grown financially stronger, so the reinsurance cessions that were effectively a substitute for capital became less necessary.

- It has become more difficult for new insurers to enter the market, so demand for those proportional cessions that are needed to protect young and small portfolios has dropped.

- There has been a shift from proportional to non-proportional reinsurance.

- There is a lot less reciprocal business traded from company to company.

- With year-to-year renewals making reinsurance conditions less predictable, cessions are reduced to what is absolutely necessary.

- The soft direct insurance market has reduced reinsurance premiums.

- The steady increase in insured values leads to a steady increase in insurer retentions in order to maintain insurers' retention ratios.

Turning to the future demand for reinsurance, Mr. Baumguertel said there will be fewer global treaty arrangements.

Also, reinsurance will become more specific, and reinsurers will less frequently follow the fortunes of cedants, he added.

Instead, reinsurance will serve

more rationally defined purposes, namely per-risk capacity, catastrophe protection and the equalization of results over time, Mr. Baumguertel said.

Facultative reinsurance will play a central role in generating per-risk capacity. It will also persistently substitute for treaty reinsurance as it becomes more important to assess individual risks to balance portfolios, he contended.

Demand for catastrophe protection is increasing as catastrophic losses become more frequent, he said.

However, catastrophe reinsurance rates fluctuate in extremes because both sides take a speculative attitude toward these coverages, Mr. Baumguertel asserted.

This, in turn, was caused by a lack of information on the potential exposures, he said.

The more detailed consideration is given to this sort of exposure and the more commonly agreed methods are used to assess them, "the more stability will be reached as to the amount of reinsurance capacity and pricing with the final effect that more demand for reinsurance will emerge," Mr. Baumguertel said.

Finally, reinsurers must be allowed to build up the necessary capacity to underwrite risks in the future, he said.

Both traditional reinsurance and financial reinsurance can be used to balance insurers' results over time, he said.

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### NOTICES

#### IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS COUNTY DEPARTMENT, CHANCERY DIVISION

IN THE MATTER OF THE LIQUIDATION OF PROVIDENT INSURANCE COMPANY F/K/A ILLINOIS LIFE & ACCIDENT INSURANCE COMPANY

NO. 91 CH 00227

#### NOTICE OF CLAIMS DATE AND PROCEDURES

PLEASE TAKE NOTICE, that on January 9, 1991 an Agreed Order of Liquidation With a Finding of Insolvency was entered against Provident Insurance Company ("Provident") by the Honorable Arthur L. Dunne, Judge of the Circuit Court of Cook County, Illinois. James W. Schacht, Acting Director of Insurance of the State of Illinois, is the statutory and court affirmed Liquidator of Provident.

TAKE FURTHER NOTICE, that pursuant to the Order of the said Court, all rights and liabilities of Provident and of its creditors, policyholders and all other persons interested in its assets are fixed as of January 9, 1991, unless otherwise provided by such other Order of the Court.

TAKE FURTHER NOTICE, that pursuant to the Order of the said Court, all direct policies or contracts of insurance previously issued by Provident (formerly Illinois Life & Accident Insurance Company) are cancelled as of January 9, 1991, except those policies or contracts of insurance which are "covered policies within the meaning of the Illinois Life and Health Insurance Guaranty Association Law (Ill. Rev. Stat. 1989, Ch. 73, par. 1065.80-1, et seq.), or any similar law of any other state, or the obligations, or any part thereof, of which the Illinois Life and Health Guaranty Association, or any similar organization in any other state, is obligated to assure payment of, which shall remain in full force and effect until cancelled, or until they expire, in accordance with their terms.

TAKE FURTHER NOTICE, that the form of and required content of all Proofs of Claim are described in Illinois Revised Statutes 1989, Chapter 73, Paragraph 821. Proofs of Claim, together with supporting documents, if any, are to be filed with, and may be secured from, the Special Deputy Liquidator, Provident Insurance Company, In Liquidation, 446 East Ontario Street, Suite 700, Chicago, Illinois 60611. Filing shall occur upon the receipt of Proof of Claim by the Liquidator. The Liquidator reserves the right to require such additional information with respect to any claims as he may deem necessary. The Liquidator further

reserves all rights to any and all defenses of Provident concerning such claim. All Proofs of Claim must be duly sworn to before an Officer authorized to take oaths.

THE LAST DATE FOR THE FILING OF PROOFS OF CLAIM WITH THE LIQUIDATOR AT HIS ABOVE-MENTIONED OFFICE IS SEPTEMBER 9, 1991 AT 4:30 P.M., CHICAGO TIME. NO PERSON HAVING OR CLAIMING TO HAVE ANY CLAIMS, CONTINGENT OR OTHERWISE, AGAINST PROVIDENT INSURANCE COMPANY SHALL PARTICIPATE IN ANY DISTRIBUTION OF THE ASSETS OF THE COMPANY UNLESS SUCH CLAIMS ARE FILED WITH AND RECEIVED BY THE LIQUIDATOR ON OR BEFORE SEPTEMBER 9, 1991 AT 4:30 P.M., C.D.T.; AND IF ANY SUCH CLAIMS ARE CONTINGENT CLAIMS, THEY MUST BE LIQUIDATED PURSUANT TO SECTION 209 OF THE ILLINOIS INSURANCE CODE (ILL. REV. STAT. 1989, CH. 73, PAR. 821) ON OR BEFORE SEPTEMBER 9, 1991 AT 4:30 P.M., C.D.T.

James W. Schacht, Special Deputy Liquidator, Office of the Special Deputy, 446 East Ontario Street, Suite 700, Chicago, Illinois 60611, (312) 915-4700.

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## INTERNATIONAL

### Tail coverage

Continued from page 31

period of 36 calendar months after the date of termination, but only in respect of acts committed before the date of termination."

In March 1985, the Minet slip's leading underwriters gave a notice of non-renewal of policies that were due to expire May 31, 1987. But in the following months, some of the syndicates participating on the first excess layer decided they would renew the coverage on June 1, 1987.

Syndicate 126 and other underwriters decided not to renew their participation on the first excess layer, Lord Justice Neill noted in his ruling. Meanwhile, syndicate 126 partici-

pated in the third excess layer of the program, said the judge. The inception of these annual policies, which had two-year extended discovery clauses, was June 1, 1985.

However, syndicate 126 gave a 60-day notice of cancellation that it would not renew the third layer policies effective June 1986.

"These policies expired on June 1, 1986, subject to any discovery extension cover which might be available to the assured for a further period of 24 months," or until June 1988, said Lord Justice Neill.

Before giving notice of its decision not to renew, Mr. Harris wrote to Minet in October 1985 arguing that policyholders of the line slip should not be entitled to extended discovery coverage unless all of the underwriters on the slip maintained the same stance and refused to renew.

Mr. Harris informed Minet that legal counsel "considers that the (extended discovery) clause is operable against the market as a whole and not against a single syndicate."

Although other syndicates had renewed their coverage, the accountants sought to exercise their right to extended discovery periods from the London underwriters that canceled coverage, including syndicate 126.

"Syndicate 126, however, maintained their argument that because some syndicates had renewed the coverage, discovery extension rights could not be exercised against them. The rights had to be exercised against all the underwriters or against none," said Lord Justice Neill.

The six accounting firms filed a writ in October 1988 against syndicate 126 seeking a declaration that they were entitled to extended discovery coverage on the third-layer excess policies.

The writ was later amended to include the same declaration for the first-layer excess policies on which the syndicate had participated.

Hearing the case, Justice Leggatt in the High Court in July 1989 rejected syndicate 126's arguments that underwriters act collectively and not individually under policies written via a line slip.

At Lloyd's, each member acts "for his own part and not one for another" so that "liability of each underwriting member is accepted solely for his account," the court papers say, citing the Lloyd's Act of 1982.

However, syndicate 126 argued in the High Court that while the liability of each Lloyd's member is indi-

vidual, the actions of underwriters are collective when writing policies together.

Justice Leggatt disagreed. "In practice the liability of the underwriters to extend the cover granted by the policies refers to the liability of each syndicate to the extent of its line express on the policies. . . . It follows that syndicate 126 is bound to the extent of its line to afford indemnity to the plaintiffs under the discovery extension clause in their respective policies."

Lord Justice Neill of the Court of Appeal agreed with Justice Leggatt's finding. "I am satisfied that both in fact and in law the phrase 'this policy' means and includes. . . a bundle of separate contracts. Accordingly, though for certain purposes the underwriters act collectively, it is necessary to examine in any particular case whether an individual syndicate retains the right to act separately.

"It seems to me that the fact that the policy incorporates a number of separate contracts means that the individual syndicates are free not only to decide how to deal with a particular claim but also to decide whether or not they wish to renew or to cancel in accordance with the terms of the policy," Lord Justice Neill said.

"I see no reason why their decision to renew coverage of the assured should affect the right of the assured to claim discovery extension cover against other syndicates who may have decided not to renew."

Lord Justice Neill's decision was confirmed by the Court of Appeal's other two judges, Lord Justice Mann and Sir David Croom-Johnson.

