MARCH 26, 1990

# Business Insurance®

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## Update

### Judge grants A&A new trial in $27.4 million E&O suit

LOS ANGELES—Alexander & Alexander Inc. will receive a new trial in a case in which a Los Angeles jury had ordered the broker and two units to pay Whittaker Corp. $27.4 million for arranging inadequate product liability coverage for the company.

Los Angeles-based Whittaker sued A&A in 1984 for leaving Whittaker without adequate product liability coverage when the broker restructured Whittaker's liability insurance program

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# Increasing rates in London may hit U.S. underwriters

**By STACY SHAPIRO**

LONDON—U.S. ceding companies whose reinsurance programs renew July 1 could face a rough time in light of premium increases imposed in the London market this month for Japanese ceding companies with sparkling loss experience.

The premium increases for Japanese insurers' cargo catastrophe reinsurance and non-marine catastrophe reinsurance are a sign of the times in the London market, following a string of catastrophic losses like the explosion of the Piper Alpha and Enchova drilling rigs in 1988; Hurricane Hugo, the California earthquake and the Phillips Petroleum Co. plant explosion in Texas last year; and the rash of European windstorms earlier this year.

During April 1 renewals, rates for Japanese cargo catastrophe reinsurance in some cases were doubled. And, while rates for non-marine catastrophe reinsurance held steady, Japanese ceding companies had expected rates to be lowered. In addition, the Japanese insurers will cede more premium to non-marine reinsurers since their own premium volume is increasing by 7% to 9%.

London and Japanese sources believe the hardening in the London market will continue, affecting reinsurers, insurers and policyholders worldwide.

"The rate increases will continue to be required, especially from Lloyd's of London," said Isao Kuzuhara, associate director and general manager of the reinsurance department of the international operation of Dai-Tokyo Fire & Marine Insurance Co. Ltd. of Japan.

"With the series of losses, the market has suddenly turned to a hardening market," which will continue through the end of the year, he said.

The Japanese experience during April 1 reinsurance renewals "is a

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# Court overturns pro-policyholder coverage ruling in asbestos case

**By STACY ADLER**

NEW ORLEANS—One of the biggest policyholder victories in asbestos property damage coverage litigation is being wiped off the books because the case was tried in the wrong court.

The 5th U.S. Circuit Court of Appeals earlier this month reversed a 1988 ruling that ordered several insurers to indemnify W.R. Grace & Co. for a massive asbestos property damage settlement between the former asbestos producer and 83 Texas school districts (*BI*, Feb. 15, 1988).

The appellate court reversed because the District Court did not have proper jurisdiction over the litigation.

Grace will either seek to have the 5th Circuit panel reconsider its decision or seek a review of the appellate ruling by the full 5th Circuit, said Grace attorney Jerold Oshinsky of Anderson, Kill, Olick & Oshinsky in Washington, D.C.

The company may also seek U.S. Supreme Court review of the case, Mr. Oshinsky said.

Policyholders could be hurt because the 1988 trial court decision that asbestos constitutes property damage and that all policies in place from the time asbestos is installed until it is removed or con-

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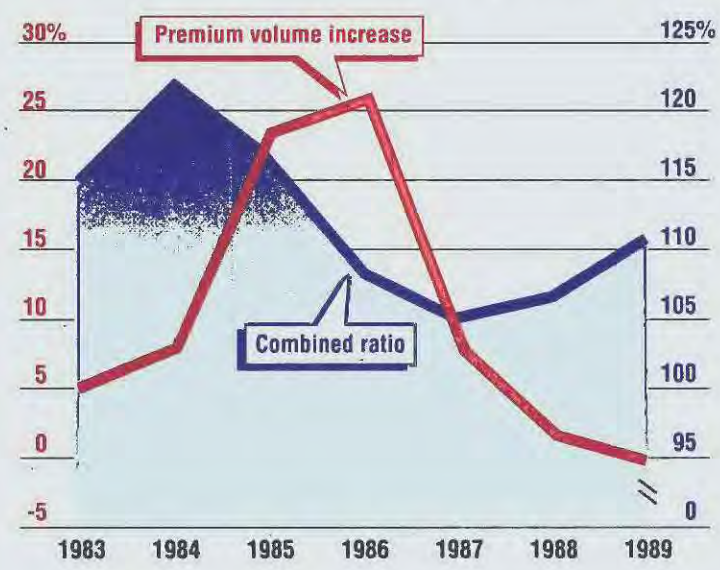
# Insurer results: A mixed bag

## Insurers' slump worsens

Property/casualty insurers' combined ratios zoomed upward in 1989, while net premium volume actually declined.




Source: *BI* survey of leading commercial insurers

BI/HOLLY SEGUINE

## P/C insurers expect another poor year

**By JUDY GREENWALD**

Commercial property/casualty insurers are bracing for another year of poor underwriting results.

Because 1990 underwriting results will largely reflect business written at last year's poor rates, even if prices rise substantially later this year—which many say is unlikely—it will not be enough to cause insurers' combined ratios to rebound.

In fact, observers say, perhaps only a sharp drop in catastrophe losses could stop insurers' 1990 combined ratios from increasing above year-end 1989 levels. U.S. insurers reported a record $7.64 billion in catastrophe losses last year, 2½ times the previous high (*BI*, March 5).

Meanwhile, observers add, there is no immediate end to inadequate pricing in sight.

While many insurers and securities analysts believe rates have now essentially stabilized and some say overall rates are beginning to creep upward, they acknowledge that these increases still are insufficient to offset more rapidly rising loss costs.

And some observers warn that rates could even start to decline again before the market finally hardens.

Hit by both deteriorating underwriting results and high catastro-

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**Multiline insurers defend the quality of their assets. Page 32**

## Health profits improve

**By JUDY GREENWALD**

Group health insurers, which generally reported vastly improved results in 1989, are looking forward to another solid year in 1990.

Operating profits have improved markedly for both group indemnity and health maintenance organization operations. In some cases, HMO operations either became profitable or approached profitability for the first time.

Significant premium increases in 1989 were the major factor behind health insurers' improved results, observers say, adding that premium increases in 1990 will be more moderate (*BI*, Dec. 18, 1989).

In addition, health insurers point to better cost control techniques as another factor contributing to the turnaround.

"Clearly, price increases in both our indemnity operations as well as our HMO operations were the key" to improved results, commented Chris Doerr, a senior vp and chief financial officer of CIGNA Corp.'s employee benefits group.

CIGNA's group indemnity business, excluding aftertax realized investment results, reported $218 million in operating income in 1989, up 26% from $173 million in 1988. And losses stemming from CIGNA's HMO business were cut to $21 million from $144 million.

Last year, CIGNA raised premiums 45% to 55% on its small-case group indemnity business, which it defines as 50 to 200 lives, said Mr. Doerr. The insurer introduced 25% to 35% premium increases for larger indemnity accounts, he said, while HMO premiums were hiked 20% to 30%.

Rates hikes have moderated this year, said Mr. Doerr. "In 1989, obviously, price increases were

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NEWSPAPER

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**Museum has no coverage for stolen masterpieces** Page 3

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## Update

### New A&A, Whittaker trial

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in 1979. As a result, Whittaker alleged, it did not have insurance for the cost of repairing defects in about 2,000 railroad freight cars it manufactured and sold under warranty through early 1981.

A Los Angeles Superior Court jury in January found the A&A companies were negligent and breached their contract with Whittaker and awarded Whittaker $27.4 million (*BI*, Jan. 15).

A&A filed a multiple-point motion seeking a new trial, and a Los Angeles Superior Court judge on March 16 agreed with two points: The suit was barred by the two-year statute of limitations, since Whittaker knew about the inadequate coverage in 1980, and the damage occurred before A&A became Whittaker's broker.

But, "the judge has not ruled that they are right," said Whittaker attorney Lawrence Barth of Munger, Tolles & Olson in Los Angeles, noting that the judge denied all other grounds in A&A's motion. "All he's saying is, 'Try it again,' " he said.

A&A would only say that it is "pleased" with the decision.

### Medical procedures studied

CHICAGO—A new project by the American Medical Assn., Rand Corp. and the Academic Medical Center Consortium will attempt to identify and promote appropriate health care procedures while curtailing inappropriate treatment.

The Clinical Appropriateness Initiative is developing practice guidelines for selected medical and surgical procedures, diagnoses and conditions to give health care providers information on how to most efficiently treat common ailments. The groups hope the guidelines will encourage physicians to perform fewer unnecessary procedures.

According to a Rand study of 5,000 Medicare patients, 22% of certain procedures—including heart X-rays, scraping of blood vessels and fiber optic stomach X-rays—were inappropriately used. Rand says unnecessary tests and procedures add more than $50 billion yearly to the nation's $600 billion health care bill.

Albert Williams, director of the health sciences program at Rand in Santa Monica, Calif., said some of the savings gleaned from eliminating inappropriate treatment could help fund the costs of health care coverage for the nation's 37 million uninsured people.

Studies on appropriateness criteria for cataract surgery, aortic aneurysm surgery, carotid endarterectomy—or blood vessel scraping—and coronary artery bypass surgery are under way.

The first phase of the initiative is funded by a $975,000 grant from the John A. Hartford Foundation and a $500,000 grant from the Commonwealth Fund, both in New York.

The project will be extended as additional funding is obtained.

### Petromark seeks new capital

NASHVILLE, Tenn.—Petroleum Marketers Mutual Insurance Co. is seeking $18 million in capital contributions from policyholders by April 9 to avert a collapse caused by severe reserve deficiencies.

In a March 22 letter to policyholders of the risk retention group, President Scott F. Blankinship said an actuarial review by the Tillinghast division of Towers, Perrin, Forster & Crosby Inc. "generally confirmed" severe underreserving reported in a study by The Wyatt Co.

Wyatt found Petromark's reserves deficient by $20 million, a shortfall that would cause the insurer's surplus to drop from a reported $9.5 million at year-end 1989 to a deficit of $10.5 million.

Mr. Blankinship said last month that if the Wyatt findings were confirmed, Petromark would need to raise additional capital or face liquidation by the Tennessee Insurance Department (*BI*, Feb. 19).

Petromark is asking its 1,100 policyholders to contribute an amount equal to 100% of their projected annual renewal premium. The company would raise $23 million if all policyholders contribute, but it is assuming that some will drop out, said Max Clay, president of The Planning Corp., the Reston, Va.-based underwriting manager for Petromark.

Non-contributing members will not have coverage renewed.

Petromark—which has been operating under Insurance Department supervision since Feb. 7—has stopped writing new business and offers only 60-day renewals pending the outcome of its capital infusion plan.

Members are scheduled to meet April 5 to vote on the plan.

### Fortunato named N.J. regulator

TRENTON, N.J.—The New Jersey Senate is expected to confirm former insurance executive Samuel Fortunato as insurance commissioner, following his appointment by Gov. James Florio.

Mr. Fortunato, who most recently had a private law practice in Little Silver, N.J., is former chairman, chief executive officer and president of Metropolitan Property & Liability Insurance Co. of Warwick, R.I. He held a variety of positions at the subsidiary of Metropolitan Life Insurance Co. from 1976 to 1986.

Gov. Florio also appointed Jay Angoff, coordinator of auto insurance reform group Citizens Auto Revolt and former counsel to the National Insurance Consumer Organization, and Jasper Jackson, who is now serving as acting commissioner, to deputy insurance commissioner posts.

Former Insurance Commissioner Kenneth Merin, a Republican, resigned in January shortly before Gov. Florio, a Democrat, took office (*BI*, Jan. 15).

*Updates continued on page 38*

### Errors & omissions

• The gross revenues of Feasterville, Pa.-based First Risk Management Co. were incorrectly stated in the directory of risk management consultants in the March 12 issue. First Risk Management's total 1989 gross revenues were approximately $1 million. Pure risk management consulting revenues totaled $820,000. Also, First Risk Management (P.R.) Inc. is a San Juan, Puerto Rico-based subsidiary.

• Robert D. Brignall's law firm has changed its name to Vandeveer, Garzia P.C. and is located in Detroit. The firm's location was incorrectly reported in the March 12 issue.

# Byrne blames bad audits for several insolvencies

**By DOUGLAS McLEOD**

WASHINGTON—Shoddy accounting practices are undermining property/casualty insurer solvency, and regulators and insurers must correct these practices to avert future insurer failures, a prominent insurer executive says.

While fraud has contributed to some insurer collapses, poor financial reporting presents a more pervasive threat to the industry, John J. Byrne, chairman and chief executive of Fund American Cos. Inc., parent of Fireman's Fund Insurance Cos., told the House Oversight and Investigations Subcommittee last week.

"There are indeed solvency problems in the insurance industry which permeate even those companies in which criminal or wrongful behavior has never taken place," Mr. Byrne said.

"Insurer accounting practices leave much to be desired, and unless regulators and insurers themselves make a commitment to disciplined balance sheets and honest accounting practices, our problems will only grow," he said.

Mr. Byrne was one of several insurance officials—including representatives of the National Assn. of Insurance Brokers and the Reinsurance Assn. of America—to comment before the subcommittee on the insurance solvency report it released last month (*BI*, Feb. 26).

Focusing on the failures of Mission Insurance Co., Transit Casualty Co. and Carlos I. Miro's Anglo-American Insurance Co. of Louisiana, the report labeled state insurance regulation "seriously deficient" and drew parallels between insurer insolvencies and the early stages of the savings and loan crisis.

Mr. Byrne testified last Monday that the report was "a bit apocalyptic," adding that it "simply is not true" that the insurance industry is "teetering on the brink of insolvency."

However, he outlined several financial reporting practices that he suggested distort insurers' true condition and make solvency regulation more difficult.

In statutory financial statements, he noted, insurers report bonds at their original cost rather than current market value, and "that is a serious flaw, in my opinion."

Differences between cost and

*Continued on page 36*

**Good management trims claims for utility**

# Cutting work comp costs

**By MEG FLETCHER**

NEW ORLEANS—The nation's "safest" utility controls workers compensation claims costs by emphasizing safety and bringing injured workers back to work as soon as possible.

Good management practices that cut down on the number of accidents also can help reduce the cost of claims that do occur, explains Martha H. Miller, workers compensation and rehabilitation administrator for Consumers Power Co. of Jackson, Mich.

Consumers Power, which self-insures its workers compensation risks, has received a National Safety Council award five times in eight years for having the fewest lost workdays among large U.S. gas and electric utilities, a company spokesman said.

Ms. Miller joined state workers compensation system administrators and insurers in discussing management practices at "Forum II—Workers' Compensation Healthcare Cost Containment—A Progress Report," a meeting held Feb. 28 to March 3 in New Orleans by International Workers' Compensation Foundation Inc. The foundation is an educational and research affiliate of the International Assn. of Industrial Accident Boards & Commissions.

Unlike many companies, the safety and health department, rather than the legal department, manages workers compensation claims. That "unusual" arrangement fosters open discussion between safety and workers compensation personnel and introduces the element of human suffering into safety deliberations, Ms. Miller said.

In addition, having senior managers review all workers comp cases involving lost work time gives lower-level managers incentive to eradicate problems before they cause claims, she said.