Mr. Harris said he welcomes the House of Lords' review of the case. Underwriters act collectively rather than individually on each line slip, he said, noting that the leader or leaders on the slip decide the terms and conditions that are followed by all other underwriters.

"If you run off, then you run off the whole of the slip," not just part of it, Mr. Harris pointed out. "I am not (fighting in court) out of vindictiveness but because I passionately believe that the policy wording should be for all underwriters on the slip, not just some of them."

If underwriters are to be held individually responsible for a slip's policy wording, then every underwriter should be able to put his own wording on the slip, Mr. Harris said.

In that case, a policyholder who bought coverage under a line slip could have several different policy wordings to follow. ■

## LONDON

Continued from page 31

him the second-largest private shareholder. Lord Pearson holds 5% of the shares.

The company says its brokerage revenues are now about 15 million pounds (\$26.9 million).

### Pulbrook suit

Nearly 900 Lloyd's of London members have stepped up legal action against Pulbrook Underwriting Management Ltd. and eight members' agents stemming from huge losses by two syndicates managed by Pulbrook.

Some 323 members of syndicate 90's 1982 underwriting year last week served a writ against Pulbrook and the members' agencies. Another 562 members on syndicate 334's 1985 underwriting year intend to issue a writ by the end of the month against those parties. The members are suing Pulbrook for negligence in placing runoff reinsurance contracts for the syndicates and their members agents for placing them on the syndicates.

Members of syndicate 334 had to pay 29.4 million pounds (\$52.7 million at current exchange rates) after an arbitration panel voided a runoff contract written by Merrett syndicate 417/418 (BI, March 5, 1990; Feb. 12, 1990).

And members of syndicate 90 faced a cash call of about 17 million pounds (\$30.5 million) after settlement of a dispute over a runoff policy that was 50% written by syndicate 317/661 managed by R.H.M. Outhwaite (Underwriting Agencies) Ltd. (BI, May 28, 1990). ■

## Record Aussie cargo claim paid after carrier hits rocks

MELBOURNE, Australia—A marine underwriting agency has paid what it believes is a record Australian market cargo claim of \$10.5 million Australian (\$8.1 million) after a bulk carrier struck rocks 15 miles off the nation's Southwest coast and sank.

The cargo carried by the Sanko Harvest was insured for a total of \$11.2 million Australian (\$8.6 million).

However, the payout was reduced to \$10.5 million Australian after "adjustments were made because the cargo had not yet reached its destinations," said David C. Chaplin, who is claims manager for Associated Marine Insurers Agents Pty. Ltd. of Melbourne.

Associated Marine Insurers Agents Pty. Ltd. is a joint venture of GRE Insurance Ltd. and Commercial Union Assurance Co. of Australia Ltd.

The claim still was probably the largest marine cargo loss in the Australian market, according to Mr. Chaplin.

The cargo, 31,000 metric tons of

phosphate fertilizers, was owned by Sydney-based importer Summitomo Australia Ltd.

The fertilizer was water soluble and was not polluting the waters, Mr. Chaplin said.

The 33,000 metric ton Sanko Harvest, a Panamanian-registered carrier, is owned by Sanko Shipping of Tokyo.

Mr. Chaplin said the hull, which has a market value of around \$12 million Australian (\$9.2 million), was insured by a Japanese company.

Mr. Chaplin would not identify the insurer.

The ship's liability coverage is placed with the Gard Protection & Indemnity Club of Norway, Mr. Chaplin said.

The ship, the Sanko Harvest, was en route to three Western Australian ports from Tampa, Fla.

The ship struck a reef in uncharted waters off the Southwest coast of Australia on Feb. 14.

The ship sank three days later.

All 15 Korean crew members were rescued.

The ship, which had 720 metric

tons of fuel oil on board, sank in 20 meters of water, leaking all but 74 metric tons of oil into the ocean, according to Capt. David Oliver of Western Australia's Department of Marine and Harbors.

Cleanup costs could be as high as \$500,000 Australian (\$384,250), according to Capt. Oliver.

The government likely will ask the ship's owner to cover the costs, Capt. Oliver said last month after the accident.

The oil spill is destroying rare New Zealand fur pups on Hood Island and Seal Island in the Recherche Archipelago, according to Capt. Oliver.

Hood Island is about three miles from the site of the accident, and Seal Island is 15 miles away.

Heavy seas hampered the early efforts to contain the ship's spill, Capt. Oliver said.

"We tried to disperse the oil before it reached the beaches, but it got ashore," he said.

He said the Western Australian government would investigate the accident.

—By Kate McIlwaine

# State regulators

*Continued from page 2*  
 Connecticut, Idaho, Indiana, Kansas, Maryland, Massachusetts, Minnesota, Mississippi, Missouri, Nebraska, New Hampshire, New Jersey, North Carolina, North Dakota, Oregon, Rhode Island, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia and Wyoming.  
 Regulators in California and Pennsylvania are developing proposals that they expect will be introduced later this year, Ms. Johnson said in an interview.  
 Last December, Florida and New York became the first accredited states.  
 The NAIC also is organizing evaluation teams to visit Illinois and four other states that have applied for accreditation this year, said James Schacht, acting direc-

tor of the Illinois Insurance Department, in an interview. Mr. Schacht declined to identify the four other states.  
 "The states are responding as we indicated they would," Mr. Pomeroy said, including his state of North Dakota, where a 135-page insurance bill, H.B. 1242, has set a new record for length.  
 Nearly all the major industry trade groups have joined Mr. Pomeroy, a former NAIC president, in lobbying for the bill, he said in an interview.  
 One major exception is the National Assn. of Insurance Brokers. The group opposes the NAIC producer-controlled insurer model law because the trade group fears brokers would be too easily found liable, Mr. Pomeroy said.  
 The NAIC is now trying to develop more incentives for states to adopt its financial regulation stan-

dards. For example, beginning in 1994, accredited states generally will not accept reports of insurance company examinations from unaccredited states. That will make it a liability for an insurer to be domiciled in a non-accredited state because it will be subject to examinations from additional states, Mr. Schacht explained.  
 The NAIC will "crank up the heat" on states that do not seek accreditation, Mr. Pomeroy said.  
 Financial regulations and the accreditation plan are only part of the commissioners' approach, he said.  
 Calling the last three years a period of rapid "evolutionary" changes, he cited recent NAIC actions including: modifying an insurer's annual convention statement to require review by a certified public accountant and actuary; enhancing the NAIC central

support staff; and strengthening the commissioner peer review system.  
 In Washington, however, Rep. Dingell has announced he is drafting federal legislation to accomplish some of the same goals, said Mary-Moore Hamrick, minority counsel to the House Energy & Commerce Committee (BI, Jan. 14).  
 Ms. Hamrick said Rep. Dingell plans to address topics including improving general solvency standards, the solvency of both domestic and international insurers and reinsurers, the reporting of financial information, and solvency enforcement.  
 Rep. Dingell will not introduce any legislation until the General Accounting Office completes a report on the NAIC, she said.  
 Preliminary proposals are now being discussed by staff members. These include: allowing insurers to

opt for federal licenses; mandatory federal licenses for reinsurers and non-U.S. companies; a federal role in guaranty funds or liquidation processes; and setting up a federal regulatory body like the Securities and Exchange Commission.  
 Ms. Hamrick encouraged insurance industry representatives to make their views known to legislators.  
 In response, Mr. Pomeroy said the NAIC has little disagreement that some regulatory changes must be made.  
 But those changes, he argued, ought to be made at the state level, because the federal government is "a much more political arena."  
 In addition, Mr. Pomeroy warned against leaving rate regulation to the states and solvency surveillance to the federal government because the two are "critically interlinked."

# Screen out weak insurers, experts say

By MEG FLETCHER

**CHICAGO**—Risk managers can do a lot to screen out financially troubled companies from their list of potential insurers, experts say.  
 "This question of insurance company solvency is very serious," stressed Arthur P. Bostwick, risk manager of Stone Container Corp. of Chicago.  
 Mr. Bostwick—along with a regulator, an attorney and a security consultant—presented tips on how to select an insurer at a recent symposium in Chicago co-sponsored by The Society of Chartered Property & Casualty Underwriters.  
 James Schacht, acting director of the Illinois Insurance Department, recommended that buyers looking for a solid company:  
 • First, select a competent broker whose goals are quality and security.  
 • Seek out "large and old" insurance companies, even if a newer alternative has impressive sponsorship.  
 • Make sure the insurance company is run by insurance professionals.  
 • Make sure that foreign insurers have good local representatives.  
 • Examine the insurer's financial status before placing coverage with it.  
 To obtain such information, buyers should consult rating organizations like A.M. Best Co. of