Joint employer-employee safety committees, intro-

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# Sheriffs' program to stop underwriting in New York

**By LINDA J. COLLINS**

NEW YORK—A controversial national police professional liability coverage program has agreed to stop writing business in New York state and has tentatively agreed to allow law enforcement agencies to leave the program under favorable conditions.

Under a proposed agreement between regulators and the American Justice Insurance Reciprocal, a risk retention group domiciled in Indiana, about one dozen participating New York police and sheriffs' departments have been offered two withdrawal options.

The New York department says the program has operated illegally in the state for years (*BI*, Feb. 5).

AJIR is the reconstituted version of The Star Pool, a self-insurance pool formed in 1986 and sponsored by The National Sheriffs' Assn. When The Star Pool was reformed into AJIR this year, pool members automatically became AJIR members.

AJIR was formed to resolve disputes with at least 10 states, which found that The Star Pool was operating illegally or without proper authorization.

The risk retention group is now set to write in 45 states and is seeking approval in other states, said Thomas A. Dickman, vp of J.W.F. Specialty Co., the AJIR's Indianapolis-based administrator.

In New York, the state general

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## Inside


- Allied-Signal's managed care network is a fine example of innovative solutions to soaring health care costs, says this week's editorial. **PAGE 8**
- In Speaking Out, RLI Corp.'s Gerald D. Stephens outlines how the insurance industry must manage itself for success in the 1990s. **PAGE 23**
- Catastrophic losses in 1989 underscore the need for loss prevention and loss control in 1990, says Factory Mutual's John A. Love in Perspectives. **PAGE 24**
- Australians are divided over whether their highly competitive insurance market may be hardening. **PAGE 27**
- Six nations face legal action for failing to properly implement the EC's product liability directive. **PAGE 27**
- Weather-related losses are costing the insurance industry escalating sums of money, underwriters agree at a recent conference on global warming. **PAGE 27**


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# Stolen art not insured

## Lack of coverage not unusual: Brokers

**By STACY ADLER**

BOSTON—While much of the art community is shocked that the Isabella Stewart Gardner Museum does not have insurance to cover a $200 million art theft, the news surprises few in the risk management and insurance community.

Many small museums do not purchase fine arts theft insurance because the cost would be prohibitive, according to brokers specializing in placing the coverage.

While rates for the coverage have remained stable in the past few years, skyrocketing art values have made adequately insuring valuable collections very expensive, brokers say.

"More museums than you would think do not have insurance because their budgets are limited," said Bruce Perkins, vp and partner with brokerage Flather & Co. Inc. in Washington, D.C.

"A good deal of the smaller house museums do not carry theft insurance," he said.

Many museums "simply do not believe in insuring their permanent collections," agreed William Allen, president of Allen Insurance Associates in Los Angeles.

However, Hunter T. Block, a Washington, D.C., fine arts insurance broker, said that "most museums, regardless of size, carry some insurance."

**Rembrandt's 'The Storm on the Sea of Galilee' was among 12 pieces of art stolen March 18 from the Isabella Stewart Gardner Museum in Boston.**

The theft from the Gardner Museum—which has what is considered one of the nation's finest private collections—is believed to be the largest art theft in U.S. history. The museum, a converted four-story stone mansion styled after a 15th-century Venetian palace, has housed the collection since 1903.

Gardner Museum officials explain that one of the reasons the museum is not insured for theft is because the cost of the coverage would be "prohibitive."

Gardner officials say the museum was quoted $3 million in annual premiums for theft insurance.

However, Mr. Block called the quote excessive.

Museum officials also explained that they had little reason to purchase theft insurance because Isabella Stewart Gardner—a famous turn-of-the-century figure who assembled the collection—specified in her will that the museum could never buy or substitute other works of art.

"The board decided a number of years ago not to insure the collection since even if an insurance policy paid off, the museum could not use the money to replace the items lost," a spokesman explained.

However, the Gardner Museum does have insurance to cover damage to and restoration of its artworks.

The theft occurred on March 18, when thieves disguised themselves as Boston police officers.

After tying up two guards, the thieves disconnected the electronic security system and made off with a

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# 2 states move to ease benefit mandates

**By LOUISE KERTESZ**

Two states are expected to enact legislation that would encourage small employers to offer insured health care programs that do not provide coverage for procedures that the states now require insurers to cover.

The legislation in Virginia and Washington is an attempt to quash one reason why many small employers do not now offer health care coverage to their workers: the high cost of offering a broad array of state-mandated benefits.

For instance, many states require insured health care plans to offer coverage for chiropractic or mental health care services.

While many large employers can afford to self-insure their health care plans—and thus are exempted from state benefit mandates under the Employee Retirement Income Security Act of 1974—most small employers can neither afford to self-insure nor offer insured plans that meet state mandates.

As a result, about 47% of the 14.4 million working uninsured are employed by employers with fewer than 25 workers, according to the Pepper Commission (*BI*, March 12).

Observers say the so-called reduced-benefit programs authorized by the proposals are a step in the right direction, but that they would not solve all the problems created by state coverage mandates.

"I think they're great and every state ought to do it," said Woody Eno, an attorney in the Legal State Affairs Office of the Washington, D.C.-based Health Insurance Assn. of America, referring to the Virginia and Washington bills.

State coverage mandates have driven up the cost of group health insurance premiums, and "states have to find a way to provide basic coverage" without jeopardizing the survival of small businesses, he asserted.

For example, a 1989 Virginia Bureau of Insurance survey showed that benefits required under state laws hiked the cost of group health insurance in the state by 20%.

"The whole idea is to make the plan more affordable to small employers and increase the chances they will offer it to their employees," said Donna DeWitt, product manager at Blue Cross & Blue Shield of Virginia in Richmond.

In addition, "when states make benefits so diverse, they really hamper multistate insurers from offering programs on a national basis and getting economies of scale," pointed out the HIAA's Mr. Eno, who expects more states to allow small employers to offer health care plans that do not include certain mandated coverages.

However, he also cautioned that since benefit requirements vary from state to state, plans offering reduced benefits also will probably vary from state to state.

John Hickey, a partner with benefit consultant Kwasha Lipton of Fort Lee, N.J., agreed that the Virginia and Washington legislation is "a step in the right direction," because "employers should have the right to decide what insurance coverage to offer based on considerations of cost and employee relations."

But, Mr. Hickey said he supports eliminating state-mandated benefits for all employers, because many mandates are the result of "pressure from special interest groups like chiropractors and mental health practitioners who want to make sure they're covered."

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# Consolidation ahead for reinsurers: Experts

**By CAROLYN ALDRED**

HAMILTON, Bermuda—The 1990s will see a consolidation of the reinsurance industry, resulting in bigger, better-capitalized global reinsurers, reinsurance experts say.

"The insurance industry was meant to stabilize the balance sheet. One of the key qualitative advantages of transferring risk is to create stability," explained Albert J. Beer, senior vp of Skandia America Reinsurance Corp.

However, currently "it is not uncommon to see a company with billions of dollars of assets transferring risks to a company with millions of dollars of assets," he told delegates at the 14th International Captive Insurance and Reinsurance Forum.

The annual gathering of captive insurance and reinsurance experts was held March 13-16 by the Tillinghast division of Towers, Perrin, Forster & Crosby Inc.

The insurance and reinsurance industry "has been through a decade of chaos with significant price fluctuations and serious unrecoverables," Mr. Beer pointed out.

"I certainly see consolidation" in the 1990s, he said, adding that some "sages" have predicted that in five to seven years there will be just five to seven major insurance and reinsurance entities.

"International companies will have a significant advantage," said

Mr. Beer. "We will see a lot of activity to amalgamate" in the coming years, he predicted.

Even "captives themselves are starting to get more global," Mr. Beer said.

"The availability of cheap reinsurance in recent years encouraged a whole number of changes in the reinsurance market," said Jim Bannister, chairman of the DYP Insurance & Reinsurance Research Group Ltd., a London-based consulting and publishing company.

"A massive retrocessional market has been a feature of the reinsurance market. Why do big players retrocede to much smaller players? The cash flows from the rich to the less rich to the poor," he said.

However, "we have begun to see some very large losses exposing the retrocessional weaknesses," said Mr. Bannister.

As a result, the retrocessional market is surviving on "borrowed time," he warned.

Already, "30 Lloyd's of London syndicates have run out of reinsurance cover," in light of the many huge losses spiraling the retrocessional market, including the explosion of the Piper Alpha drilling rig and claims from Hurricane Hugo and European windstorms, said Mr. Bannister.

However, recent huge losses and the collapse of the retrocessional market could well cause "a dramatic change in the reinsurance market," predicted Mr. Bannister.

"The only people who can take advantage of the changes are the

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# PacTel to offer managed care network in '91

**By JERRY GEISEL**

SAN FRANCISCO—Pacific Telesis Group is the first of the regional telephone companies to unveil a managed health care network to try to hold down escalating medical costs.

Pacific Bell and several other operating units of San Francisco-based PacTel plan to launch a new managed health care network on Jan. 1.

The network, to be administered by CIGNA Corp., will replace several self-insured indemnity plans and a yet-to-be determined number of the 10 health maintenance organizations currently offered by PacTel and its subsidiaries.

"We believe it will allow us to bring down cost escalation to a manageable level," said Neil Austin, Pacific Bell's staff manager of health plans.

"We're spending over $250 million annually on medical care" and the new program will help contain those costs, added Jim Beck, director of health and welfare plans at Pacific Bell.

Health care costs have been increasing by 12% to 15% a year at PacTel.

PacTel's move comes on the heels of the announcement of spectacular cost savings reaped by Allied-Signal Inc., the first major company to offer a national managed care network with one insurer.

Morristown, N.J.-based Allied-Signal has said that, based on early results, it could save $200 million over three years from its network, also administered by CIGNA (*BI*, March 19).

More employers are expected to follow these companies' lead and scrap their traditional health care programs in favor of managed

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# Government seeks tougher benefit rules

By JERRY GEISEL

WASHINGTON—Benefit legislation proposed last week by the Labor Department would result in more lawsuits against employers by pension and welfare plan participants, boost penalties for violating federal rules and raise auditing costs, experts say.

Under the new enforcement package, which the Labor Department will ask Congress to act on:

- Courts would be required to award reasonable attorneys' fees and expert witness fees to plaintiffs who successfully sue employers or plan fiduciaries for violations of the Employee Retirement Income Security Act of 1974.

Currently, courts have the discretion to award attorneys' fees to successful plaintiffs.

- The current 5% penalty for engaging in a transaction that is prohibited under ERISA would be increased to 10% of the value of the transaction.

For example, if an employer improperly removed $1 million from its pension fund, it would have to pay a $100,000 penalty.

- The secretary of labor could award a "bounty" or a portion of the civil penalties assessed in a suit filed by the Labor Department to an individual who supplied information to the Department about the violation.

The bounty could amount to up to 10% of the civil penalty assessed.

- Courts would not give deference to decisions by pension and welfare plan administrators when reviewing cases involving the denial or reduction of benefits.

Instead, courts would have to engage in a "de novo" review, or a fresh review of the facts.

- Pension plan assets held by regulated financial institutions, such as banks and insurance companies, no longer would be exempt from full-scale audits.

While details of this provision have not been finalized, a pension plan's auditor would be required to receive a special report from the financial institution's independent auditors, and then the plan's auditor would determine whether the report is sufficient to meet the plan's audit objectives.

- Require an accountant to obtain a peer review every three years to be considered qualified to conduct a required ERISA audit.

In addition, the enforcement package calls for multiple employer welfare arrangements, also known as METs, to file registration statements with the Labor Department. The department says that this requirement would provide significant assistance to state insurance departments in regulating the trusts.

In announcing the proposed changes, Labor Secretary Elizabeth H. Dole said: "We need to put some teeth into our laws to make sure individuals can exercise their rights to protect their pensions. These changes in the law will make pension plans more accountable to the department and therefore better protect workers and retirees."

The proposals also come in the wake of charges by the Labor Department's Office of the Inspector General that pension funds could face financial problems along the lines of the current crisis in the savings and loan industry.

These charges have been rejected as absurd by benefit consultants.

"For the most part, pension plans are fully funded and are properly and lawfully run," said Steve Vernon, a consultant with The Wyatt Co. in Sherman Oaks, Calif.

"There has been an exaggeration of abuses," agreed Tom Butterworth, a consultant in the Rowayton, Conn., office of Hewitt Associates.

The Labor Department proposal to require courts to award attorneys' fees and expert witness fees to successful plaintiffs is likely to boost litigation against employers, benefit experts say.

"This will make it a lot more likely that plaintiffs' attorneys will accept an ERISA case," said John Woyke, a principal with TPF&C, the benefits consulting division of Towers, Perrin, Forster & Crosby Inc. in Valhalla, N.Y.

Experts disagree, though, on whether the "bounty" provision will result in more litigation against employers.

"Bounties could encourage employees to bring frivolous charges against employers," said Wyatt's Mr. Vernon.

But TPF&C's Mr. Woyke said he doubted whether many more employees would turn in employers to receive a bounty.

At the same time, limited Labor Department enforcement staff resources means the department only could act on a relatively small number of employee tips, experts say. ■


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# Bank sues D&O insurer for coverage

By MARK A. HOFMANN

NEWARK, N.J.—Bank holding company First Fidelity Bancorp. is suing National Union Fire Insurance Co. of Pittsburgh, Pa., for $15.25 million to help cover a directors and officers liability settlement with a group of shareholders.

In a suit filed March 16 in U.S. District Court for the Eastern District of Pennsylvania in Philadelphia, First Fidelity claims that its primary D&O policy with National Union must contribute to a $30 million settlement in a class-action suit against 10 directors and officers by shareholders.

An excess D&O insurer, which First Fidelity would not name, is paying $14.75 million of the settlement.

A spokesman for New York-based American International Group Inc., National Union's parent, declined to comment on the case.

The shareholder suit, filed in U.S. District Court in Newark in March 1989, charged the defendants deliberately withheld information about bad loans made by Fidelcor Inc. of Philadelphia until nine months after the two banks merged in February 1988 to form the 18th-largest U.S. bank holding company.

In addition, the complaint alleged that some First Fidelity officers knew that those losses would drive down the stock price, and then sold their holdings in November 1988, before the losses were made public.

Under a tentative settlement of that suit, reached on March 16, defendants do not admit any wrongdoing, the First Fidelity spokesman said.

The agreement must be approved by U.S. District Court Judge Lee H. Sarokin. ■

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# Firm to penalize smokers, overweight workers

By MICHAEL SCHACHNER

U-Haul International Inc. employees and their dependents who use tobacco products or do not meet weight requirements will soon pay $10 per month toward the cost of their health care coverage under a program which is designed to focus employees' attention on wellness.

Phoenix, Ariz.-based U-Haul on April 1 will begin deducting from employees' semi-monthly paychecks $5 per covered life to combat rising health care costs in its self-insured health care plan. U-Haul's plan covers 18,000 employees and dependents.

However, the company says it will waive the $5 copayment requirement if covered lives do not smoke or use tobacco in any other form and if their body weight falls within certain specified limits.

Employees and dependents will be on the honor system to report whether they smoke or otherwise use tobacco and to report their accurate weight.

U-Haul workers currently are not required to make any monthly contributions toward the cost of their health care coverage.

The company said it is not trying to penalize employees but rather is trying to encourage workers to avoid the health problems associated with poor physical condition.