Oldwick, N.J., and should be especially concerned about deteriorating results, Mr. Schacht said.  
 Mr. Bostwick sounded one cautionary note about Best's rating information: The qualitative management reports are drafted by the insurance company managers cited in the reports.  
 "It's sort of like a fox in the henhouse," Mr. Bostwick cautioned.  
 He also advised would-be buyers to consider additional sources of information about an insurer's financial ability, including ratings by Standard & Poor's Corp. and Duff & Phelps Inc., consultant reports, brokerage "watch lists," newspaper and magazine articles and insurer annual reports.  
 In addition, an insurer's annual financial statement submitted to state regulators is "a very critical document" because of the data it contains, Mr. Bostwick said.  
 The annual statement, dubbed the "yellow peril," is more helpful due to recent changes, including one exhibit that shows the age of an insurer's recoverables and identifies late-paying reinsurers, said Phillip L. Schwartz, vp-financial reporting and associate general counsel of the American Insurance Assn.  
 Reviewing consecutive annual statements also can be helpful, especially if a buyer checks Schedule F for the names of the company's reinsurers, Illinois' Mr. Schacht said.  
 Avoid an insurer that changes all its reinsurers from one year to the

next, Mr. Schacht added.  
 Once insured, policyholders need to continue using common sense to detect whether an insurer is developing financial problems, Mr. Schacht said.  
 "Companies get into trouble because of the ways they do business," he said.  
 Warning signs, he said, include whether the insurer is: charging unusual prices, ceasing to write new business, making significant management changes or paying claims slowly or sloppily.  
 And, Mr. Schacht quipped, when insurers send unsolicited letters assuring policyholders that everything is fine, "call your broker quickly."  
 Risk managers also need to research a company independently because they cannot always depend on state regulators to use their authority properly, said Beth Kravetz, an insurance attorney in Washington, D.C.  
 As an example, she cited details of the 1989 insolvency of Rent-Rite Advantage Services Inc., a Risk Retention Group discussed in a U.S. Commerce Department report. Rent-Rite, which was domiciled in New Mexico, was sponsored by an Albuquerque-based reservation service for independent car and truck rental companies.  
 The Risk Retention Act of 1986 required that the state charter Rent-Rite as an insurance company, which in New Mexico would require it to have \$500,000 in capital and \$500,000 in initial surplus,

according to Ms. Kravetz.  
 Instead, it was chartered as a risk retention group—a category not recognized by the state—and allowed to begin operations with only \$250,000 in capital and surplus, she said.  
 Rent-Rite was writing business in 19 states in 1988. It did most of its business in Florida, where it ignored a regulatory order to cease and desist, and in California, "where the group's filing was apparently ignored for two years," the Commerce Department report said.  
 By 1989, however, the company sought voluntary receivership after a New Mexico Insurance Department examination found it insolvent by \$689,464 at year-end 1988 (BI, Aug. 21, 1989).  
 In light of Rent-Rite's experience, Ms. Kravetz recommended that a risk manager evaluate a risk retention group's financial stability, management, plan of operation and commitment to risk management.  
 In addition, panelist Trevor H. Jones, chairman of London-based Insurance Services Group, and publisher of "Insurance Security Services Newsletter," cautioned risk managers that insurers "do lie, cheat and steal out there."  
 He explained two calculations he uses as part of a quick analysis of an insurer's balance sheet to determine its financial viability.  
 First, he divides the insurer's

claim reserves by its underwriting profit or loss (excluding investment income), which reveals the number of years of net written premium in claims reserves.  
 An insurance company writing direct, short-tail business should have at least 1.2 years in reserves and a company writing long-tail business, like a reinsurer, should have two to 2.5 years in reserves, Mr. Jones said. In comparison, Swiss Reinsurance Co. "keeps 3.2 years' premium in the kitty for claims," he said.  
 If the outcome is less than one year for non-reinsurers—or less than 1.8 years for reinsurers—more research is necessary, he added.  
 A second calculation entails dividing the insurer's underwriting profit or loss (excluding investment income) by its paid-up capital, less any retained losses, Mr. Jones said.  
 That calculation lets an observer know how much capital has been lost this year, he said.  
 An acceptable insurance company can lose "10% or so," which is usually made up by investment income, he said. But buyers should be wary of insurers with worse results, which are symptomatic of "overtrading" by using policyholders' money and not their own, Mr. Jones said.  
 R. Michael Cass of R.M. Cass Associates, an insurance consultant in Barrington, Ill. moderated the session.

# Additional consulting firms

*The following risk management consulting firms were not listed in the annual directory of risk management consultants that was published in the March 4 issue of Business Insurance.*

**CONFIRM Inc.**  
 111-B Green St., P.O. Box 265, Albany, N.Y. 12201; 518-426-9301; fax: 518-426-9298  
**Year founded:** 1989.  
**Independent.**  
**Services provided:** 100% of gross revenues from risk management consulting, including 20% continuous consulting, 15% risk management audits, 65% special risk management consulting projects.  
**Frequent special projects:** Analysis of necessary insurance limits, insurance contract analysis, loss prevention audits, risk management organization studies, preparation of specifications for bidding.  
**Occasional special projects:** Risk retention analysis, captive feasibility studies, claims auditing, assessment of broker service and remuneration, loss settlement assistance, quantitative analysis and statistical forecasting, agency evaluations, expert wit-

ness testimony.  
**Staff:** Four total; all professionals, including two principal consultants, two consultants. Professional designations include three CPCUs, one CSP, one associate in loss control management, one associate in claims.  
**Clients:** 25 total; 85% with risk and insurance budgets less than \$1 million, 10% with \$1 million-\$5 million, 5% with \$10 million-\$25 million. One association client. Minimum size client, \$50,000.  
**Compensation:** By the project; on retainer; by the hour: principal consultant, \$100-\$125; consultant, \$50-\$75; clerical, \$35.  
**Principal officers:** James P. Faughnan Jr., president; Charles H. Cornish, vp; Paul J. Clesak, director-engineering services.  
**Risk Management Consulting Associates Inc.**  
 11 Harristown Road, Glen Rock, N.J. 07452; P.O. Box 600, Fair Lawn, N.J. 07410; 201-444-3888; fax: 201-444-9335  
**Year founded:** 1990.  
**Independent.**  
**Services provided:** 100% of gross revenues from risk management con-

sulting, including 90% continuous consulting, 5% risk management audits, 5% special risk management consulting projects.  
**Frequent special projects:** Analysis of necessary insurance limits, insurance contract analysis, assessment of broker service and remuneration, loss settlement assistance, preparation of specifications for bidding, acquisition study, due diligence.  
**Occasional special projects:** Risk retention analysis, captive feasibility studies, claims auditing, environmental, loss prevention audits, risk management organization studies, quantitative analysis and statistical forecasting, consulting on the design of risk management information systems.  
**Specialties:** Manufacturing, hospitality, retail, real estate and service industries.  
**Staff:** Five total; three professionals, including one principal consultant, two consultants.  
**Clients:** 45% with risk and insurance budgets less than \$1 million, 35% with \$1 million-\$5 million, 20% with \$5 million-\$10 million. Minimum size client, \$300,000.  
**Compensation:** By the project, on retainer, by the hour.  
**Principal officers:** Gary D. Salt, president.

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# Guaranty fund debate before legislators

## AIA lobbies for exclusion of large firms



CHICAGO—The controversy over whether large policyholders should be able to recover from state guaranty funds is moving from the courthouse to the state house. The American Insurance Assn. is now lobbying in states with pending guaranty fund legislation to have large policyholders excluded from guaranty fund protection, according to Philip L. Schwartz, vp-financial reporting and associate general

counsel of the Washington, D.C.-based group.

Mr. Schwartz described those efforts at a recent symposium co-sponsored by the Society of Chartered Property & Casualty Underwriters and the society's Risk Management Section.

Specifically, the AIA is seeking to:

- Exclude policyholders with at least \$10 million in net worth from guaranty fund coverage for either first- or third-party claims.

- Exclude policyholders from recovering from guaranty funds for all excess insurers that wrote excess of a \$300,000 primary layer or self-insured retention.

Some guaranty funds have paid four \$300,000 claims to large policyholders because they had coverage from four different insolvent

**'Trying to fix the guaranty fund system by excluding large insureds is like throwing the passengers out of a leaking lifeboat to save the boat,' says Paul Brown, director of governmental affairs for New York-based RIMS.**

insurance companies at four different excess levels, according to Mr. Schwartz.

"Nobody imagined that you would get hit four times" by a single policyholder, Mr. Schwartz commented.

- Limit a guaranty fund's payout to an aggregate of \$10 million per policy.

Right now, Union Carbide Corp. may be allowed to collect \$32.5

million from the Connecticut guaranty fund. A court last month ruled that the fund's \$300,000 cap on covered claims applies separately to each of the roughly 550,000 claims filed by victims of the 1984 poison gas disaster in Bhopal, India (BI, Feb. 11).

Efforts to curb guaranty fund payouts got a boost last month from a federal court. The Michigan property/casualty guaranty fund is

able to constitutionally deny coverage to policyholders with substantial net worth, the court ruled.

The 6th U.S. Circuit Court of Appeals last month reversed a lower court ruling favoring policyholders in a lawsuit brought by Borman's Inc., a Detroit-based unit of The Great Atlantic & Pacific Tea Co. against the Michigan fund (BI, Feb. 11).

Neither that decision nor the AIA's efforts sit well with the Risk & Insurance Management Society Inc.

"Large commercial policyholders should be covered by guaranty funds," said Paul Brown, director of governmental affairs for New York-based RIMS.

Guaranty fund assessments are tacked on to the premiums that large policyholders pay, Mr. Brown said. Limiting coverage constitutes "taxation without indemnification," he said.

"Trying to fix the guaranty fund system by excluding large insureds is like throwing the passengers out of a leaking lifeboat to save the boat," Mr. Brown said.

In response to insurer arguments for excluding large policyholders, Mr. Brown pointed out that risk managers buy insurance because they have decided that their companies cannot afford potential losses.

In addition, arguing that sophisticated risk managers should be able to detect financially troubled insurers is holding them to a standard that many state insurance regulators cannot meet, Mr. Brown added.

"The focus needs to be put on improving the (guaranty fund) system," Mr. Brown said.

RIMS favors some type of national—but not federal—guaranty fund, perhaps overseen by the National Assn. of Insurance Commissioners, he added.

The group, however, maintains that self-insured companies should not be required to participate in guaranty funds, he said following the meeting to correct a statement he made during the discussion.

—By Meg Fletcher

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## CPCU hosts solvency symposium

CHICAGO—The Society of Chartered Property & Casualty Underwriters and the society's Risk Management Section co-sponsored a day-long symposium on insurer solvency March 14 at the O'Hare Hilton Hotel in Chicago.

About 30 persons heard several speakers discuss solvency-related issues important to commercial policyholders.

Based in Malvern, Pa., the society considers itself the nation's leading professional organization in property/casualty insurance.

The Society of CPCU will hold its annual meeting and seminar Oct. 20-23 at the Hilton Riverside and Towers in New Orleans.

For additional information about the society, contact Rebecca Bodenner, Publicity Coordinator, 720 Providence Road, P.O. Box 3009, Malvern, Pa. 19355-0709; 215-251-2739. For information about the society's Risk Management Section, write Mari Jennings, Sections Coordinator, at the same address or call 215-251-2741.

—By Meg Fletcher

## Punitive damages

Continued from page 1

preme Court held 7-to-1 that the due process clause of the 14th Amendment does not mandate specific limits on the ability of juries to award punitive damages (*BI*, March 11). Writing for the majority, Justice Harry A. Blackmun said: "We cannot say that the common law method for assessing punitive damages is so inherently unfair as to deny due process and be per se unconstitutional."

However, the court did rule that there is a constitutional "line" that punitive awards cannot cross. The Constitution requires trial judges to properly instruct juries about the purpose of punitive damages and requires significant judicial review of jury awards, the court ruled.

The case involved an Alabama jury award of \$1.1 million in compensatory and punitive damages against Pacific Mutual Life Insurance Co. of Newport Beach, Calif., for the fraud committed by one of its agents.

The high court upheld the Alabama award because the jury was specifically told what punitive damages are intended to do and because the appellate court reviewing the award used explicit criteria.

On March 18, following its Pacific Mutual ruling, the high court remanded for reconsideration seven other cases involving punitive damage awards ranging from \$400,000 to \$2.5 million. It also upheld two punitive damage awards from Alabama, which presumably were subject to the same procedures as the award in the Pacific Mutual case (see related story).

By remanding the cases—rather than simply denying review—the court confirmed that the business community rightly claimed to have gained ground in the Pacific Mutual decision, said Victor Schwartz, a prominent defense lawyer.

"If the consumers' bar was right (in its claim to victory), the court would have dismissed all of the petitions," said Mr. Schwartz, a partner with Crowell & Moring in Washington, D.C.

The high court's recent action "proves that Pacific Mutual wasn't a loss for business," agreed Robert D. Monin, president of the Defense Research Institute, a Chicago-based group backed by defense attorneys.

In remanding the seven punitive damage cases, the high court is confirming that the Constitution requires "meaningful jury instructions and rigorous post-verdict review," said Andrew L. Frey of Mayer, Brown & Platt in Washington, D.C.

In addition, the high court is clearing its docket of punitive damage cases and sending this issue back to the states, experts say.

"The justices are leaving this issue to the states," said Paul Brown, governmental affairs director for the Risk & Insurance Management Society Inc. of New York.

"The court is exercising judicial

discretion," he said. "The justices don't want to spend their time reviewing any more punitive damage cases until the state courts have had a chance to review their actions in light of the Pacific Mutual case."

The Supreme Court's "hope is that by sending this issue back to the states, state court judges and state legislators will get the message and do something to rationalize the system," agreed Mr. Frey.

"The court is very disturbed by what it is seeing," he said, noting that all eight justices involved in the Pacific Mutual case expressed concern about how damages are awarded.

"The court has now given ammunition to state court judges and state legislators to enact reforms," he said.

The problem is that judges and legislators know that the Alabama system is reasonable, but do not know what other systems would be, according to attorneys.

Some changes that could emerge in the near future, according to Mr. Schwartz, are:

- Specific jury instructions.
- Establishing explicit standards for judicial review of punitive damage awards.
- Raising the standard of proof necessary to award punitive damages to "clear and convincing evidence" from a "preponderance of evidence."
- Making sure evidence of a defendant's wealth does not play a role in punitive awards.

"We are now going to go through a process of trial and error" as state courts and legislatures attempt to define what is reasonable, explained Mr. Monin. In the end, each state could set a different standard of reasonableness, he said.

But consumer groups and plaintiffs' lawyers are skeptical that state courts or legislators will respond to the recent Supreme Court actions.

"Most states already require adequate jury instructions and there are judicial review procedures," said Michael Maher, president of the Assn. of Trial Lawyers of America in Washington, D.C.

"The court has given the states very broad power to use appropriate punitive damages to protect the public and secure the rights of victims," he said.

"Punitive damages are not only appropriate, but they are a positive factor in deterring unsafe products, consumer fraud and unsafe working conditions," said Linda Lipsen, legislative counsel for Consumers Union in Washington, D.C.

By viewing the rulings as an impetus for reform, the business community is "trying to spin straw into gold," she said. "Manufacturers are trying to get any kind of a win out of this. They are grasping at straws."

"Whatever the Supreme Court did, they would use it to fuel efforts that have been going on for more than a decade" to make it harder for plaintiffs to win punitive damages, she said. ■

## Lower courts to reassess punitive damages

# 7 cases to be reviewed

By STACY ADLER

WASHINGTON—The seven punitive damage cases remanded by the Supreme Court last week for lower court review involve punitive damage awards ranging from \$400,000 to \$2.5 million.

The cases were remanded for lower court review in light of the Supreme Court's recent ruling that due process requires that all punitive damage awards be the result of careful jury instruction and subject to meaningful judicial review (see story, page 1).

In addition, the high court affirmed two punitive damage awards from Alabama.

The seven cases the court remanded involved:

- An award of \$2 million in punitive and \$558,000 in compensatory damages. A California jury made the award against Pacific Lighting Corp., now known as Pacific Enterprises, and two former subsidiaries, Fredericks Development Corp. and Dunn Properties Corp., for refusing to pay a real estate broker's fee.

The trial judge overruled the jury verdict against Pacific Lighting.

On appeal, the California Court of Appeals reinstated the verdict, expressly finding there was no due process violation in awarding punitive damages against Pacific Lighting.

The defendants appealed but the California Supreme Court refused to review the case.

*Pacific Light Corp. vs. MGW Inc., U.S. Supreme Court; No. 90-626.*

- A Georgia jury's award of \$1.3 million in punitive and \$5,001 in compensatory damages against the Gwinnett County, Ga., Hospital Authority for negligence in taking a burn patient to a county hospital rather than a private hospital burn unit.

The hospital authority challenged the state law that allowed punitive damages in a "tort action in which there are aggravating circumstances, in either the act or the intention."

The plaintiffs alleged the hospital was motivated by greed in deciding where to take the burn victim.

The Georgia Supreme Court upheld the constitutionality of the statute and the jury's award. The court found that Georgia law allowing trial judges to set aside punitive damage awards and the right to appellate review of punitive damage awards sufficiently protect a defendant's right to due process.

The state high court also found that the award was not excessive.

*Hospital Authority of Gwinnett County vs. Jones, U.S. Supreme Court; No. 89-1315.*

- An award of \$500,000 in punitive and \$79,519 in compensatory

damages against Portec Inc. for misappropriation of trade secrets and breach of fiduciary duty.

The 10th U.S. Circuit Court of Appeals had reduced the punitive award from \$1.5 million, ruling that the award, which was nearly 19 times the compensatory damages, was excessive.

*Portec Inc. vs. Post Office, U.S. Supreme Court; No. 90-827.*

- An award of \$500,000 in punitive and \$6,658 in compensatory damages by a federal judge in Mississippi in a non-jury trial against Reserve Life Insurance Co., a Sammons Enterprises Inc. unit, for bad faith failure to pay a health insurance claim.

The 5th U.S. Circuit Court of Appeals upheld the judge's ruling, finding that due process is not violated when an insurance company is put on notice that specific conduct can result in punitive damages.

The 5th Circuit noted that Reserve Life previously had been hit with a punitive damage award for gross negligence in processing a claim.