Current deductibles and coinsurance levels will be maintained under its health care plan.

Deductibles are $100 for individual coverage and $250 for family coverage.

The plan pays 80% of health care costs above the deductibles and 100% of costs after individuals incur $1,100 in annual out-of-pocket costs and families incur $1,250 in annual out-of-pocket costs.

The U-Haul program is similar to a pilot program that Houston-based Baker Hughes Inc. began Jan. 1 (*BI*, Jan. 8).

**Benefit beat**

## Baseball benefit fund

Major League Baseball franchise owners will contribute $55 million annually over the next four years to the Major League Players Assn.'s health care and pension fund, under terms of the March 19 agreement that ended the owners' 32-day spring training lockout.

The annual contribution to the fund will represent a 41% increase from the $39 million annual contribution stipulated under the expired four-year contract.

The association uses the fund to finance a defined benefit pension plan for retired ballplayers and a group health care plan for active and retired ballplayers and their dependents, according to a spokesman for the Major League Players Assn.

A committee consisting of two player representatives and two management representatives will determine how the $55 million annual contribution will be apportioned among the benefit plans, the spokesman said.

The players association spokesman declined to comment on when the committee would make its determination.

## Vision care benefits

Workers want annual eye examinations and the cost of a pair of eyeglasses covered under their group health care plans and would be willing to trade some other benefits for vision care coverage, according to a survey of 1,005 workers nationwide conducted by New York-based Research & Forecasts Inc.

Slightly under a third of those responding to the survey said their group health care plans cover the entire cost of eyeglasses, according to the "Pearle Managed Vision Care Report on Public Attitudes Toward Eye Care," prepared for Pearle Managed Vision Care, a subsidiary of Dallas-based Pearle Inc.

Of the approximately 693 workers whose current group health care plans do not cover the cost of glasses, 66% said that those plans should cover the cost of one pair eyeglasses annually .

The survey also found that about 35% of the respondents are covered for annual eye examinations under their group plans.

Of the approximately 65% of respondents who are not covered for an annual eye exam, 69% said such annual checkups should be covered.

According to the survey, 18% of the respondents have not had an eye examination in the past three years because of the cost of eye exams.

By comparison, 23% of the workers have not had physical examinations within the past three years and 22% have not had dental examinations in the past three years because of the costs of those exams.

The survey also asked the workers what benefits they would be willing to trade for these vision benefits.

Thirty-six percent of the workers reported they would trade their current mental health care coverage for programs that would pay the cost of an annual eye examination and the cost of one pair of eyeglasses.

In addition, 45% of workers aged 18 to 34 would make the trade-off, compared with 32% of workers aged 35 to 64, and 26% of workers 65 and older, according to the survey.

Meanwhile, 64% of workers would trade a vacation day for the benefit, 58% would trade two personal days, 17% would trade coverage for an annual physical, 16% would trade their dental coverage, 11% would trade their disability insurance and 9% would trade their group life insurance benefit, according to the survey.

But, while nearly all survey respondents believed that employers could help contain health care costs if they offered more preventive care coverage, 62% said that including vision care coverage would drive up the overall cost of health care coverage.

Only 13% said overall health care costs would decrease if vision care coverage was included in employers health care plans, and 18% said including vision care would have no effect on employer's health care costs.

Copies of the survey are available free from Research & Forecasts Inc., Attention Pearle Inc., 301 E. 57th St., New York, N.Y. 10022. ■

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# Opinions

## Managed care scores victory

ALLIED-SIGNAL INC.'s bold national managed health care network is a shining example of what innovative employers—and their insurers—can do to hold down soaring health care costs.

Allied-Signal, as reported earlier this month (*BI,* March 19), estimates that its managed care program will save the company $200 million in health care costs over the program's three-year course.

Indeed, Allied-Signal says annual per-capita health care cost for the 43,000 employees in the managed care program, which began in March 1988, was about $2,450, or 23% less than the $3,200 cost the company projected had the employees and their dependents remained in a traditional indemnity plan.

Allied-Signal Chairman and Chief Executive Officer Edward L. Hennessy Jr. had it right when he said that companies have to learn to manage health care costs just as they manage other business expenses.

Many companies, though, have done very little to truly manage their health care expenditures. In many cases, when health care costs rise, employers simply raise deductibles or coinsurance requirements, an approach that shifts costs rather than manages them.

Allied-Signal has been successful in managing its health care costs because its strategy focuses on changing the behavior of both employees and providers.

Under the strategy, employees have financial incentives—in terms of enriched benefits—to use a network of CIGNA Corp. health maintenance organizations. At the same time, providers in that network have incentives to offer necessary but cost-efficient health care.

Primary physicians, for example, typically receive a fee for each Allied-Signal employee that selects them, while specialists are paid on a schedule and hospital payments are made on a per-diem basis.

It's clear that the program is eliminating a lot of unnecessary care, a key cause of spiraling health care costs. Allied-Signal reports, for example, that hospital stays for participants in the managed care program averaged 4.8 days, compared with an average length of stay of 7.3 days for employees and dependents covered under Allied-Signal's indemnity plan.

The message that Allied-Signal's program should deliver is that rising health care costs are not an immortal dragon, but can be slain through gutsy, imaginative actions.

Allied-Signal, of course, is not the only employer using its ingenuity to try to tame health care costs.

For instance, we recently reported on how several employers are running medical clinics as part of a successful strategy to control and manage costs (*BI,* March 5).

The success of Allied-Signal and other employers in controlling health care costs should not be lost on those policymakers in Washington who want to dictate the structure of employer-provided health care plans.

If employers are forced to offer a strict federally prescribed set of benefits, innovative strategies to control health care costs, such as Allied-Signal's, could be lost and health care inflation will remain unchecked.

We hope that never is allowed to happen.

# Letters

## Another flaw in Visclosky bill

To the editor: The March 5 article proclaimed "Business Rips Visclosky Bill." A dozen arguments against the bill were cited. They ranged from the bill being unnecessary to unworkable.

I was somewhat surprised that none of the rebuttals included a comparison of the history of jointly trusteed funds vs. company-sponsored funds.

The investment experience of the multiemployer plans historically has been at least 1% lower than a single-employer defined benefit plan. With this bill Rep. Pete Visclosky, D-Ind., is asking corporate America to increase its retirement plan costs about 20% (actuaries say a 1% decrease in return increases costs 20%).

The Multiemployer Pension Plan Amendments Act of 1980 and its attendant withdrawal liabilities give ample evidence of how poorly jointly managed plans have funded many of their benefit obligations.

Rep. Visclosky has stated, "My justification for the bill is that the money is theirs (employees')." Courts have upheld that the funds belong to the companies and have allowed reversions. The benefits are the employees' as they earn and vest them. How a company pays or funds for the obligation is up to the company. The bill is bad pension policy.

The company-sponsored system with ERISA protection for employees is working well. The Visclosky bill just complicates administration with no cost benefit justification.

**Joseph G. Charles**
Group Director
Government and Industry Relations
Ryder System Inc.
Miami

*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.*

## Only attorneys win in coverage fights

To the editor: While the industrial giants and the insurance giants fight over who will pay for environmental cleanup, they both fall into the legal trap that has been set for them.

This legal trap will cost the taxpayer several billion dollars over and above the pure remedial cost.

Industry and insurance companies must join together to work for responsible legislation to cause remediation free of legal cost.

Environmental attorneys turn garbage into champagne before our very eyes.

**Richard K. Fox**
R. K. Fox & Associates
Noblesville, Ind.

## Tort proposal shifts cost to work comp

To the editor: In our haste to enact meaningful federal product liability reform legislation, let us not overlook the seemingly innocuous provision buried in S. 1400, the product liability reform bill now before the Senate Commerce Committee, that would shift much of the current cost of product liability onto the workers compensation system (*BI,* March 5).

The employers that fund the workers compensation system generally are not the same as the manufacturers that pay product liability costs. Let us reform the product liability system. Let us not merely shift the liability onto the backs of companies whose employees happen to be injured by other people's products.

**W. Kirk Liddell**
President
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# Reinsurance

*Continued from page 3*

major players. 1990 may be the year when the big players get back their large share of the reinsurance market," Mr. Bannister said.

Policyholders and insurers "need more stability and reinsurers need more size than ever before because of the unpredictability and size of risks today," added Tom N. Kellogg, senior vp of General Reinsurance Corp. of Stamford, Conn., the largest U.S. reinsurance company.

In the last three or four years, General Re "has spent many more hours studying companies we place our retrocessions with. We now only place our own retrocessions with institution-size companies," he said.

"Sometimes that means we have to say goodbye to some old, small friends," he said, adding that ceding companies more and more are looking for reliability.

"And reliability is being there 20 years from now to handle the claims and pay for the claims," said Mr. Kellogg.

"Capital is important to focus on because it provides the bedrock to pay for losses," he explained.

And capital can "evaporate overnight" as recent sharp downturns in the Japanese stock market have shown, Mr. Kellogg pointed out.

Mr. Bannister

Mr. Kellogg

Mr. Kellogg noted that initial 1989 returns from 63 members of the Reinsurance Assn. of America show that the U.S. reinsurance industry reported a policyholder surplus of $11.9 billion, compared with net written premium volume of $10.7 billion.

While Mr. Kellogg first noted that "policyholder surplus seems to be adequate," he then asked, "How solid and willing is that capital?"

Mr. Kellogg continued by rhetorically asking how leveraged the capital would be "by exposures; by ambiguities in loss reserves; by (tightening) retrocessional capacity; by changes in the value of assets; by cash flow; by pyramiding of corporate structures; by currency exchange rates?"

"There seems to be enough capital but there are things happening that could shrink that capital," warned Mr. Kellogg.

For example, recent catastrophes will dramatically decrease gross retrocessional capacity, Mr. Kellogg said, agreeing with Mr. Bannister.

"Lloyd's and other foreign markets have completed their retreat from the U.S. casualty area. Today, the pull will be from the property catastrophe" market, he said.

The reduction of retrocessional catastrophe protection will "decrease the viability of small reinsurers," Mr. Kellogg believes.

"Before, a small reinsurer may have taken a $1 million to $2 million gross line on a catastrophe program. But without retrocessional cover, or with the prohibitive costs of retrocessional cover, it may now only be able to write a $250,000 to $300,000 line," he said.

As a result, the small reinsurer will be shown less business and will be forced to write the lines no one else wants to take, Mr. Kellogg noted.

"Consolidation is going to be tougher for the smaller reinsurers," Mr. Kellogg said. The whole underlying risk structure of reinsurance has changed over the years, he noted.

"Insurance started off insuring property; it now insures large amounts of casualty. That's a big change. There never has been a time with as much loss reserves compared with policyholder surplus," he said.

According to A.M. Best Co., the industrywide ratio of loss reserves to policyholder surplus has increased to an estimated 197.8% in 1989 from 111.7% in 1972, said Mr. Kellogg.

This is based on estimated 1989 property/casualty surplus of $134 billion and estimated reserves of $265 billion, according to Mr. Kellogg.

This development "leaves much less margin for insurers to make a mistake in their reserves," noted Mr. Kellogg.

"With that amount of leverage you have to get it right, which means studying losses in a way we have never done before," he stressed.

Mr. Kellogg noted that General Re recently asked several stock analysts what was the minimum amount of capital they felt was necessary to start a reinsurance company in the 1990s, said Mr. Kellogg.

To be taken seriously, the stock analysts believe, a reinsurer must have at least $150 million in capital and surplus and also must have "a recognizable management team and 'clear' capital," said Mr. Kellogg.

Meanwhile, reinsurers likely will move closer to direct policyholders as the distinction between insurance and reinsurance becomes more and more blurred, noted Mr. Beer.

Mr. Beer

"The insurance/reinsurance fuzziness is a critical issue which has to be addressed," he told delegates in a speech. "The concept of the reinsurance community has to be examined.

"The line is getting very fuzzy as to where insurance ends and reinsurance begins. It used to be very clear," he said.

In addition, as self-insured retentions rise and policyholders make increasing use of the alternative risk market "the ability of a reinsurance entity" to provide immediate access to a policyholder will increase, according to Mr. Beer.

Already "the reinsurance and primary insurance community are competing more and more for the same business," he said.

And, very often, the competitors are part of the same insurance group or corporation, he added.

*Continued on next page*

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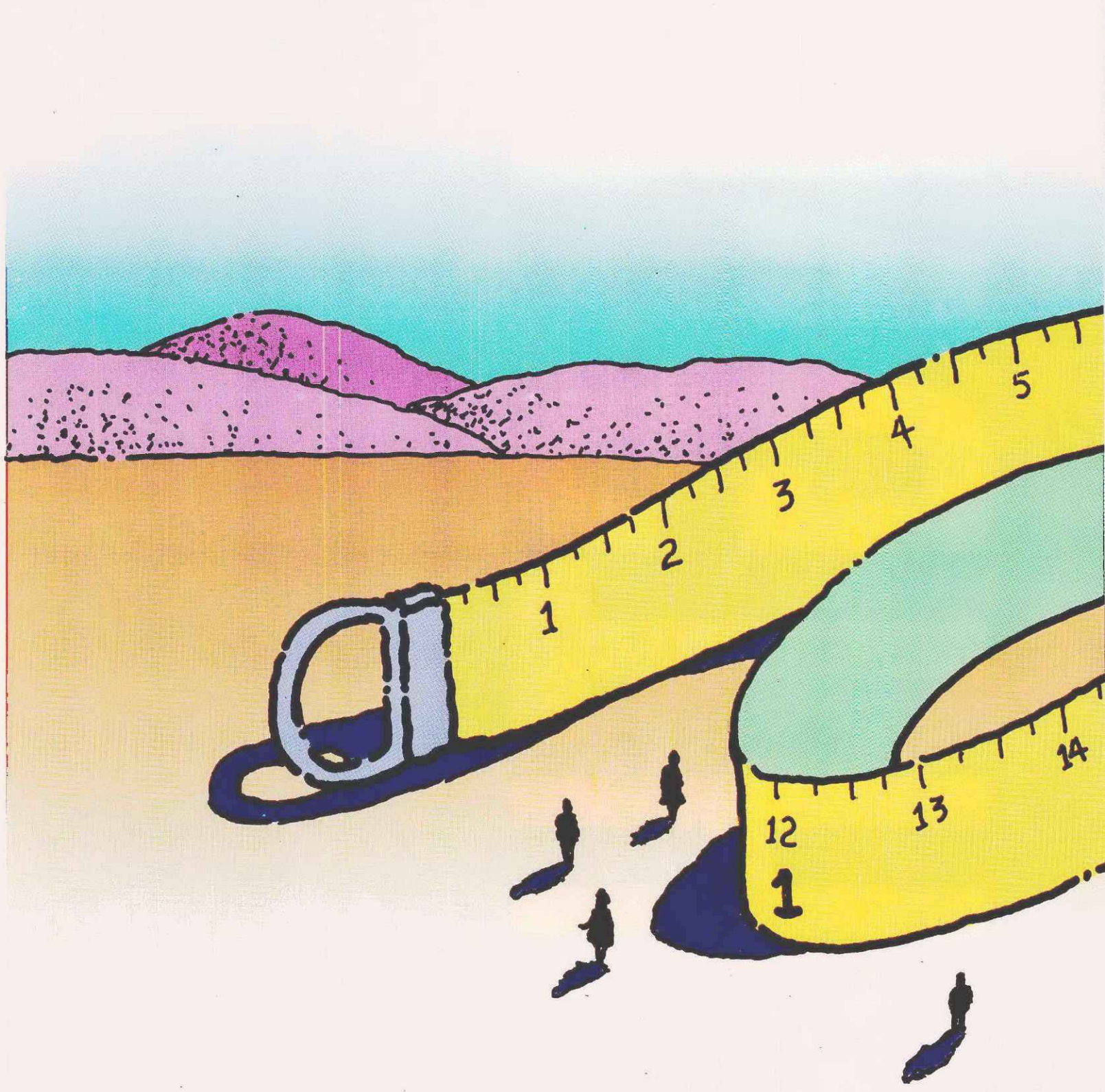

*Continued from previous page*

The 1980s was the era when reinsurers "were forced to react" by the buyers of insurance and this will continue, Mr. Beer contended.