*Reserve Life Insurance Co. vs. Eichensoer, U.S. Supreme Court; No. 89-1303.*

- An award of \$400,000 in punitive and \$7,923.50 in compensatory damages award by a federal jury in Missouri against Clayton Brokerage Co. of St. Louis for commodities fraud and breach of a fiduciary duty.

The 8th U.S. Circuit Court of Appeals upheld the jury verdict, finding that even though punitive damages are civil in nature they do not require proof "beyond a reasonable doubt" as is required in criminal cases.

The appellate court also found that evidence of the brokerage's net worth that was given to the jury did not violate the brokerage's right to equal protection because the evidence was not admitted for the purpose of determining punitive damages.

The court also found that the punitive damage award—which is more than 50 times the compensatory award—was not excessive.

*Clayton Brokerage Co. of St. Louis Inc. vs. Jordan, U.S. Supreme Court; No. 88-1483.*

- An award of \$2.5 million in punitive and \$485,000 in compensatory damages against the International Society for Krishna Consciousness of California for intentional infliction of emotional distress upon the mother of a 14-year-old girl who was "brain-washed" and hidden from her parents.

The trial judge reduced the jury's original \$32.6 million award for compensatory and punitive damages.

The sect appealed, arguing that the punitive award violated its First Amendment right to religious freedom. ■

The California Court of Appeals upheld the jury's verdict finding that the punitive damages were awarded for extreme and outrageous conduct that was not constitutionally protected.

The California Supreme Court refused to review the case.

*International Society for Krishna Consciousness vs. George, U.S. Supreme Court; No. 89-1399.*

- An award of \$2 million in punitive and \$500,000 in compensatory damages against the Church of Scientology of California for intentional infliction of emotional distress in coercing participation in religious practices.

A California jury awarded \$30 million in punitive and \$5 million in compensatory damages, but the State Court of Appeals reduced the award, ruling that the jury's verdict was so excessive as to evince "prejudice or passion."

The California Supreme Court refused to review the award.

In addition to questioning whether the punitive damages award violates due process, the church claims that imposing punitive damages for religious activity violates its First Amendment guarantee of religious freedom.

*Church of Scientology of California vs. Wollersheim, U.S. Supreme Court; No. 1361.*

The U.S. Supreme Court also refused to review two decisions by Alabama courts awarding punitive damages.

The two cases involve:  
• A \$750,000 punitive damages award by an Alabama jury against Massachusetts Mutual Life Insurance Co. for fraud.

A policyholder alleged that the insurer's agent failed to tell him that the accumulated cash value of a life insurance policy he purchased in 1967 would be used to pay premiums for an additional insurance policy that the agent persuaded him to buy.

The insurer challenged the constitutionality of awarding punitive damages when no actual damages were proven and when the insurer did not know of its agent's wrongful acts.

The Alabama Supreme Court upheld the award, ruling it was constitutional and not excessive.

*Massachusetts Mutual Life Insurance Co. vs. Collins, U.S. Supreme Court; No. 90-244.*

- A \$600,000 punitive damage award against General American Life Insurance Co. for life insurance fraud. The trial court reduced the award from \$2.5 million originally awarded by the jury.

*General American Life vs. Simmons, U.S. Supreme Court; No. 90-73.* ■

# Insurers seek to block new Prop. 103 rules

By LOUISE KERTESZ

LOS ANGELES—Nearly 80 insurance companies say they will file suit next week to halt hearings on Insurance Commissioner John Garamendi's new proposed regulations to implement the 20% insurance "charge" rollback mandated by Proposition 103.

The massive suit, led by units of Hartford Group Inc., Travelers Corp. and Chubb Corp., among others, claims that Mr. Garamendi is illegally seeking to relitigate issues that were already decided by former Commissioner Roxani Gillespie.

Attorneys for the insurers announced last week that they will file suit April 3 in Superior Court in Los Angeles to give Mr. Garamendi an opportunity to present his arguments to the court by that date. That way, Superior Court Judge Dzintra Janavs

will be able to hear both sides on April 3, said insurer attorney Steven H. Weinstein, a partner with Barger & Wolen in Los Angeles.

When Mr. Garamendi took office in January as the state's first elected insurance commissioner, he set aside regulations Ms. Gillespie had adopted to implement Proposition 103's insurance "charge" rollback provision, as well as other regulations she adopted to implement other provisions of the law (*BI*, Jan. 14).

Under the law, which voters narrowly approved in November 1988, insurers must roll back insurance charges to 20% below November 1987 levels unless they would be "substantially threatened with insolvency."

But, the California Supreme Court in May 1988 found the provision unconstitutional and ruled that insurers are entitled to a "fair rate of return" (*BI*, May 8, 1989). The court, though,

did not define a fair rate of return.

Following months of hearings on generic issues, Ms. Gillespie in June 1990 established a benchmark 11.2% rate of return on all insurers' combined business between November 1988 and November 1989 for determining rollbacks (*BI*, June 18, 1990).

The Insurance Department has so far conducted company-specific rollback hearings only for SAFECO Corp. and California State Automobile Assn. using regulations Ms. Gillespie established (*BI*, Aug. 13, 1990).

And, Mr. Garamendi has yet to rule on an administrative law judge's recommendation that SAFECO refund \$17.5 million and CSAA issue no refunds (*BI*, Jan. 28).

Instead, Mr. Garamendi wants to adopt new regulations for implementing the rollback provision.

Mr. Garamendi in January announced an expedited timetable of

hearings in an attempt to adopt the proposed new rules by March 15, but he since has delayed that timetable. Though he is expected to release amended new regulations implementing Proposition 103 at a public hearing on Tuesday, public hearings on those rules and other issues will continue through June.

Mr. Garamendi has said he will not approve any new rates until the hearings on insurance charge rollbacks are completed and rollback orders have been issued.

The suit—papers for which are about 1½ feet thick—claims last year's hearings and Ms. Gillespie's decision constitute "a closed record" that cannot be relitigated.

The insurers now want Ms. Gillespie's decision applied to them as part of the so-called company-specific rollback hearings that were to follow the hearings on generic issues.

"The new insurance commissioner blatantly proposes to ignore" previous proceedings on rollbacks and on rate approval, the suit says. "The new commissioner cannot now simply ignore the result of this binding adjudication and embark on a new set of hearings to decide again the same issues," the suit charges.

"More than two years of administrative proceedings to implement Proposition 103's rollback provisions will be illegally washed away" if Mr. Garamendi is allowed to hold hearings on his proposed regulations to implement Proposition 103, the suit claims.

That would cause the insurers "irreparable harm," because they devoted "an enormous amount of time, effort and expense" to the four-month hearing process culminating in Ms. Gillespie's June 1990 decision, according to the suit. ■

## Municipal liability

Continued from page 1

lion—or \$1 million for every blow police officers reportedly inflicted.

The city of Los Angeles self-funds its liability exposures.

Because the 9th Circuit's decision in the Mason County case is now the law in the 12 jurisdictions, including California, governed by the 9th Circuit, any civil litigation involving Mr. King's case would be subject to the ruling, noted Mason County attorney Nancy K. McCoid of Merrick, Hofstedt & Lindsey in Seattle.

Civil rights attorney Stephen Yagman said the appellate ruling is significant because it requires that police be taught not only how to use force, but also how much force they can apply before they violate an individual's civil rights.

Police departments now will have to provide adequate, ongoing training about what force is constitutionally permissible "or they will be subject to enormous liability for not doing so," said Mr. Yagman, a partner with Yagman & Yagman in Los Angeles.

Consequently, "any insurance carrier that might insure against losses for police misconduct now would be well-advised to require as a condition of coverage that the insured provide this kind of training, and that if such training is not provided, that there be an exception to coverage, as is the case with many errors and omissions policies," Mr. Yagman said.

The 9th Circuit's ruling likely will play a role in another LAPD police brutality case that goes to trial in September, said Mr. Yagman, who is representing that plaintiff.

In that case, known as the Dalton Avenue case, 77 LAPD officers allegedly invaded the homes of two black families in 1988, ripping out sinks and toilets and smashing windows and television sets in retribution for a telephoned threat to a police station.

The 9th Circuit ruling also likely will influence *Mace vs. Los Angeles County*, in which the plaintiff alleges that a sheriff's deputy struck him in the groin and irreparably injured him, said plaintiff's attorney Tom Barham of Barham & Ostrow in Los Angeles.

"The deputy claimed he was trained to hit someone in the groin when it isn't a life-threatening situation," Mr. Barham said.

According to Mr. Barham, courts nationwide for several years have

used at least one of three standards to determine municipal liability in cases alleging excessive use of force:

- When a police or sheriff's department decision-maker has final authority to establish municipal policy regarding practices and activities that later are deemed to be illegal. This standard was established by the U.S. Supreme Court in *Pembaur vs. the City of Cincinnati* in 1986.

- When the municipality's policy-makers are "indifferent to the need" to train officers about the constitutional limitations to the use of force. This standard was established by the U.S. Supreme Court in *Canton vs. Harris* in 1987.