For example, Skandia recently chose to establish a dedicated unit for the alternative risk market "as there's an alternative risk market which will not go away," he said.

"There really is an art to dealing with alternative risk transfer and we are seeing more and more people providing dedicated services to the alternative risk market," he noted.

"Reinsurers are going to have to offer more services to captives. Actuarial data, etc., is part of the underwriting process and should be available to the client," Mr. Kellogg said during a subsequent workshop.

"Reinsurers no longer can simply provide the traditional reinsurance" with no additional services, he added.

Meanwhile, Messrs. Beer, Bannister and Kellogg agreed that an offshore domicile is now the most suitable location to establish a new reinsurer with capital and surplus of $150 million to $200 million.

An offshore location offers financial advantages but, more importantly, it offers the most immediate access to the alternative risk financing market, the speakers pointed out following a question from the audience. ■

# Computers called key to future for insurers

**By MICHAEL BRADFORD**

HAMILTON, Bermuda—Information technology is shaping the future of the insurance industry, according to the head of a London-based consultant.

The industry's future "could well be entirely information-based," said Jim Bannister, chairman of DYP Insurance & Reinsurance Research Group Ltd. in London.

Information technology is rapidly developing, Mr. Bannister said at the 14th annual International Captive Insurance & Reinsurance Forum earlier this month in Bermuda. "Screen-based access to data is almost universal. Almost every policy file in the insurance industry in most of the world is now captured electronically."

But despite the technological advances in information processing, the amount of paper used in the insurance industry hasn't decreased much, he said, though "it will come."

The technique of image processing—which allows printed documents to be scanned into computer systems instead of typed in—will be the method by which paper files are reduced, he said.

"One of the reasons why claims service is so slow in London. . .is that the claims file wanders around. It's a dog-eared document often with 100 or 200 pages, carried around by claims brokers from one company to another. Image processing would mean that the claims file would be instantly accessible to any underwriter."

Mr. Bannister pointed out that insurance systems are being developed that will be "quite staggering" if they work.

These network systems could replace all the individual computer systems in the insurance market and tie brokers and insurers together, he said.

"Networks can facilitate the flow of information and they could lead to full electronic placing" of risks, Mr. Bannister predicted.

But, he said, "I don't see bargaining on big accounts being entirely displaced. It's almost impossible to visualize it." The majority of transactions, however, are fairly routine and lend themselves to electronic placement, he noted.

Captives also will be affected by the advances in information technology, Mr. Bannister said.

"If you've got a network where everybody can join in, why should captives be left out?" he asked.

Mr. Bannister said such an arrangement will make it much easier for captives and their parents to shop for unbundled services and coverages. "You key in and put it out for offer and have people bid for your business," he said.

And if a broker or insurer wants to know the type of business in which the captive's parent is engaged, image processing allows them to find out.

"If they want to know about you, they use image processing to look at any one of your plants," said Mr. Bannister. "There's the diagram, there's the photograph."

On another topic, Mr. Bannister said while taxation will remain an important issue to consider when forming offshore captives, there are other significant reasons to consider when establishing a captive.

He pointed out that "the attraction of Bermuda and other offshore domiciles is essentially a low or nil tax environment for the insurance company operation."

But the absence of local taxes is not the only reason for forming offshore insurers, he emphasized.

Captives can be an important "insurance buying weapon," Mr. Bannister pointed out. "When you've got a captive, insurance companies treat you in a different way.

"Companies with captives tend to be treated rather better—not always, it's not a general rule—by the insurance market," he said. And such treatment can come in the form of lower premiums from an insurer that fears losing an account to the captive, Mr. Bannister pointed out.

Captives also can function as profit centers, he noted, "especially in insuring related risks of the company." ■

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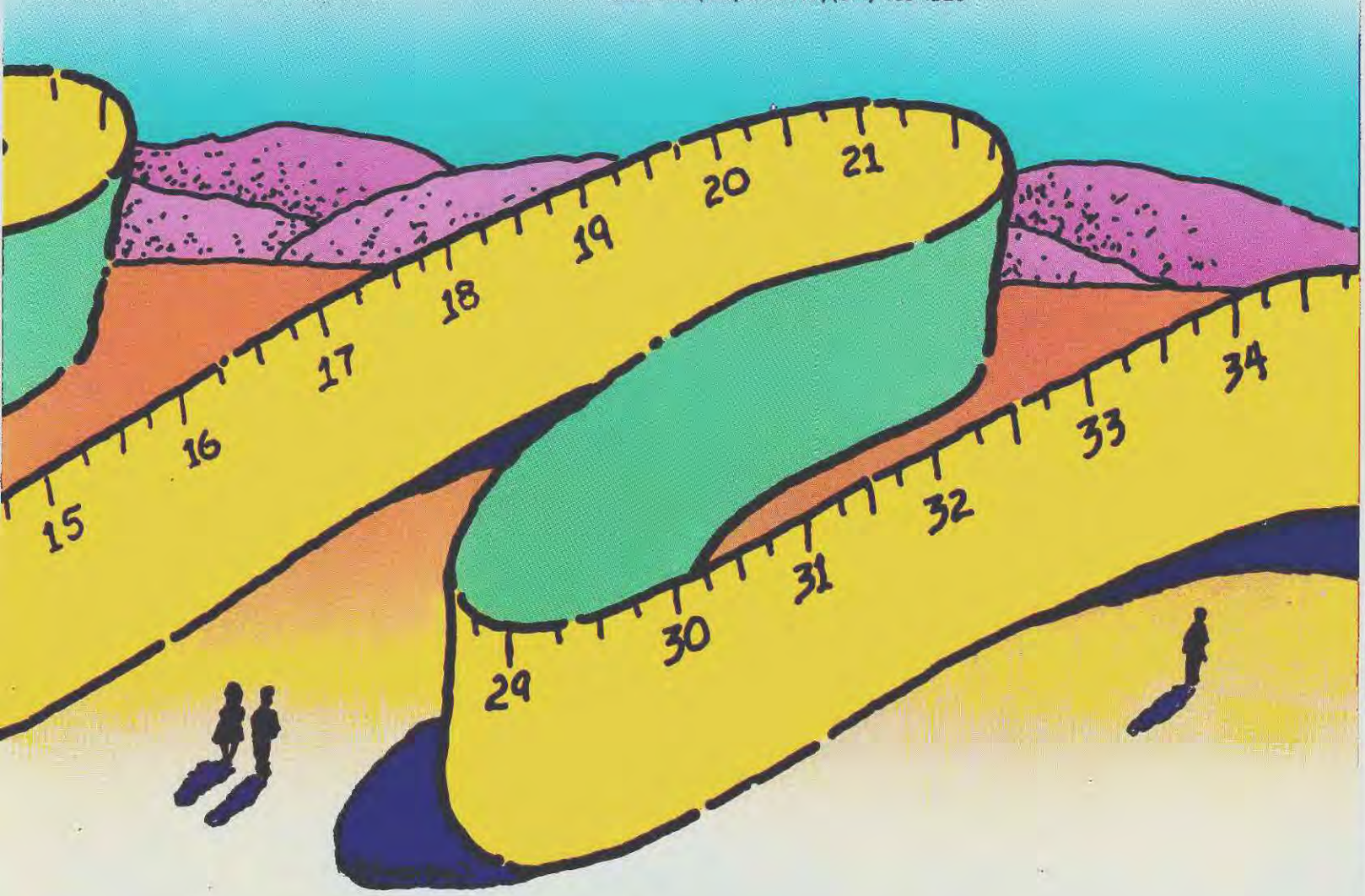

# Reducing captive confidentiality

## More data would aid planning: Manager

By MICHAEL BRADFORD

HAMILTON, Bermuda—Captive management would improve if captives relaxed some of their rigid confidentiality standards to make public more data on their operations, says the head of captive management for a large broker.

Charles M. Patrick Jr., chief executive officer of Alexander & Alexander Captive Management Services in New York, said providing more data would allow better planning for the worldwide captive community.

"What I am proposing is that as an industry, we develop means of publishing information which will provide accurate, solid data upon which all of us can base future planning," Mr. Patrick said during a panel discussion at the 14th annual International Captive Insurance & Reinsurance Forum earlier this month in Bermuda.

The move toward greater disclosure seems to be picking up momentum, according to the panel.

Dennis J. Farthing, chairman of the Institute of Risk Management in London, said that because captives are being formed less for tax reasons, they are more forthcoming with information.

"The tax element of captives has been pushed into the background," said Mr. Farthing. "And once that happens, I find people are willing to talk. I suspect you may find the information you seek will be easier to come by in the future because we are moving into a regime of disclosure."

H. Felix Kloman, panel moderator and vp and principal with Tillinghast in Stamford, Conn., said the number of group captives participating in an annual Tillinghast study has increased.

"The more open disclosure there is of information, I think the better we will be able to run these facilities, and on top of that, I think we're going to have a stronger argument with our friendly tax adversaries in the future," he said.

D. Hugh Rosenbaum, also a panel moderator and a principal with Tillinghast in Stamford, disagreed that increased disclosure will benefit the captive business.

With complete disclosure, Mr. Rosenbaum said, captives could come to be "judged in terms of classical insurance companies instead of on their own merits as risk financing, funding mechanisms."

A&A is heading full steam ahead into increased disclosure, according to Mr. Patrick.

The company has published data gathered by its captive management units and may expand the types of information it collects and prints, he said.

In fact, data gleaned from the files of A&A insurance managers "astonished us," Mr. Patrick remarked, adding that "not only were we getting data directly from the captive financial statements, but the totals were amazing."

For example, A&A found that captives it managed were strong moneymakers, churning out total profits of $78.5 million in 1988.

A&A decided to gather the information because it had no consolidated data on premiums, profits and assets of captives under management, Mr. Patrick said.

"Confidentiality and secrecy still make it difficult to tabulate data on captive insurance companies," he remarked. "Some domiciles treat the formation of these entities as confidential and therefore published information on them must be developed in other ways. Other domiciles consider licensing of an insurance company as public information, but no other information, financial for example, is published."

A&A asked its captive managers for net premium, net profit, loss reserves, total assets and other financial information. Reports came back from offices that manage 162 captives in several domiciles.

By its calculations, A&A managed captives that wrote $505.6 million in gross premiums in 1988 with capital and surplus amounting to $541.3 million. Results also included a breakdown of gross premiums and profit reports for each domicile and captives' total assets and equity in each location.

The company was excited enough to publish the results in a pamphlet—"1988 Composite Financials"—Mr. Patrick said. "We may be the first management firm ever to release this type of information to the public."

Profit information is particularly important, claims Mr. Patrick, "because it should be, in our opinion, a key performance measure for captives." In many cases, he added, parents thinking of forming captives won't approve formation unless there are solid indications that they can be moneymakers.

Although he acknowledged that forming a captive as a profit center is a controversial notion, Mr. Patrick also said that an unprofitable insurance subsidiary will not survive in a long-term business plan.

Mr. Farthing said, however, that the emphasis should be on risk management, not profits, when structuring a captive.

In selling the captive concept, people do themselves a disservice if they allow themselves to be "driven down that track," he said. "Once you've started on that, you've set the pattern," he added, and the attitude that the insurer should be a moneymaker first and a risk management tool second will prevail.

"I think a lot more effort ought to be put into selling the captive as a risk management tool only," Mr. Farthing remarked. "Emphasize that it isn't there to make money."

Mr. Kloman said, "All too often we've seen captives formed with minimum capital because the promoters of the captive say, 'Look how little you can set aside and what you can do with it and how easy it is to gain access to the reinsurance market.'

"If indeed it is going to be a risk management tool and indeed a risk management reserve," said Mr. Kloman, "I would argue the other way: that you ought to substantially overcapitalize the facility."

The company should be run at "zero profit" every year and the capital may become a contingency reserve for future claims, said Mr. Kloman. ■


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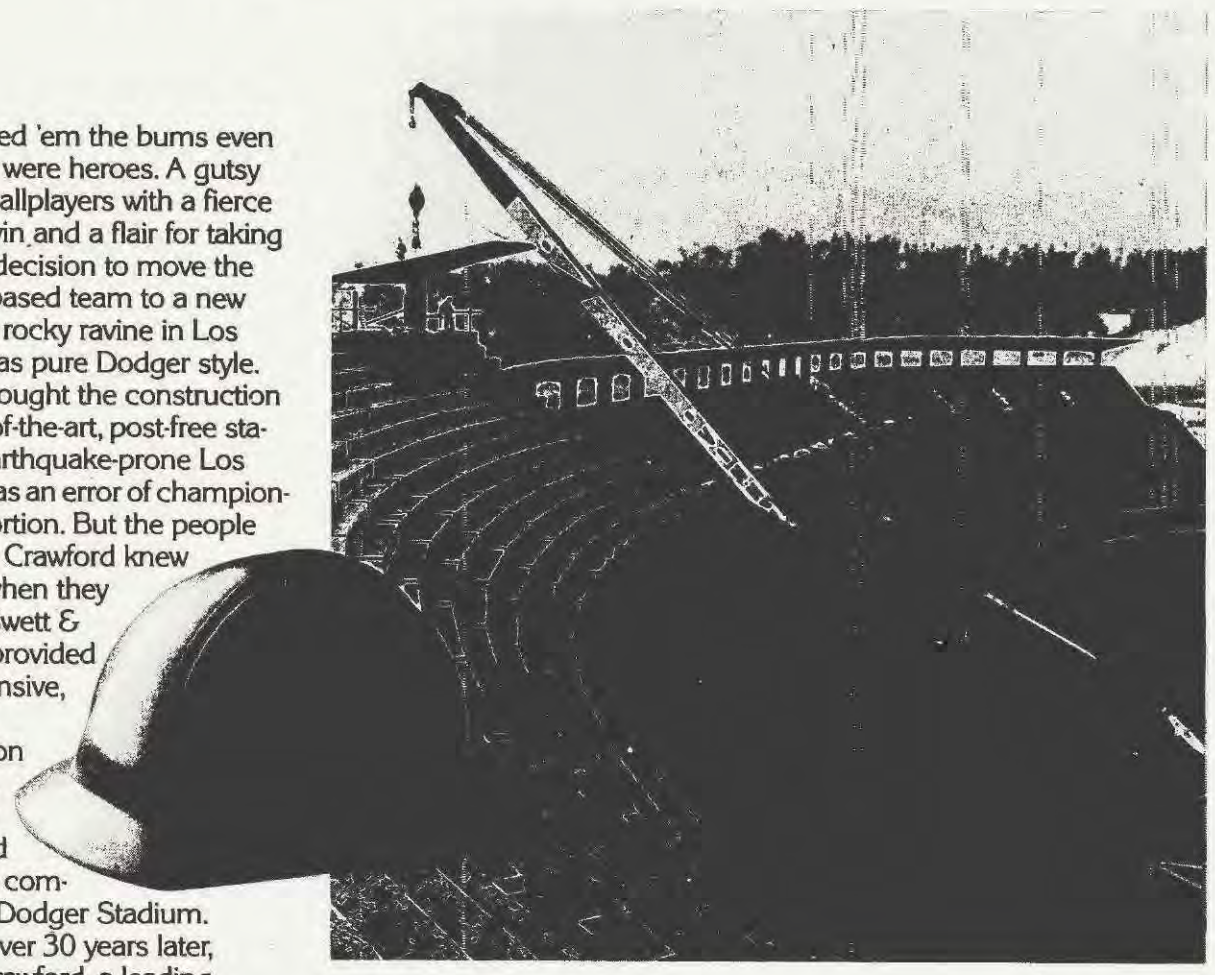

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# Rate increases aren't sufficient, analyst believes

By KATHRYN J. McINTYRE

HAMILTON, Bermuda—Commercial property/casualty insurance underwriters failed to obtain the rate increases needed during recent renewals, an insurance industry stock analyst says.