- When excessive use of force is a "pattern and practice." This standard was established by the 4th U.S. Circuit Court of Appeals in *Spell vs. McDaniel* in 1987. The Supreme Court refused to review the case.

The 9th Circuit cited the first two cases in ruling that Mason County was liable for failing to adequately train law enforcement officers about legal limits on the use of force. "Mason County's failure to train its officers in the legal limits of the use of force constituted 'deliberate indifference' to the safety of its inhabitants as a matter of law," the court said.

"The training that the deputies received was woefully inadequate, if it can be said to have existed at all," the court said. "Instead of academy training, the sheriff's department devised a 'field training program' for the officers. While this program may have seemed adequate on paper, in practice it was never followed. Indeed, one of the department's two original field training officers, both of whom quit, called the program 'a joke.'"

The court said "the issue is not whether the officers had received any training—most of the deputies involved had some training, even if it was minimal at best—rather the issue is the adequacy of that training.

"More importantly, while they may have had some training in the use of force, they received no training in the constitutional limits of the use of force," the court said.

Citing *Canton vs. Harris*, the court said that "if the need for more or different training is so obvious and the inadequacy so likely to result in the violation of constitutional rights... the policymakers of the city can reasonably be said to have been deliberately indifferent to the need."

The Mason County verdicts are covered by general liability insurance underwritten by Scottsdale Insurance Co. of Scottsdale, Ariz., according to plaintiffs' attorney Mr. Ford.

Neither Scottsdale nor attorneys for the county would comment on the county's coverage.

Municipal risk managers in the 9th Circuit contacted by *Business Insurance* are confident that their law enforcement officials are being adequately trained (see related story).

However, some suggest that police officer training programs can be improved, particularly at the supervisory level, which is where officers get their marching orders.

"They don't have adequate supervision out in the field," said attorney Mr. Barham, who was a Los Angeles police officer in the 1960s. "There are some people who do not have the temperament to be police officers."

Improved training may be warranted if the nationwide probe into police brutality ordered by the U.S. Justice Department after the Los Angeles incident unveils a nationwide pattern, said U.S. Attorney General Richard Thornburgh on the March 17 broadcast of NBC's "Meet the Press." "That, I think, will then lay the basis for some remedial efforts at better training, at better mechanisms within police departments to curter this part of activity," he said.

Better management training on the limits on the use of force also could reduce cities' exposure to liability claims, said San Diego's risk manager, D. Cruz Gonzalez. But obtaining funding can be difficult, he said.

Four sessions at the upcoming Public Risk Management Assn. conference will focus on various aspects of police liability.

"The Secrets of Managing Police Liability" will focus on issues such as the Mason County and Los Angeles cases, and "I Shot the Sheriff" is designed to show municipal risk managers how to improve their relationship with the police department, a PRIMA spokeswoman said.

A session on jails will cover the protection of inmates' civil rights, and a mock trial will show what happens in litigation over an arrest that goes awry, she said.

More information on the May 12-15 conference in Atlanta is available from PRIMA at 703-528-7701.

• *Davis vs. Mason County, 9th U.S. Circuit Court of Appeals, No. 88-3947.*

## Training adequate: Risk managers

Municipalities already adequately train their police officers on the constitutional use of force as required by a recent appellate court ruling, contend risk managers contacted by *Business Insurance*.

"The training that our law enforcement officers get is adequate" to prevent problems, said Keith Grand, risk manager for the city of San Francisco.

However, the 9th U.S. Circuit of Appeals ruling that municipalities and law enforcement agencies are responsible for training officers on the legal limits of the use of force "has heightened every police department's awareness," he said (see story, page 1).

The ruling "has not changed the way we do business" in San Diego, said the city's risk manager, D. Cruz Gonzalez. "We've always trained against excessive use of force, and I don't think we have a bad record."

Just last month Mr. Gonzalez met with police department officials to discuss liability claims, he said.

The city's largest police liability claim was settled for \$9 million in 1990. But, that case involved a traffic accident in which a motorist suffered critical injuries after his car was broadsided by a patrol car.

The city paid \$983,000 in claims related to excessive use of force in 1990, up 9.3% from \$899,000 in 1989. The claims represent about 41% of the city's total liability claims—including third-party property damage—of \$2.4 million in 1990, excluding the single loss of \$9 million.

The city self-insures the first \$5 million of its liability exposures. Skandia America Corp. of New York writes \$2 million of coverage excess of \$5 million, and National Union Fire Insurance Co. of Pittsburgh, Pa., a unit of American International Group Inc., writes a \$10 million layer excess of \$7 million.

The city of Portland, Ore., has ongoing in-service training for police officers with curriculum standards

set by the National Assn. of Law Enforcement Officers, Risk Manager Fred Cuthbertson said.

And, Washoe County, Nev., which includes the city of Reno, has "over the last two years brought in consultants to review policies, procedures and training programs" and has amended policies when warranted, said Risk Manager Ray Sibley.

For example, deputies who have been on the force for several years now are required to undergo re-training in the use of equipment and techniques, he said.

But, the re-training program was not prompted by a surge in brutality claims, he said. The county has paid a total of only \$547,716 in police liability claims since 1980. Rather, the need for the retraining program "was painfully brought to our attention" by an increase in workers compensation claims filed by officers injured on the job, he said.

The county, which self-insures its liability exposures, also is protected from huge damage awards related to police activities by a \$50,000 statutory cap on municipal liability, according to Mr. Sibley.

In Los Angeles, training bulletins on department policies and tactics are regularly distributed to each of the police department's 8,400 officers, officers said.

During training sessions "we tell cadets that the force has to be reasonable, it has to be necessary and it has to be the minimum necessary to accomplish the task," said Sgt. Fred Nichols, officer in charge of physical training and self-defense at the LAPD's police academy.

The city, which self-insures its liability exposures, paid \$8 million in police liability claims in 1990, said Mike Inouye, chief administrative analyst in the city's risk management department. Figures on how much was paid for claims related to excessive use of force are not available, he said.

—By Joanne Wojcik

## Update

### Questions raised on BICs bill

Continued from page 2

types of BICs.

The Treasury Department's section-by-section analysis of the 300-page bill says BICs offered to pension plans no longer would be considered a deposit eligible for FDIC pass-through insurance.

Pass-through FDIC coverage now gives each BIC beneficiary up to \$100,000 of federal deposit insurance. BICs, which often are offered as an investment option in 401(k) plans, can cover many beneficiaries.

However, the legislation defines a BIC as a contract that provides for the deposit of funds over an extended period of time at a specified rate of interest, regardless of whether the funds can be withdrawn without penalty prior to maturity.

That definition appears to exclude so-called bullet BICs in which lump-sum deposits must be made on a specified date. Other BICs, known as window BICs, allow contributions over a certain period of time, that is, during an "open-window" period.

"The wording in the legislation could be construed as leaving a loophole for certain types of BICs. But I'm doubtful if that was the intent," said Kim McCarrel, a Wyatt Co. consultant in Portland, Ore.

Some banks already are trying to develop new products for defined contribution plans that would qualify for FDIC coverage (*BI*, Feb. 25).

### Exxon settles N.Y. oil spill case

LINDEN, N.J.—EXXON Corp. will pay \$15 million to settle criminal charges and civil litigation stemming from a pipeline leak that spilled 567,000 gallons of heating oil into Arthur Kill last year (*BI*, Feb. 12, 1990).

To resolve the criminal action, Exxon agreed to plead guilty to a misdemeanor violation of the Clean Water Act and pay \$5 million in connection with these charges, said a spokesman in Linden, N.J. Of the \$5 million, which has been paid into an escrow account, \$200,000 will be a fine. The remaining \$4.8 million will be restitution to the governments of New York state, New Jersey, New York City and the city of Elizabeth, N.J.

Exxon also resolved pending civil litigation by agreeing to provide \$10 million over five years to trustees of the four state and local governments to fund environmental conservation initiatives. Those include purchasing wetlands near the spill site and improving them to be used as conservation areas and parks.

The spokesman said Exxon "typically" is self-insured for such losses.

### Outhwaite ruling appealed

LONDON—Lloyd's of London syndicates managed by Roberts & Hiscox Ltd. are appealing an arbitrator's decision that runoff reinsurance policies written by syndicates managed by R.H.M. Outhwaite (Underwriting Agencies) Ltd. do not have to pay some asbestos-related claims.

The arbitrator ruled that the Outhwaite policies did not have to pay claims settled under the Wellington Agreement, said Clive Boxer, an attorney representing Hiscox. Insurers that were members of the now-defunct Asbestos Claims Facility agreed under Wellington to settle asbestos bodily injury coverage disputes and to provide a joint defense against victims' claims (*BI*, March 11; July 1, 1985).

The trial, set for April 9 in London's High Court, will be the first time a dispute is argued in open court over whether a reinsurer must pay claims settled under Wellington, Mr. Boxer said.

At a hearing this month, the Outhwaite agency argued the appeal should not be heard in an English court because the arbitrator wrote his decision at his Paris home and France follows different legal rules.

While the court agreed with that argument, it ruled that Outhwaite could not make the argument because it already had agreed to abide by the arbitration under British law. Outhwaite is appealing this point to the House of Lords, Britain's highest court.

### Local IAA, PIA invited to talks

WASHINGTON—State and regional representatives of the Independent Insurance Agents of America and the National Assn. of Professional Insurance Agents were invited by the IAA last week to meet April 10 in Dallas to resume talks about merging the two trade groups.

Merger talks between the IAA and PIA executive committees broke off last month amid disagreement on issues of organization, membership and management. IAA President A. William Bailey Jr. believes that those issues can be resolved by opening the negotiations to state and regional affiliates on both sides.

Until last year, the national PIA had opposed the merger, though agents from both associations generally have supported merging both the national and state organizations (*BI*, July 23, 1990).

Mr. Bailey also announced the formation of an IAA national task force to help state associations merge with their PIA counterparts.

### Briefly noted

A federal judge in Milwaukee fined McCook, Ill.-based contractor S.A. Healy Co. \$750,000 for violations of federal workplace safety rules. Three Healy employees were killed in a methane gas explosion during construction of a Milwaukee sewer project in 1988. The firm also was convicted on two counts of reckless homicide earlier this year (*BI*, Jan. 7). . . . High winds and flooding caused an estimated \$40 million of insured property damage to portions of California and Nevada March 2-4, reports the Property Claim Services division of the American Insurance Services Group. Parts of Kansas, Illinois and Indiana sustained an estimated \$30 million of insured property damage March 11-12 because of wind, hail, tornadoes, ice and snow. . . . The Alliance Syndicate Inc. is expected to regain its underwriting privileges Friday, a week after it turned over financial records requested by the Illinois Insurance Exchange (*BI*, Feb. 25). . . . The House Education and Labor Committee last week approved legislation, H.R. 2, that would allow employees up to 12 weeks of unpaid job-protected family leave. Any employer-provided health care coverage would continue as if the employee were still working (*BI*, Jan. 4). The bill moves to the Personnel and Police Subcommittee of the House Administration Committee.

# After their surprising surge, what awaits broker stocks?

By LEONARD M. WILSON  
Special to Business Insurance

THE CURRENT STOCK market advance qualifies as one of the steepest on record. The climb from the October depths of last year amounts to a rebound of 27%, using the Standard & Poor's 500 index as a benchmark.

However, despite the pall of soft rates in commercial property/casualty insurance lines and a general lack of earnings momentum, the publicly held insurance brokerage stocks surpassed the gain in the market averages.

Frankly, we were surprised to find that the brokerage shares outperformed the market. The performance was better than we would have expected, given the lack of a fundamental catalyst.

Possibly, the upsurge in financial services stocks from what seemed like a bottomless descent has carried the brokerage stocks along with the tide of changing sentiment.

This recent strength has prompted us to think about the longer-term appreciation potential of the brokerage stocks. Price appreciation is a topic that deserves, at least for this column, to supplant the fixation with the course of premium rates.

Achieving growth in capital is the rationale for investment analysis. Accordingly, we think it is appropriate to explore whether brokerage shares would be attractive investments over a time frame long enough to overcome or perhaps put aside the current concerns about premium rates.

An investment time frame, we thought, ought to be long enough to allow normal, trend-line growth rates to asset themselves, yet not so long as to discourage the genuine long-term investor having a bias toward good companies with strong underlying fundamentals.

Insurance brokers, we believe, can be accurately described as good companies.

We chose 1995 as the terminal year of the

holding period for this exercise in potential return. We elected to use 1991 earnings estimates as the base from which to project 1995 earnings for the individual brokers.

Over the past 20 years, the publicly held insurance brokers have registered earnings growth of around 15% compounded annually. Gains flagged in the competitive phases of the insurance cycle and accelerated during the tight markets.

It can be argued that the publicly held brokers have seen their best years and now are entering a stage of relative maturity during which annual growth over a full cycle must decelerate.

But we expect brokers' annual earnings growth to match trend-line progress of 15% annually through 1995 on the strength of a firming in premium rates at some point within the next several years. Rising rates translate into quicker revenue growth, profit margin expansion and typically several years of better than trend-line growth.

Applying the designated growth rate, we project an earnings level in 1995 of roughly 80% greater than 1991 estimated earnings. We calculated the following price-to-earnings ratios for the public brokerage firms based on these projections for 1995: Marsh & McLennan Cos. Inc., 10.0; Alexander & Alexander Services Inc., 9.5; Willis Corroon P.L.C., 8.5; and Arthur J. Gallagher & Co. Inc., 10.0.

The earnings projections through 1995 are, of course, subject to the usual uncertainties. Will expenses be properly controlled? Are we facing any structural changes in brokerage compensation? Will soft insurance markets persist in defiance of normative expectations?

We cannot be sure about earning power in the future, but insurance brokers have shown themselves to be unusually resilient in finding the means to extend their track record of long-term growth. Therefore, we are comfortable with our 1995 projections.

Brokerage stocks currently sell at about 17 times 1991 earnings estimates. Valuations based on 1995 projections seem to afford considerable opportunity for appreciation if current price-to-earnings ratios are maintained over the time period.

Again, though, there are no guarantees that they will be, and it is quite possible that a change in investor perceptions of fundamentals will cause the ratios to contract.

This assessment of price appreciation potential cannot be complete without a projection of earnings and valuation of the stock market as a whole. We believe that corporate earnings will rise at an average rate of 8% annually through 1995.

Applying this growth rate to the earnings of the companies in the S&P 500, we calculate that the index based on current prices is selling at 10.4 times the projected earnings for 1995.

Brokerage shares, given our estimates above, are just a smidgen cheaper than the market average based on 1995 estimates, with a composite price-to-earnings ratio of 10 for the brokers vs. 10.4 for the market as a whole.

As long as we have followed the publicly held brokers, their price-to-earnings ratios have materially exceeded the stock market's overall valuation.

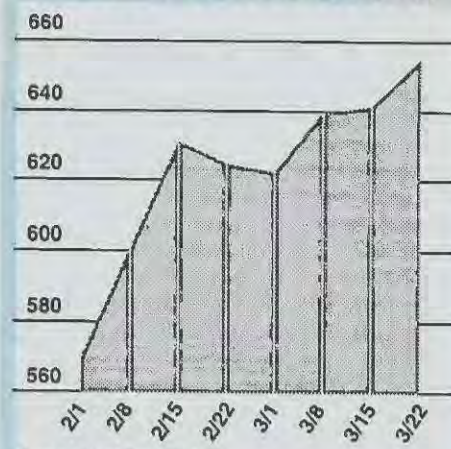
Brokerage shares, based on this 1995 scenario, clearly are quite favorably priced, though they do not look especially undervalued based on the 1991 price-to-earnings ratio.

In this exercise, we are dealing with the future, and much can go awry with the estimates. But allowing for plenty of uncertainty, it would appear that our long-term investor could almost ignore the cyclical nature of the insurance market in his investment calculus of insurance brokerage potential returns.

Many investors are loath to buy and hold a stock for almost four years in a stock market that has become notable for its volatility. Moreover, the risk in insurance brokerage remains the possibility of chronically soft insurance markets that erode the actual growth rate in earnings well below our predicted trend-line rate of progress.

Time frames, rates of return and degree of risk are critical factors in any investment decision. At the core of expectations for the insurance brokers is a necessary confidence that underlying growth can be sustained through much of this decade.

## BI Insurance Index



Base = 100 on Dec. 29, 1978  
Source: Nordby International Inc.

Insurance industry stocks shot up last week as the *Business Insurance Index* rose 14.6 points to 654.7 on March 22, from 640.1 on March 15. Advancing issues for the week were led by Sierra Health Services, up 22.0%; United Healthcare Corp., up 18.9%; and HMO America Inc., up 13.5%. Declining issues for the week followed Phoenix RE Corp., down 9.1%; Transamerica, down 7.8%; and USF&G Corp., down 7.3%. The most active issue for the week was U.S. Healthcare, with 4.7 million shares traded. The *BI Index* was up 2.1%; The Standard & Poor's 500 dropped 1.6%; the Dow Jones 30 Industrials were down 3.0%; and the New York Stock Exchange Composite fell 1.5%.