"Average commercial prices increased 3% to 5%" at recent renewals, according to Myron M. Picoult, senior vp and senior insurance analyst at Oppenheimer & Co. in New York.

"It was a far cry from the 10% they were looking for," Mr. Picoult said at the 14th annual International Captive Insurance & Reinsurance Forum earlier this month in Bermuda.

"They needed at least high single-digit increases," Mr. Picoult said of commercial insurance prices.

Furthermore, Mr. Picoult suggested there is only a "50-50" chance that commercial insurers will raise rates enough in 1991 to improve their profits.

Mr. Picoult

Mr. Picoult said a combination of factors prevents commercial insurers from raising rates to produce acceptable profits for investors. Among these are "fear of pushing more business to captives," as well as concern about how insurance regulators would react.

"This industry defies logic" in its pricing practices, he said.

Mr. Picoult placed some of the blame for the insurance industry's poor pricing practices on insurance regulation and the guaranty fund system.

"There is no reason for major, well-run companies to make up for the stupidity of other companies," Mr. Picoult asserted, referring to assessments on solvent insurance companies to pay claims against insolvent insurance companies.

Mr. Picoult suggested that large commercial insurance buyers should not be provided with guaranty fund protection against the risk that an insurance company will go broke.

"If those buyers want to lowball, let them accept that risk," he said.

An alternate approach to solvency regulation may be "minimum federal standards," he said.

In addition, Mr. Picoult called for holding actuaries and accountants responsible for the accuracy of insurance company financial statements. "There is an enormous amount of compromising" in the preparation of financial statements, he said.

"The balance sheet is the real problem in this business and it's getting worse," he said. "The numbers being reported by insurers are dirty, plain and simple," Mr. Picoult pointed out, explaining that insurers are not properly recognizing the impact of higher taxes that they must pay, in addition to unrecoverable reinsurance and higher retentions.

The cost of new taxes adds "two to three points to the combined ratio," he said.

Mr. Picoult also suggested that insurance company management should hold more stock in their companies. "The amount of stock owned by executives is negligible," he complained. "It's far different when it's your money on the line," he said.

He advised risk managers to "do your own analysis" of the financial strength of insurance companies and to be "very demanding' of foreign insurers that do not provide the information and data needed to make that analysis.

Robert W. Sturgis, a vp and director of Tillinghast, commented later during a panel that "analysis will only take you so far."

"You also need to rely on your sense of smell and street talk," Mr. Sturgis advised risk managers. ■


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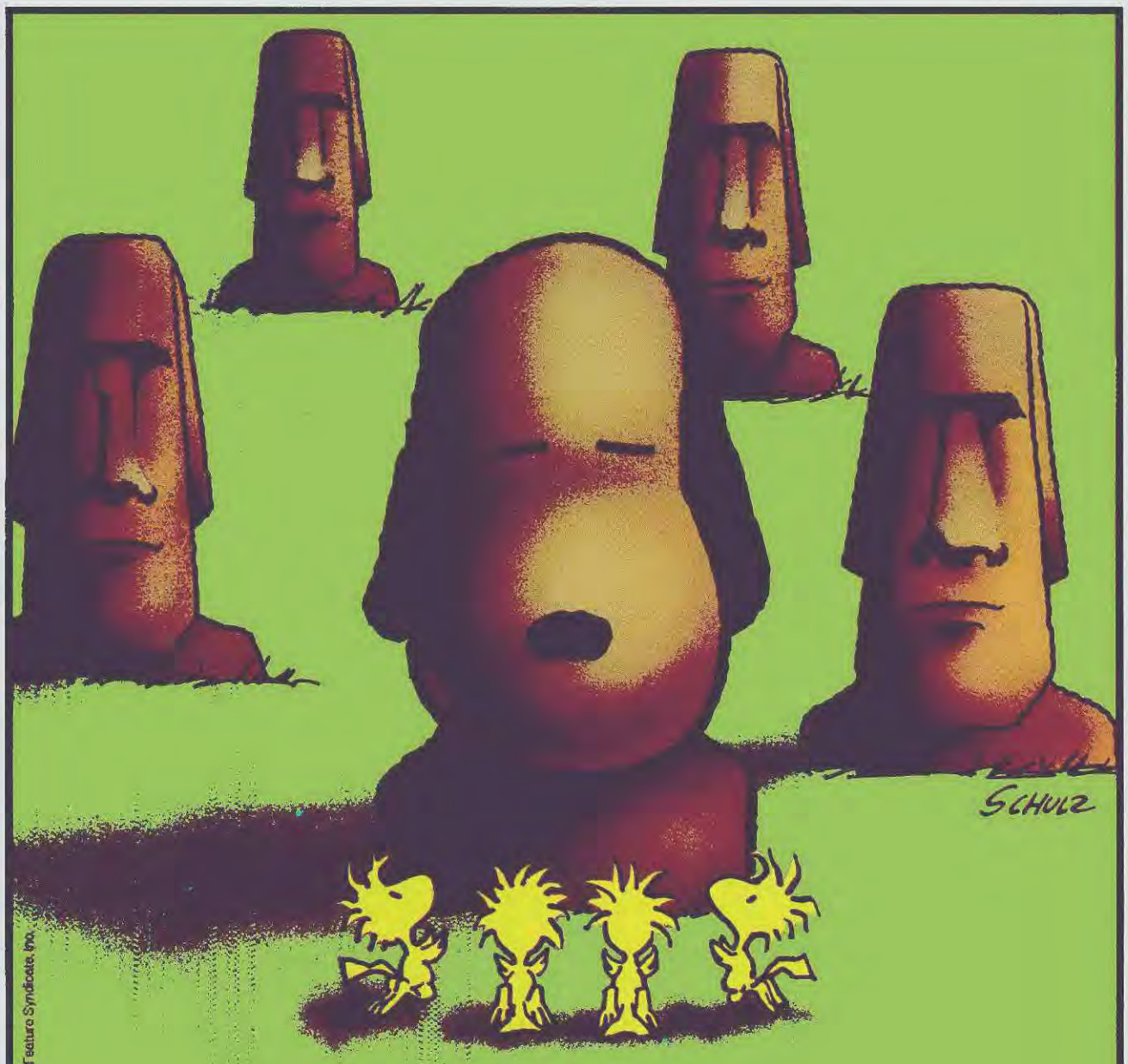


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# Need for captives remains strong

## Experts singing praises of single, group facilities

By MICHAEL BRADFORD

HAMILTON, Bermuda—Corporations and other institutions continue to need both single-parent and group captives, say those who have formed and managed the insurers.

Group captive insurers will work if owners have a long-term commitment and do not focus solely on price competition in the facility's early years, said speakers at the 14th International Captive Insurance & Reinsurance Forum in Bermuda earlier this month.

Another speaker praised single-parent captive insurance companies as flexible management tools, though he said they are often underutilized.

Arthur H. Deters, president and chief executive officer of International Risk Management Group Ltd. in Bermuda, said single-parent captives offer "an important, flexible tool in a large corporation's financial management function."

He described them as "the ideal vehicle to focus the corporation's overall risk management program, particularly for corporations that have a diversity of operations, or are geographically widespread, or both."

Most single-parent captive insurers are underutilized, according to Mr. Deters.

Mr. Deters

Particularly when outside managers run the captive insurer, there is often "a concentration on administration rather than effective utilization of the captive," he said.

Inside managers also underutilize the facilities, according to Mr. Deters. "Most risk managers and their outside insurance advisers are constantly going up the learning curve of how to use the captive insurance company more effectively."

Parent company structure may also retard growth of a captive, he said. "This is especially true when the insurance manager is not directly responsible for the captive or is instructed to view the captive as just another competitive market."

Mr. Deters attributes some of the current underutilization of captive insurers to their overuse in the past.

During captives' heyday in the 1970s and early 1980s, too many companies expanded too rapidly, "especially in the area of writing unrelated risks. And most of their results were either disastrous or something less than favorable," said Mr. Deters.

On the group captive side, Clyde Hall, risk manager at Princeton University in Princeton, N.J., said captive insurers with multiple ownership will continue to form.

"There are needs to be met, regardless of the market cycle," said Mr. Hall, whose university belongs to Genesis Ltd., a Bermuda captive that writes property/casualty insurance for educational institutions.

Mr. Hall predicts a continued expansion of both types of captives, especially for educational institutions.

Mr. Hall

Mr. Hall also listed characteristics that organizations considering formation of a group captive insurer should have in common:

- Size and scope of operations.
- "Appetite for risk" that the captive will assume.
- A willingness to resolve up front how captive members will share in premium allocations and financial responsibilities of paying claims.

A group captive should "first and foremost" have a strong risk management program, said Mr. Hall.

Group captives should also stress that members need to be in for the long haul, he said.

"This can be a problem. Risk managers can get very antsy when the market is down and quite frankly, I'm one of them."

Prices can be so low in a soft commercial market that members may ask, "Wait a minute, what am I doing in this captive?" Mr. Hall pointed out. "But nevertheless, long-term commitments are extremely important."

Arthur G. Broadhurst, vp of United Educators Insurance Risk Retention Group Inc., a Vermont-domiciled facility that provides educational institutions with educators' legal liability and excess liability coverages, agreed that commitments should be top priority among group captive members.

Mr. Broadhurst

Mr. Broadhurst pointed out that "memories are short and commitment to long-term solutions runs shallow when the immediate urgency of the hard market is no longer a factor. Insurance buyers and brokers who should know better become price buyers in a soft market."

A captive insurance company formed "for the primary purpose of providing lower price to member-policyholders is likely to disappoint its members" because savings will be limited in the early years, he said.

"Pricing must be conservative until there is sufficient operating experience, premium flow and spread of risk to justify lower premiums," according to Mr. Broadhurst.

He cautioned that in a soft commercial insurance market, such as the present market, "an alternative market cannot and should not compete on price."

Mary Breighner, director of risk management at Columbia University in New York, also participated in the panel discussion. ■


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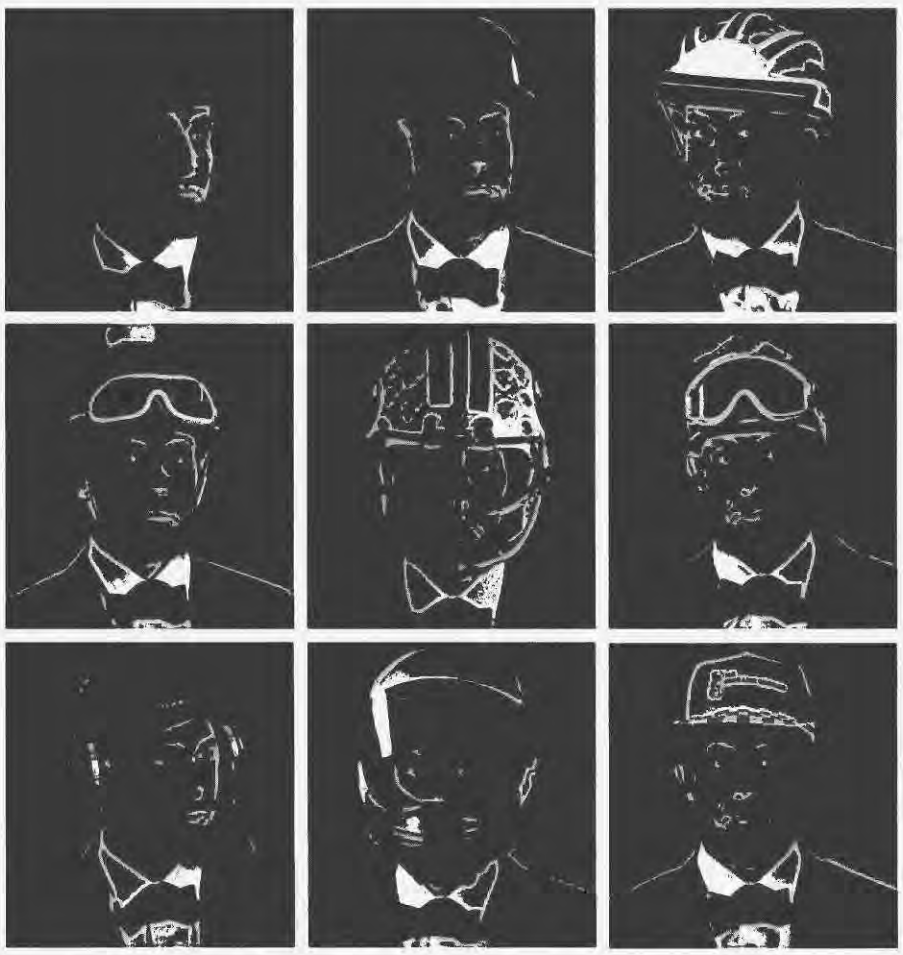

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# Captive premium write-offs still not resolved: Attorney

By CAROLYN ALDRED

HAMILTON, Bermuda—The tax man and the captive insurer still disagree on many issues and their skirmishes show few signs of abating, says an attorney.

The question of whether premiums paid to captives are tax deductible "has been around for 15 to 20 years and has been addressed in a dozen or so court cases," said George R. Abramowitz, a partner of Sutherland, Asbill & Brennan in Washington, D.C. Mr. Abrams has helped design and implement several group and single-parent captive insurance companies.

"It's remarkable to me that even though, after all this time, I can tell you about the issues, I can tell you very few answers," said Mr. Abramowitz.

Recent developments have "if anything, raised more questions," he said.

Differing interpretation of what should constitutes an insurance transaction is the main tax issue facing captives today, he said.

"It's long been established that insurance premium is tax-deductible and that an insurer can get tax credit for reserves," he explained. But to the Internal Revenue Service, "self-insurance is non-insurance and cannot be taxed as insurance until a loss is paid," he told the 14th annual International Captive Insurance & Reinsurance Forum earlier this month in Bermuda.