## British Issues

March 21 Companies	Price pence	P/E	Div. pence	Yield %	1 Week	
					High	Low
Comm Union	529	N/M	30.7	5.8	547	529
Genl Accident	570	N/M	35.7	6.3	580	562
Gen Royal Exch	225	N/M	15.9	7.1	230	220
Royal	463	N/M	34.7	7.5	469	458
Sun Alliance	379	N/M	18.7	4.9	398	379
<b>Brokers</b>						
Bradstock	154	17.5	6.0	3.9	154	149
CE Heath	524	15.5	34.5	6.6	524	516
Hogg Group	198	13.2	10.7	5.4	198	192
Lloyd Thompson	360	24.0	10.0	2.8	360	347
PWS Holdings	94	11.5	4.7	5.0	94	94
Sedgwick Grp	267	25.7	16.0	6.0	267	257
Steel Brt Jones	326	17.0	16.3	5.0	326	314
Willis Corroon	312	16.5	17.6	5.6	315	310

Source: Philip Olsen, Insurance Industry Analyst  
London

# BI Industry Stock Report

MARCH 18, 1991 THROUGH MARCH 22, 1991

	Weekly Price	% change	Year to Date % change	Annual		Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value	Weekly Price	% change	Year to Date % change	Annual		Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value																							
				High	Low										High	Low																													
<b>BROKERS</b>																																													
Alexander & Alexander	NYS	25.50	-3.77	10.27	28.88	16.13	324	1.00	3.92	19	9.18	2.78	41.63	1.52	1.22	50.25	29.00	9	0.92	2.21	14	31.82	1.31																						
Gallagher Arthur J & Co	NYS	28.00	0.00	20.43	28.38	19.75	17	0.64	2.29	20	5.33	5.25	50.50	-1.00	17.44	56.50	30.75	146	2.72	5.39	12	49.19	1.03																						
Frank B Hall	NYS	3.50	7.69	-3.45	4.25	2.00	33	0.00	0.00	-7	-2.80	-1.25	37.50	-1.96	13.64	39.00	25.50	178	0.20	0.53	16	22.81	1.64																						
Hibb, Rogal & Hamilton	OTC	15.00	1.69	1.69	16.50	11.25	194	0.36	2.40	21	4.60	3.26	45.25	10.37	38.17	45.50	24.75	56	0.00	0.00	17	15.22	2.97																						
Marsh & McLennan	NYS	79.13	-0.31	1.44	82.25	59.75	501	2.60	3.29	19	10.56	7.49	3.25	1.94	8.33	3.75	2.25	4	0.00	0.00	-	7.76	0.42																						
Poe & Associates	OTC	9.63	-3.75	20.31	13.00	7.75	12	0.40	4.16	9	2.40	4.01	30.25	8.04	79.26	34.50	11.75	554	1.32	4.36	6	37.50	0.81																						
BROKERS AVERAGE																								0.2	7.2						2.3	12													
<b>CONGLOMERATES &amp; HOLDING COMPANIES</b>																																													
Berkley WR Corp	OTC	42.25	-3.98	12.67	46.50	28.50	123	0.48	1.14	14	25.06	1.69	16.00	0.00	29.27	17.00	11.75	7	0.00	0.00	11	14.43	1.11																						
Berkshire Hathaway Inc	NYS	7925.00	-0.31	18.73	8900.00	5675.00	0	0.00	0.00	25	2869.00	2.76	15.50	-4.62	6.90	16.38	9.50	62	0.44	2.84	8	12.42	1.25																						
ITT (Hartford Group)	NYS	54.25	-1.81	13.02	60.88	40.25	877	1.72	3.17	7	56.33	0.96	67.75	-0.73	7.97	70.25	47.00	627	2.60	3.84	8	43.47	1.56																						
Sears (Allstate)	NYS	32.63	1.95	28.57	39.50	22.00	2546	2.00	6.13	13	37.75	0.86	37.88	-1.94	15.21	40.50	25.13	659	1.36	3.59	9	24.87	1.52																						
CONGLOMERATES AVERAGE																								-1.0	18.2						2.6	15													
<b>INSURERS/REINSURERS</b>																																													
Aetna Life & Casualty	NYS	44.50	-1.11	14.10	54.38	29.00	768	2.76	6.20	8	58.11	0.77	14.00	0.00	13.13	15.25	8.38	10	0.24	1.71	10	10.61	1.32																						
American General	NYS	37.88	1.03	23.17	50.63	23.50	532	2.00	5.28	8	34.68	1.09	6.63	-1.85	55.88	11.75	4.25	94	0.36	5.43	21	13.75	0.48																						
American Heritage	NYS	23.25	-4.12	10.71	24.39	19.63	9	1.00	4.30	11	22.60	1.03	16.75	0.00	18.25	12.50	12.50	28	1.04	6.21	7	15.72	1.07																						
American Indemnity/Fin'l	OTC	6.50	0.00	100.00	7.13	2.75	37	0.08	1.23	-20	17.38	0.37	2.44	-2.48	55.98	3.00	1.25	63	0.00	0.00	-14	4.19	0.58																						
American International	NYS	90.63	0.00	17.89	96.25	57.00	1277	0.44	0.49	13	41.92	2.16	50.75	-0.49	7.41	56.50	34.50	14	0.26	0.51	30	70.93	0.72																						
Aon Corp	NYS	35.63	0.7	2.52	41.38	26.75	329	1.60	4.49	10	19.62	1.82	53.75	-3.59	9.97	56.13	38.00	205	1.40	2.60	13	13.23	4.06																						
Argonaut Group	OTC	81.00	2.53	26.56	80.00	53.00	8	1.60	1.98	8	36.83	2.20	35.38	-7.82	8.43	41.00	23.25	1411	1.96	5.54	11	34.63	1.02																						
AVEMCO Corp	NYS	29.63	1.7	17.33	30.13	21.13	11	0.44	1.49	19	9.52	3.11	22.88	-2.66	37.59	33.50	11.50	1059	1.60	6.99	-12	44.85	0.51																						
Baldwin & Lyons Inc	OTC	24.50	2.06	30.67	24.50	17.00	2	0.28	1.14	9	20.80	1.18	25.00	0.00	8.11	27.50	16.25	67	0.60	2.40	10	16.91	1.48																						
Belvedere Corp	ASE	2.75	0.00	10.00	4.63	1.75	106	0.04	1.45	69	8.03	0.34	40.75	-4.68	16.01	43.00	28.75	2	1.32	3.24	7	22.56	1.81																						
Chandler Insurance	OTC	4.13	6.45	-40.00	9.75	2.75	170	0.00	0.00	-5	9.53	0.43	9.50	-7.32	26.67	29.50	7.00	1843	0.20	2.11	-2	22.87	0.42																						
Chubb Corp	NYS	67.63	0.19	24.65	70.25	34.63	1035	1.48	2.19	11	66.64	0.70	59.00	0.00	26.54	63.00	32.13	448	0.80	1.36	11	31.20	1.89																						
CIGNA Corp	NYS	46.88	1.90	14.68	55.50	33.25	842	3.04	6.49	11	66.64	0.70	37.63	4.51	34.38	41.75	23.25	198	1.48	3.93	9	54.34	0.69																						
CNA Financial Corp	NYS	83.63	-0.45	21.86	92.50	49.50	84	0.00	0.00	14	54.87	1.52	37.75	0.00	22.76	40.25	24.50	321	0.80	2.12	16	33.99	1.11																						
Continental Corp	NYS	27.13	-0.91	9.05	31.38	15.75	535	2.60	9.59	11	41.36	0.66	13.50	0.93	24.14	22.63	9.38	12	1.08	8.00	-15	32.90	0.41																						
Durham Corp	OTC	26.50	-7.02	-5.36	34.00	23.00	20	0.92	3.47	13	26.32	1.01	18.38	0.68	15.75	23.00	14.75	18	1.00	5.44	8	27.73	0.66																						
Fund American Corp	NYS	60.75	1.46	17.11	61.75	29.50	224	0.68	1.12	25	32.74	1.86	16.88	-0.74	23.85	18.25	9.88	37	1.00	5.93	-33	13.81	1.22																						
Fremont General Corp	OTC	19.00	8.57	31.03	19.75	10.13	378	0.80	4.21	6	19.09	1.00	18.38	0.68	15.75	23.00	14.75	18	1.00	5.44	8	27.73	0.66																						
Frontier Insurance Group	NYS	23.25	3.33	22.37	33.00	15.38	17	0.00	0.00	10	7.29	3.19	26.00	9.47	60.00	12.00	713	0.00	0.00	18	6.35	4.09																							
General RE Corp	NYS	92.13	-3.41	-0.94	99.88	69.00	850	1.68	1.82	13	29.04	3.17	4.75	-2.56	0.00	7.63	4.00	2	0.00	0.00	15	2.99	1.59																						
Hanover Insurance Co	OTC	30.00	8.11	13.21	30.25	21.00	82	0.44	1.47	12	32.03	0.94	26.38	21.97	91.82	26.63	5.50	578	0.00	0.00	78	0.62	42.54																						
Hartfordville Group	OTC	28.00	0.00	22.40	30.00	13.50	59	0.64	2.29	9	18.94	1.48	38.75	18.77	66.67	37.75	9.38	3325	0.06	0.15	31	0.34	113.97																						
Hartford Steam Boiler	NYS	57.75	3.82	18.46	62.13	43.50	135	0.00	0.00	-	18.94	3.05	9.50	1.33	18.75	11.38	6.63	7	0.20	2.11	12	5.70	1.67																						
Kansas City Life Ins	OTC	33.50	0.00	8.50	36.50	30.00	3	1.20	3.58	9	39.22	0.85	49.88	12.08	69.79	49.63	11.13	4655	0.48	0.66	31	3.07	16.25																						
Kemper Corp	NYS	32.00	-2.29	34.74	43.13	17.13	114	0.92	2.88	1																																			

# Waldo was right.

Ralph Waldo Emerson said,  
"Hitch your wagon to a star."

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