In the early 1970s "when the captive movement got up some steam, the IRS got concerned that something was not right and that the special benefits shouldn't apply to affiliates of companies writing insurance," he noted.

One clear result emerged from a series of legal challenges: A wholly owned insurer writing business for only its parent will not be treated as an insurer for the purposes of deducting premium payments, Mr. Abramowitz said.

However, the trend was upset by a 1989 ruling by the 6th U.S. Circuit Court of Appeals—in a case involving Humana Inc.—that said a subsidiary's premium payments to a captive insurer owned by its parent are tax-deductible, Mr. Abramowitz said (*BI*, Aug. 7, 1989).

Although the decision has not been appealed, "it is clear that the IRS is not buying" the Humana ruling and the issue still may likely be decided by the Supreme Court, he warned.

Meanwhile, the deductibility of premiums paid to captives that write unrelated third-party risks still is very unclear, according to Mr. Abramowitz.

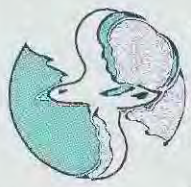
He said that before the Humana ruling, premium payments between related parties could apparently only be deductible if a captive was formed by several unrelated parties—a group captive—or if a captive insured a material amount of unrelated risk.

"Historically, the IRS has generally approved of group captives," said Mr. Abramowitz.

But "unofficially, the IRS appears to be backing away from" that position, he said. "Applying the 'economic family' analysis, some revenue agents have tried to disallow the deduction for a proportion of premiums paid corresponding to the payer's ownership interest in the captive."

The "economic family" theory, handed down by the IRS in a 1977 revenue ruling, states that since a corporation and a wholly owned captive subsidiary are part of one "economic family" and since the corporation ultimately bears the profits or losses of the captive, the transaction between parent and captive does not constitute insurance for tax purposes. This position was reinforced in a subsequent 1987 revenue ruling, which states that corporations cannot deduct premiums paid to a wholly owned insurance subsidiary regardless of how much unrelated business the captive writes (*BI*, Aug. 7, 1989).

For example, "under this theory, a 15% shareholder would be allowed to deduct only 85% of the premiums it paid," he explained.



Mr. Abramowitz praised a 1987 U.S. Tax Court ruling on single-parent captives writing unrelated risks.

In that case—which involved Gulf Oil Corp. and its Bermuda-based captive, Insco Ltd.—the Tax Court denied deductions of premiums to a captive, but said in a footnote that if "at least 50%" of a captive's premiums are from unrelated business, such deductions may be allowed (*BI*, Jan. 18, 1987).

Despite that footnote, the IRS has maintained that adding unrelated risks to a wholly owned insurer's pool of business "under no circumstances can affect the analysis of whether there is true insurance between a parent and a related party," said Mr. Abramowitz.

The difference in the two approaches arises because the IRS looks "only to an insurance company's ownership to test for risk shifting instead of looking to basic insurance theory," said Mr. Abramowitz.

"In the ordinary course of an insurance company's business, insured losses are paid out of the insurer's pool of premiums rather than out of the capital. The IRS refuses to recognize that capital plays a subordinate role to policyholder premiums in the traditional framework of insurance, with premiums intended to be sufficient to cover expected losses and capital serving only as a cushion against adverse loss experience," he wrote in a paper to delegates.

"The pooling process should, through adjustments to premium rating, cause losses to be paid by insureds participating in the pool as such, and not by the insurers through payments out of capital," he said.

But "other than the Tax Court in Gulf Oil, no court has yet addressed the effect of unrelated business on the characterization of unrelated-party insurance," he said.

"The IRS intends to pursue the extension of its economic family theory to these facts" and in fact has taken that position in two cases already tried in Tax Court but not yet decided, he said.

In a case involving the Harper Group—tried in March 1988 but rebriefed recently in light of the Humana decision—the IRS maintained that premiums paid by related parties to a captive that received 30% of its premiums from unrelated parties were not deductible.

And in a case involving Amerco Inc.—tried in September 1989—the IRS argued that premiums paid by related parties to a captive with unrelated business of more than 50% were not deductible, said Mr. Abramowitz.

At least two other cases currently docketed in Tax Court also involve captives assuming unrelated risks, he noted.

In one, Sears, Roebuck & Co. says it should be allowed to deduct premiums paid by Sears and affiliates to Allstate Insurance Co., a wholly owned Sears subsidiary, and to the now-shuttered Northbrook Excess & Surplus Insurance Co., whose ultimate parent was also Sears (*BI*, March 13, 1989).

During the tax years at issue, Allstate received more than 99% of its premiums from policies covering risks of parties unrelated to Sears or its affiliates, while Northbrook received more than 94% of its premiums from unrelated parties, said Mr. Abramowitz.

In a similar case, Berwind Corp. of Philadelphia is arguing for a deduction, noting that captive's business from unrelated parties exceeded 50% of total premiums during the years at issue, he pointed out.

"Even in the extreme Sears-Allstate case, the IRS has maintained that unrelated business does not affect the character of the transactions between Sears and its affiliates and Allstate as self-insurance," he said.

Decisions in Harper and Amerco are expected this year, but "they are not likely to be definitive on the issue of the effect of unrelated risks" on the deductibility of premiums paid to captives, said Mr. Abramowitz.

"In reality, uncertainty will exist until the cases have been appealed to the circuit courts and possibly even to the Supreme Court," he said, noting that both sides have recently appealed the Gulf Oil decision. ■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# State regulators faulted on handling insolvencies

By CAROLYN ALDRED

HAMILTON, Bermuda—State insurance department procedures are totally inadequate to handle the insolvency of a reinsurer or an insurance company writing casualty business, says a retiring counsel in the Illinois Insurance Department's liquidation and receivership bureau.

Insolvencies also can pose special problems for businesses that own captive insurers, said Garry Smith, former chief counsel to the Illinois insurance director.

Mr. Smith, who spent seven years with that department, spoke at a workshop at the 14th International Captive Insurance & Reinsurance Forum sponsored this month in Bermuda by Tillinghast, a division of Towers, Perrin, Forster & Crosby Inc.

State insurance insolvency procedures and state guaranty funds were established during the last 40 years to deal primarily with the collapse of substandard automobile insurers, said Mr. Smith.

The system operated adequately during the '50s, '60s and '70s, protecting "Moms and Pops" against the failure of auto insurers, he said.

However, in the early 1980s "the first rash of large companies started to hit the tubes, heralded by Mentor and Reserve," said Mr. Smith, referring to the collapse of Mentor Insurance Ltd. in Bermuda and Reserve Insurance Co. in Illinois.

And since then, "regulators have been forced to deal with" the insolvency of some very major insurance companies, he said.

Half of the 150 major insurance and reinsurance insolvencies in the United States since 1969 have occurred in the last five years, pointed out Ronald A. Jacks, a partner with Mayer, Brown & Platt in Chicago.

"Insolvencies are not a new phenomenon; they have been a fact of life for some time. But in the last few years insolvencies have reached truly alarming proportions," said Mr. Jacks, who moderated the session.

However, the entire state system for dealing with insurance insolvencies "doesn't contemplate the insolvency of a reinsurer or an insurer which has written long-tail business," said Mr. Smith.

In some states, "regulators' approach has been one of" let's attempt to ignore it, said Mr. Smith.

Frauds "do occur—happily, very, very, very infrequently," he said.

Only three of the 67 insolvencies he worked as counsel in Illinois could be identified "as being fraudulent in intent," he said.

"The vast majority of insolvencies are the result of inadvertent and unintentional mismanagement, inability to collect reinsurance recoverables and out-and-out stupidity," said Mr. Smith.

In addition, "insurance companies do have natural deaths" when, for example, their products become outdated or redundant, noted Mr. Smith.

Insolvency regulation is "geared primarily to the unsophisticated policyholder," he said.

However, insolvency procedures can become muddled when a sophisticated policyholder, like a company with a captive insurance company, is involved.

"The impact of all these insolvencies on captive insurance companies has generated substantial legal and regulatory issues," noted Mr. Jacks.

For example, some major issues that have yet to be resolved by regulators and the U.S. courts include:

- The extent to which offsets may be allowed between a captive and an insolvent insurer or reinsurer.
- The extent to which letters of credit may be subject to unauthorized draw-downs.
- The extent to which disputes between captives and insolvent insurers may be subject to arbitration.
- The extent to which suppliers to captives may be subject to third-party claims.
- The extent to which officers and directors of insolvent insurers may be liable to liquidators.

"The present philosophy of the U.S. regulators is all over the board," said Mr. Smith.

"Many states have attempted to forbid any offsets whatsoever; other states have allowed offsets on a per-contract basis only; and other states allow offsets based on mutuality between parties," he said.

Generally, U.S. insurance law requires "a pattern of mutuality to exist. If you have an insurer fronting for a reinsurer, the offset clause recognizes that there is no mutuality between the true reinsurer and the policyholder. The claims must come through the fronting company," said Mr. Smith.

There must be privity of contract for offsets to apply and there is no privity of contract between a captive reinsurer and the policyholder if there is a fronting company in the middle, said Mr. Smith.

However, there is a mechanism a "sophisticated captive parent company can use" to avoid problems when a fronting insurers become financially impaired, he said.

Clauses in many state insurance codes, including New York and Illinois, provide "a drop-down or pass-through ability," Mr. Smith pointed out.

"If you are sophisticated enough to put in an insolvency clause, if the fronting company becomes insolvent, the true risk bearer drops down" and the reinsurer can pay the claims directly to the policyholder, he explained.

"The insolvency clause clearly provides that in the event of insolvency, a fronting company liability will cut through to the captive. You can contract a clause like that although the regulator is not going to be too happy," said Mr. Jacks.

"States have argued that it's contrary to public policy," pointed out Mr. Jacks.

However, with no insolvency clause "the reinsurer's obligation is to the fronting company, and it is immaterial that the payment made to the fronting company may not then be made in full to the policyholder," he said.

# Insurer 'creativity' urged in risk control

By KATHRYN J. McINTYRE

HAMILTON, Bermuda—Insurance companies should do more to help risk managers develop data and information necessary for a successful risk management program, suggests a recently retired European risk manager.

Insurers should show "more creativity" in risk control programs and maintain data more precisely, says Dennis Farthing, recently retired risk management adviser to mining company RTZ Corp. P.L.C. and chairman of the Institute of Risk Management in London.

Insurers are "very bad" at keeping the information risk managers need on risks, Mr. Farthing said at the 14th annual International Captive Insurance & Reinsurance Forum earlier this month in Bermuda.

He said risk managers need assistance in developing risk assessments and risk control programs, noting that he was speaking from a "European perspective" on what are international issues.

With corporate management committed to earning profits on expenditures, "putting risk control in a high priority bracket is very difficult," he wrote in a paper distributed at the conference.

Insurers, therefore, need to provide risk managers with "credible risk assessment techniques for the various types of exposure to validate postulated loss scenarios" to obtain the resources needed for corporate risk control programs, he said.

Mr. Farthing also said insurers are failing to provide all the risk transfer products risk managers need, citing pollution liability insurance as an example.

"Risk managers are struggling to find devices to fund the loss areas that insurers are walking away from," Mr. Farthing said.

If commercial insurance isn't available as needed in the European Community, "it would appeal to the bureaucrats of the commission" to set up government programs to fund risk, he warned.

Mr. Farthing also lamented the "injection of law into the business of insurance between the buyer and the seller."

While underwriters and risk managers know what coverage they have negotiated, "far too often, it's taken out of the hands of the underwriter and the risk manager" and put in the lawyers' hands, he said.

He suggested international binding arbitration would be preferable to the current system of litigating coverage disputes.

Finally, Mr. Farthing criticized the insurance industry for spending too much time in conferences discussing insurance executives' approach to the business and too little time discussing "what the customer wants."

"You ought to have conferences about that," he said.

One of the most important legal cases involving offsets will soon be decided by the 7th U.S. Circuit Court of Appeals, Mr. Jacks said.

The liquidator of Chicago-based Reserve Insurance Co. asked the federal appeals court last November to overturn a 1985 District Court ruling that allows Reserve's reinsurers to offset 100% of some debts owed by the insolvent insurer (*BI*, Nov. 6, 1989). The case was argued before the 7th Circuit last November and December and a decision likely will be handed down by the court within the next month, said Mr. Jacks.

"This is going to be a truly significant decision as to whether offsets are allowable. What the 7th Circuit is going to hand down will become granite in U.S. law," he contended.

"If the U.S. Circuit affirms the trial court's decision—holding that reinsurers of fronting companies are able to offset—other states more likely will adopt the principle," said Mr. Jacks.

Meanwhile, the whole question of the admissibility of offsets in the United States is confusing and lacks clarity, said John Milligan-Whyte, a partner of the Bermuda-based law firm Milligan-Whyte & Smith.

The international reinsurance industry's approach to insurance and reinsurance disputes used to be based entirely on utmost good faith and a non-adversarial approach to settling differences, said Mr. Milligan-Whyte.

However, the international insurance and reinsurance industry was designed to meet the coverage demands of the 1950s. Demand has grown "so massively that the insurance industry is coming apart at the seams," he said.

"Massive changes have led to economic chaos, which led to legal chaos, which is leading to political chaos. We have a very disastrous scenario. A system which is out of control," he warned.

In Europe and London, reinsurers will offset debts to one another; that is the accepted practice, he noted. However, "the difference in approaches between the U.S. and Europe will create problems in collection" said Mr. Milligan-Whyte.

"Any disruption in the cash flow of reinsurance recoveries is going to disrupt the entire system," he warned. "The system is pretty highly leveraged and if there's a partial or complete collapse in the flow of payments it could seriously undermine the whole U.S. financial system." ■


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# Bermuda forum draws 200

HAMILTON, Bermuda—The 14th International Captive Insurance & Reinsurance Forum drew about 200 attendees to a week of unseasonably warm Atlantic weather and four days of meetings and events.

The conference, held March 13-16 at the Hamilton Princess Hotel in Bermuda, was better attended than the 1989 forum, which attracted 140 registrants. The annual meeting is sponsored by Tillinghast, a division of Towers, Perrin, Forster & Crosby Inc.

Bermuda's recent dry spell continued, but there was not much grumbling among registrants. At a time of the year that is often punctuated by showers in Bermuda, sunny skies and temperatures in the high 70s tempted attendees away from the meeting rooms.

This year's agenda featured a one-day "Captives in Brief" workshop that covered the basics of captive insurance, including discussions on the reasons for forming captives, tax and legal matters, and captive feasibility studies.

For information about the 1991 forum, contact Tillinghast, 695 E. Main St., Stamford, Conn. 06901; 203-326-5400.

# Captives told to focus on investment risk

**By MICHAEL BRADFORD**

HAMILTON, Bermuda—Captive insurance companies should be more concerned with risk than return when structuring the insurer's investment strategy, says a portfolio manager.

"I really do believe it's risk, not return, that dominates the long-run performance of your assets," said Geoffrey Towers, a portfolio manager with Citicorp in London, at the 14th annual International Captive Insurance & Reinsurance Forum earlier this month in Bermuda.

Identifying the biggest risk facing a captive's investment portfolio is simple, Mr. Towers says. The biggest risk is that an insurer will be unable to pay claims when they are due, he said, and meeting those obligations should be the driving force in investment decisions.

"It's not a question of beating an index," Mr. Towers said. "It's not a question of Dow Jones. What happens if I invest against the Dow Jones and the Dow Jones drops 50 percent? Are you going to say, 'I'm sorry, I can't pay my claims because the index went down?' "

Mr. Towers

An "almost golden" rule is that a captive insurer "should never invest more in any one investment than the fund could afford if the investment was wiped out," he advised. "The reason it isn't a golden rule is that even if you had two investments and they both went down for different reasons, you could still end up bankrupt or having the CFO breathing down your neck. But no one nasty event is going to wipe you out if you follow that rule."

Mr. Towers added, "It's really nothing more than reinsurance principles; it's just spreading the risk."

There are also credit risks and interest rate risks, Mr. Towers pointed out.

Credit risks are specific to each investment, he explained, and captive managers ought to consider "what happens if any one security runs into a problem."

Interest rate risks, on the other hand, are tied to far-flung influences like world economic conditions.

Credit risks, he said, "can wipe out part or 100% of everything you've got. They are extremely dangerous because they are very difficult to measure."

Default is the credit risk that gives most portfolio managers nightmares, said Mr. Towers. Such bad dreams, he said, rarely come true, because most investment-grade companies rarely "go bang overnight."

"Defaults are surprisingly rare," he said.

"Far more common is delay," Mr. Towers noted, pointing to Texaco Inc.'s 1987 bankruptcy filing as a classic case in which interest payments on its bonds were halted. "If you were relying on Texaco (investments) to pay your claims, what happens if you do get a claim while they're in Chapter 11?"

Liquidity, or "whether anybody wants to buy your debt or investments from you before maturity," is another credit risk facing the captive portfolio, Mr. Towers pointed out.

For example, Citicorp took over management of a portfolio that included an investment in a troubled savings and loan. That bond, he said, was impossible to sell. "There wasn't a broker in London or New York who would touch it."

Unforeseen events such as leveraged buyouts or tax law changes also can affect the creditworthiness of investments, Mr. Towers said.

Credit risks can be controlled by spreading investments among many different areas and by trimming the amount of assets invested in vehicles that can be hurt by those risks, Mr. Towers advised.

While credit risks can completely wipe out portfolios, the damage from interest rate risks is less severe, according to Mr. Towers.

"Interest rate risks can affect all of your assets, but to a lesser extent," he pointed out.

Interest rate changes are dangerous, however, because they come not only from fairly predictable factors such as inflation, but also from such unexpected sources as the tearing down of the Berlin Wall and the fall of communism across Eastern Europe, said Mr. Towers.

He offered one well-known piece of investment advice: Never buy into a mutual fund that has rocketed to a top performance one year after languishing in prior years.

"The reason you never buy into a mutual fund when it's at the top of the league is because the guy had a great bet and it paid off," said Mr. Towers. "The horse came in. Because to get to No. 1, to bring himself out of the pack, he's probably done so well in one bet that you've got to ask yourself: 'What happens if the bet doesn't pay off?' "

Instead of investing in those types of funds, "you want guys with good returns consistently with little risk," he advised.

Mr. Towers warned captive insurers they "shouldn't just look at return. You should try to find out how much risk your fund manager's taking." ■


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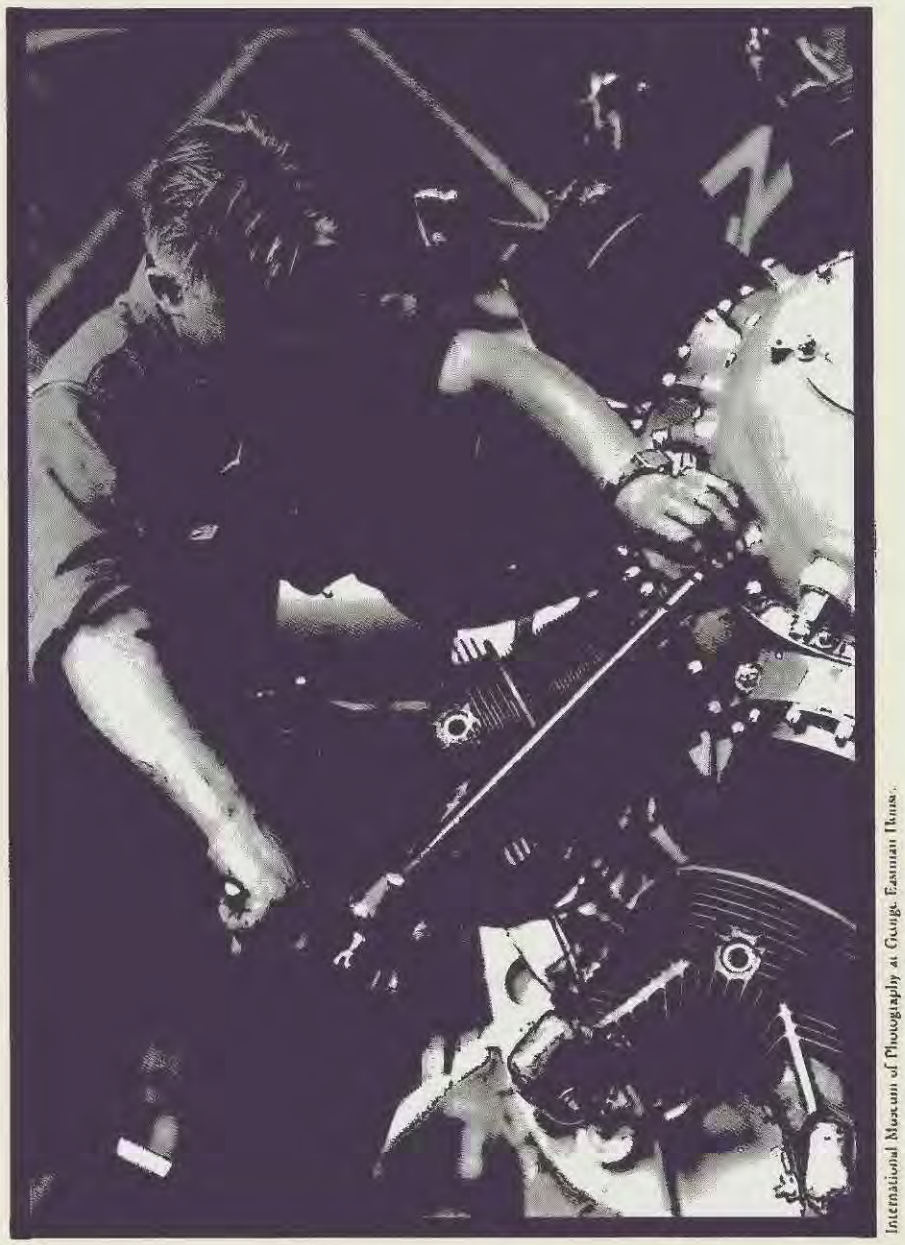

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# Blues preparing reduced-benefits plan

By LOUISE KERTESZ

RICHMOND, Va.—Blue Cross & Blue Shield of Virginia already is planning a low-cost health care insurance program for small employers that opt to offer health care coverage under the state's proposed reduced mandated benefits plan.

Under a bill designed to encourage small employers in the state to offer health care plans, certain small employers not currently offering health care coverage would be allowed to exclude state-mandated benefit requirements from insured plan offered to employees (see story, page 3).

BC/BS of Virginia in Richmond hopes to offer a reduced-benefit plan for small employers at approximately two-thirds the average cost of current comprehensive coverage, according to Donna DeWitt, product manager.

The proposed BC/BS of Virginia plan, which would be offered on a break-even basis, would cost $98 monthly for individual coverage, about 31% less than the $143 a month that large employers pay for comprehensive coverage.

Family coverage under the reduced benefits plan would cost $169 to $303 per month, or 25.7% to 58.6% less than the $408 per month under the BC/BS of Virginia's comprehensive major medical plan coverage.

The employer would have to contribute at least 50% of the cost of coverage for the employee.

Rates are "not firm," but are not expected to rise, Ms. DeWitt said. BC/BS of Virginia will continue to reassess costs and look "for more attractive" rates.

Employers, though, would be "subject to slightly higher rates" if many employees in a group are high-risk workers, defined as those who have "catastrophic illnesses," have known medical conditions, are on short-term disability leave, have had a "substantial number of missed days from work" or show indications of future medical expenses, according to a BC/BS of Virginia document.

However, no one will be denied coverage on the basis of health and employees' health status will be considered only in developing rates, according to the Blues.

The plan will cover:

- Thirty days of hospitalization per year at 80% coverage after a $250 deductible.
- Outpatient surgery and 30 days of home health care at 80% coverage. There would not be any deductible.
- Outpatient health care for accidental injuries at 80% coverage. There would be no deductible and copayments would be capped at $150 annually for each insured person.
- Comprehensive maternity care, including an educational and risk management program, at 80% coverage, after a $250 deductible.
- Preventive care, comprehensive well-baby care, two annual physician visits per person and one dental examination and an annual cleaning per child. These services are covered at 100% after a $10 per visit copayment.

Benefit limits per insured person would be $50,000 per calendar year and $1 million lifetime.

BC/BS's plan incorporates managed care techniques including pre-admission review and an established preferred provider network.

To be eligible for the BC/BS of Virginia plan, an employer with two to five employees must have 100% enrollment. A firm with six to 10 employees must enroll at least all but one employee, and a firm with 11 or more workers must enroll either 10 employees or 75% of its workforce, whichever is greater.

BC/BS of Virginia plans to offer the reduced-benefits coverage for at least two years. It will analyze the plan's enrollment and experience to determine the feasibility of continuing the program.

BC/BS will market its new product through a direct mail campaign. Marketing will be "difficult because you can't buy a list of uninsured companies," Ms. DeWitt said.

## Reduced benefits

*Continued from page 3*

And, the reduced-benefits plans leave midsized employers stuck in the middle, Mr. Hickey observed: They are ineligible for the reduced-benefits plans because they are too large, but may not be large enough to self-insure their health care plans.

People may think the new bills help the "poor small guy" and that "the big guys can afford it. That's a joke," he said. Reduced-benefits plans are a good idea that is getting "imperfect implementation," he agreed.

The Virginia reduced-benefits legislation, which unanimously passed both houses of the Legislature late last month and is expected to be signed by Gov. L. Douglas Wilder, would become effective July 1.

Of the approximately 800,000 Virginians without health care insurance—17% of the state's population—approximately 351,000 are employed by an estimated 49,000 small businesses, according to BC/BS's Ms. DeWitt.

Virginia employers could offer insured reduced-benefits programs if they employ fewer than 50 workers, including the owner, and have not offered health insurance for at least one year preceding the new policy's effective date.

Small employers that have been established for less than a year also are eligible for the program if they have never offered health care coverage to employees.

The one-year requirement is necessary to discourage companies that already offer employees comprehensive insurance from switching to the limited-benefit policies, Ms. DeWitt explained.

While "nothing legislatively" would prevent an employer from canceling its health care plan for a year so it could then offer reduced benefits, "it would be hard to get away with in terms of employee relations," she said.

Under the Virginia legislation, eligible small employers buying insured health care plans wouldn't have to offer coverage for "services that are not medically necessary or are not covered preventive health services."

The basic coverage required under the legislation is:

- A minimum of 30 days' hospitalization annually.
- Comprehensive prenatal, obstetrical and well-baby and well-child care.

This provision was drafted in recognition that "the typical uninsured Virginian is a 30- to 44-year-old woman who heads a low-income household," according to BC/BS of Virginia.

- At least two annual physician visits.

Insurers must also offer employers the option of covering mammography screening.

The legislation does not spell out coverage levels.

Of these mandated benefits, only well-baby care now is a required benefit under Virginia's mandated benefits law, while insurers must offer the option of covering obstetrical care and mammography screenings.

However, the legislation would exempt small employers from state coverage mandates for "allied services" providers like chiropractors, optometrists, physical therapists, podiatrists, professional counselors and psychologists and speech pathologists/audiologists.

Among other state mandated benefits suspended under the legislation are: dental coverage, except for limited coverage for children; 30 days of inpatient and outpatient treatment for mental, emotional and nervous disorders; and 45 days of inpatient and outpatient treatment for alcohol and drug dependence annually.

The reduced-benefits legislation also would allow insurers underwriting these health care plans to set up preferred provider networks, establish utilization review procedures and require second surgical opinions.

The proposal also would allow insurers to establish "additional managed care and cost control provisions," subject to approval by the State Corporation Commission, which oversees the Bureau of Insurance.

In addition, the legislation would require insurers to provide small employers with a "clear and understandable" explanation of the mandated benefits and the providers from whom covered lives must seek health care under a preferred provider network.

The bill also states that each small employer applying to an insurer for reduced-benefits coverage "always needs to be given the option to offer the full-coverage plan," noted a spokesman for the State Corporation Commission.

The bill contains a June 30, 1994, sunset provision.

"This is like a pilot program," explained an aide to Sen. Stanley Walker, D-Norfolk, who chaired the joint subcommittee that hammered out the bill. "It's a very innovative approach, but we have to evaluate it because we don't know if it's going to work," the aide said.

But a small business group in Virginia is wary of the legislation.

"The whole thrust" of mandated health care insurance legislation in Virginia and nationally "is that every employee will have coverage," said Lindsay U. Bruce, president of the Virginia Small Business Council Inc. in Richmond.

"That's laudable on the face of it, but from a realistic standpoint, it could be harmful" if legislators "take the next step" and require all small employers to offer health insurance, he said.

If small businesses are forced to provide health care coverage, many would have to cut their workforces, Mr. Bruce asserted.

Meanwhile, Washington Gov. Booth Gardner is expected to sign a reduced-benefits bill, which was overwhelmingly approved by the Legislature, before the bill is automatically enacted March 31.

The legislation, which is supported by small employers in the state, would become effective 90 days after it is signed or is automatically enacted.

To qualify for Washington's reduced-benefits plan, an employer must have fewer than 25 employees. And a reduced-benefits plan cannot supplant any existing health insurance program.

The reduced-benefits plan is "terribly flexible" on what benefits must be offered, according to Mel Sorensen, who lobbied for the legislation on behalf of the Washington Physicians Service, an umbrella group of all Blue Shield plans in the state; King County Medical Blue Shield in Seattle; and Blue Cross of Washington & Alaska in Seattle.

Reduced-benefits plans would have to provide unspecified levels of hospitalization and physician coverage, but "the legislation is silent" on the 18 types of coverage that insured plans now must offer under state law, Mr. Sorensen said.

Washington mandates that insured health care plans cover care delivered by podiatrists, optometrists, registered nurses, chiropractors, psychologists and dentists.

In addition, reconstructive breast surgery, chemical dependency treatment in approved facilities, mammograms under certain conditions and mental health treatment, among other items, must be covered by insured health care plans in Washington.

"Our hope is with this basic insurance available, small businesses that would like to offer health insurance but find the costs prohibitive will find it easier," said an aide to Sen. George Sellar, R-Wenatchee, chief sponsor of the bill.

The legislation is intended to result in health care premiums of $45 to $60 monthly per covered life, representing a 40% savings from standard group health insurance products, Mr. Sorensen said.

"We tried to structure the benefit package" to target that premium cost, because it was believed "small businesses would view it positively," he said. "But maybe some plans can do it for less."

Insurers have indicated that the $50 premium is feasible for a basic plan, Mr. Sorensen said.

The coverages mandated under Washington law add 10% to 12% to the cost of health insurance, testified an insurer before the Washington Senate Financial Institutions and Insurance Committee last November.

The Assn. of Washington Business has urged Gov. Gardner to sign the reduced-benefits bill.

"Under the measure, an insurance company could offer a policy tailored to each business and its employees' health care needs without being required to include all of the state's existing mandated coverages," the AWB said.

The reduced-benefits legislation "would allow a small business to get basic coverage and add to it as employees need it," said Beverly Woods, director of public affairs and a lobbyist for the AWB.

Of the 750,000 uninsured Washingtonians, 295,000 are employed, and 75% of those, or about 221,250, work for small employers, she said.

Although the intent of the Washington legislation was to provide basic coverage, "we also wanted to provide flexibility for carriers to design a whole range of products for small businesses," Mr. Sorensen explained.

Mr. Sorensen has designed a prototype reduced-benefits plan with input from underwriters and analysts under which premiums would fall into the range outlined in the legislation.

The plan would include coverage for professional services like surgical and chemotherapy procedures; hospitalization; maternity care; inpatient and outpatient chemical dependency treatment up to a $10,000 lifetime maximum; and home health care.

The prototype Washington policy would exclude coverage for physical therapy, prescription drugs, chiropractic services, newborn care, well baby care, eye examinations, immunizations and circumcisions. ■

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# Workers comp

*Continued from page 2*

duced in 1983, have helped reduce injuries by an unspecified amount, Ms. Miller said.

"Prevent the injury and we don't have to work very hard," she said.

When injuries do occur, the company uses health care providers who are familiar with its work site and emphasize an injured employee's abilities rather than disabilities, she said.

A Michigan law requiring employees to use employer-chosen physicians for the first 10 days after an injury helps make this possible, she noted.

Recuperating employees are treated with respect and allowed to participate in decisions about their return to work.

They are also allowed to return to work for as little as two hours a day, making it very difficult for employees to be away from work for an extended period of time, Ms. Miller said.

"The key to all of this is communication between providers, employees and supervisors," Ms. Miller pointed out.

New state rules allowing employers and insurers to implement cost containment measures, such as utilization review, also are expected to help employers better control workers compensation costs, added Ms. Miller, who is a member of the Michigan Workers' Compensation Heath Care Rules Advisory Board.

However, the rule remains that "if you don't manage your business, someone else will do it for you," she emphasized.

In addition, the U.S. government is studying two programs that may help it control its own workers compensation claims costs, said Ruth Berger, a Labor Department health scientist in Washington, D.C.

One program could cut administrative costs by expanding an automated system for paying federal black lung program claims to include some types of simple workers compensation claims filed by federal employees, Ms. Berger explained.

The other seeks to develop treatment and intervention guides for handling low back injury claims so claims handlers can better manage the cost of injuries, she said.

Researchers are also developing a list of characteristics, like sex and age, that will help claims handlers predict which low back injury claims are likely to become expensive, long-term ones, Ms. Berger said. For example, research indicates that women are more likely than men to have serious back injuries, she said.

The predictors are objective and preserve employee privacy because by not requiring personal information, like whether one likes his or her supervisor, Ms. Berger said.

In addition, state workers comp administrators and insurers can help contain the cost of workers compensation claims, experts say.

The state of Washington, which operates a monopolistic state workers compensation fund, increased the number of injured employees returning to work by restructuring of its vocational rehabilitation program, said Charles Holmquist, assistant director of the state Department of Labor and Industries' Medical and Rehabilitation Services in Olympia.

Over the past five years, the state consolidated five interdepartmental groups with responsibility for vocation rehabilitation into one. It also changed the focus of its staff from assessing the abilities of injured workers who had been off the job more than one year to doing whatever necessary to get injured employees back to work as soon as possible, he said.

Such extensive system changes are difficult because of the need to deal with "internal and external stakeholders" in the existing system, he said. Therefore, it is critically important that any administrator undertaking such an approach must be able to deal well with people, he said.

In addition, New York state is attempting to control workers compensation claims costs through a variety of measures.

Despite "relatively low" benefit levels, work comp medical costs in New York still have comprised only about 30% of total losses in recent years, said Donald G. Vass, first deputy executive director of the New York State Insurance Fund in New York City.

Nationally, medical costs comprise about 40% of total workers compensation costs, according to the National Council on Compensation Insurance.

Among New York's cost control measures are:

- A claimant must choose a physician authorized by the chairman of the state Workers' Compensation Board.
- An insurer may require the claimant (to) submit to a physical examination and may require that treatment be transferred to another authorized physician or treatment be terminated.
- Provider fees must conform to a fee schedule.
- Claims disputes are resolved through arbitration panels.

"This system, which was legislated at the behest of labor and the medical community in 1935, is not perfect but is certainly worth considering by any jurisdiction looking to assure quality care while considering medical costs," Mr. Vass said.

In addition, insurers have a role in containing workers compensation costs by implementing cost containment measures like utilization review and case management techniques, said Dr. John Witty, assistant vp-services for American International Health & Rehabilitation Services Inc. in Orlando, Fla., a unit of American International Group Inc.

Cost containment measures must be an outgrowth of quality care, and not just mechanisms for saving money, he said.

However, "in many states there are significant barriers to cost containment in workers compensation," pointed out Steven Millikan, vp-director of workers of compensation for the Alliance of American Insurers in Schaumburg, Ill. For example, several states still allow injured employees free choice of physicians.

Insurers—and employers—should educate and lobby legislators and state administrators about the need for worker comp cost containment, he said.

For example, the Alliance recommends that states:

- Establish guidelines for reasonable and appropriate levels of treatment.
- Limit an employee's choice of physician, while allowing insurers and employers to establish preferred providers networks.
- Implement fee schedules and strong dispute resolution procedures.
- Prohibit health care providers from billing injured workers for any portion of a bill. Sometimes providers bill an injured employee directly for the unpaid balance of contested bills, even though an employer or insurer is responsible for paying the bill.
- Require the state work comp administrator to take action against providers who overcharge.
- Impose penalties for late payment of benefits.
- Maintain a medical cost data base. ■


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# UR encouraged for work comp cases

**By MEG FLETCHER**

NEW ORLEANS—Utilization review can help cut workers compensation health care costs, UR experts say.

There is a "resounding need" for utilization review in workers compensation, said Gail Nethercut, director of workers compensation medical cost containment for San Francisco-based National Medical Audit, a unit of William M. Mercer Meidinger Hansen Inc.

Studies have indicated that about one-third of inpatient health care costs billed to employers and insurers are medically unnecessary, Ms. Nethercut said during a panel discussion at a recent conference sponsored by the International Workers' Compensation Foundation Inc. in New Orleans. The IWCF is an educational and research affiliate of the International Assn. of Industrial Accident Boards & Commissions.

Utilization review firms typically limit health care costs by asking patients to notify the UR staff before hospital admissions. UR staff nurses or physicians review the appropriateness of proposed surgery and other medical care before and during hospitalization. The patient is notified if proposed treatment is inconsistent with the most cost- and care-effective method of treatment (*BI,* Feb. 19).

But UR operates a little differently when an injured worker is involved, Ms. Nethercut explained. For example, in workers compensation cases the physician—instead of the employee—must call the UR firm for treatment authorization, she said.

UR firms get "the biggest bang for the buck" in averting unnecessary hospital admissions and controlling the number of days a patient spends in an acute care setting, she said.

But UR vendors also are increasingly focusing on limiting unnecessary treatment in outpatient facilities, where many workers injured on the job are treated, Ms. Nethercut noted.

In ongoing work comp cases, claims examiners can seek advice about a worker's treatment from the UR firm's representative, who deals directly with the physician involved, she said.

Involving a UR representative in worker injury cases can be "very helpful" in determining whether the injury is compensable, Ms. Nethercut said. Having UR representatives involved also is an excellent way to make sure that quality care is rendered, she added.

For example, one reviewer's insight into hospital procedure revealed that $7,000 of an injured worker's hospital bill stemmed from a medication error and not the work-related injury itself, Ms. Nethercut said. Ms. Nethercut noted that the bill was subsequently challenged.

A workers compensation insurer speaking at the IWCF meeting also attested to the cost savings that UR can produce.

Utilization review services saved the Arizona State Compensation Fund nearly $1.4 million in work comp health care expenses in a single year, said Peter Kilgard, vp of the fund's benefit division. Those savings were about 15 times greater than the cost of UR services, which was about $90,000, he said.

The Arizona state fund writes about half of the workers compensation coverage in the state.

One reason work comp is fraught with unnecessary health care expenditures is that many health care providers shift unreimbursed costs to work comp cases because they know employers have a statutory responsibility to provide care to workers injured on the job, contends Dr. Ronald Gots, president of National Medical Advisory Services and chairman of its affiliate Medical Claims Review Services, UR firms based in Bethesda, Md.

In addition, many physicians lack the "know-how, incentive or authority" to streamline care and costs, he said.

For example, according to Dr. Gots:

- Many physicians practicing today are not informed about medical cost containment. Even now, medical schools offer such courses only as electives, he said.

Employers and insurers can help educate physicians by emphasizing that cost containment is a goal of UR services, Dr. Gots said. And, as more employers use UR services, physicians will become better informed, he added.

In addition, as research is conducted on various treatment outcomes, physicians will become more aware of the availability of more cost-effective methods of care, he said.

- Many physicians rely too heavily on multiple and unnecessary diagnostic tests.

Until the recent rise of UR firms, physicians often lacked incentives to keep care and costs in check because multiple visits or treatments rewarded them with higher fees, Dr. Gots said. That attitude contributes to their viewing each workers compensation patient as "an annuity," he said.

"Doctors will only have the incentive to save if they are rewarded for it," Dr. Gots said. For example, guarantees of larger patient volume would help, he said.

- Many physicians may lack the "authority" to streamline care and control costs because of non-medical factors beyond their control, such as patient demands or an employer's refusal to provide a light-duty job for a recuperating worker.

It is "critical" to educate physicians about the physical requirements of an employee's job and to get doctors involved in a treatment program that has return to work as its goal, Dr. Gots said.

Meanwhile, National Medical Audit's Ms. Nethercut emphasized the importance of selecting the best UR firm for the job.

While probably any of the more than 200 UR firms can achieve cost savings, employers and insurers that pay workers compensation claims should take care in their selection of a UR provider, she said.

However, the selection process is hindered by a lack of good comparative data, she said.

One way to evaluate a UR firm's handling of workers comp cases is to categorize cases it handled according to diagnostic related groups and compare the length of stay associated with that DRG to the number of actual days billed, Ms. Nethercut said.

Other selection factors include the medical criteria UR firms use to evaluate physicians' decisions, staff members' knowledge of workers compensation and the interpersonal skills of the UR personnel who have the sensitive task of challenging physicians. ■

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# Comp medical costs skyrocketing: Study

**By MEG FLETCHER**

NEW ORLEANS—Policymakers who want to contain medical costs in state-run workers compensation systems face a difficult but essential task, research studies show.

Despite "explosive" growth in work comp medical costs, there has been little information about what drives costs and what policymakers can do to reduce the increases, says a recent study by the Cambridge, Mass.-based Workers Compensation Research Institute, a non-profit public policy research organization funded by employers and insurers.

The study, "Medical Costs in Workers' Compensation—Trends and Interstate Comparisons," analyzes trends and patterns in medical costs from 1965 to 1985 in more than 40 states. It uses data from the National Council on Compensation Insurance, independent rating organizations and exclusive state work comp funds.

From 1965 to 1985, work comp medical costs rose an average of 12.5% annually, compared with an 11.2% increase in medical costs for non-work comp cases, it reported.

Until the mid-'70s, workers compensation medical costs increased more slowly than non-work comp medical costs; the study says. Since then, workers comp costs have grown more rapidly, said Richard Victor, executive director of the WCRI, during a presentation at "Forum II—Workers' Compensation Healthcare Cost Containment—A Progress Report" in New Orleans.

From 1980 to 1985, "workers compensation medical costs were rising at a rate of more than 1½ times" that of per-claim non-workers compensation medical costs and at almost twice the rate of overall medical care inflation, according to the 70-page report.

The acceleration in work comp medical costs appears to be due to "special forces," which the study does not specifically identify. However, the study says they may include: statutory prohibitions against health care cost containment measures; employees using more work comp medical benefits during recessions; and providers shifting overhead costs to workers comp claims as employer- and governmental-sponsored group health insurance programs tighten reimbursements to providers.

In addition, the problem of work comp medical cost escalation is not necessarily connected with the rise in general medical costs, the study found. Some states with high workers compensation medical costs do not necessarily have high general medical costs.

However, some unspecified states are doing a better job of cost containment than others, the WCRI learned in follow-up research that it is currently analyzing.

Currently, there is no easy answer about what cost control measures a policymaker should implement, the report notes.

The WCRI's current data is inconclusive about the efficacy of two of the most popular cost containment techniques: medical fee schedules and allowing employers —rather than injured employees— to choose a physician.

That doesn't mean that these tools may not be useful, but only that it is necessary to research other factors in a state before they can be assessed, Mr. Victor said.

In an separate study, the Minnesota Department of Labor and Industry compared medical costs for some types of work comp cases with the cost of non-work comp cases.

It found that health care providers' charges for some types of workers compensation cases were about two times the charges for similar non-workers comp cases.

However, injured workers received more intensive physical examinations and services than did other patients, noted Lisa Thornquist, the department's acting director for research, planning and policy analysis. ■

## Forum draws about 450

NEW ORLEANS—The second annual forum to discuss workers compensation cost containment measures sponsored by the International Workers' Compensation Foundation Inc. attracted about 450 people.

Approximately 400 registrants and guests were joined by 50 exhibitors at this year's meeting, "Forum II—Workers Compensation Healthcare Cost Containment—A Progress Report," said John Shanks II, foundation president.

The forum was held Feb. 28 to March 3 in New Orleans.

The IWCF, a non-profit foundation, was established in March 1988 as the educational and research affiliate of the International Assn. of Industrial Accident Boards & Commissions.

The IAIABC's membership consists of governmental agencies involved in the administration of workers compensation laws in the United States, Canada, Australia and New Zealand. Associate members include insurers, claims administrators, self-insured employers, rehabilitation providers, doctors and lawyers.

The IAIABC recently named its first full-time director and moved its offices to his home town.

IAIABC Director Robert B. Collyer of Daytona Beach, Fla., is president of Collyer Co., a consulting firm; former co-director of the National Symposium on Workers' Compensation; and a former U.S. deputy undersecretary of labor.

He replaces J.T. Noblin, an attorney in Jackson, Miss., who served as part-time director. Mr. Noblin resigned to become clerk of the U.S. District Court for the Southern District of Mississippi.

The change to a full-time executive director was prompted, in part, by members' requests for additional services, said Thomas Gleason, IAIABC president and executive director of the Workers' Compensation Board in New York.

The IAIABC's office is located at 1575 Aviation Center Parkway, Daytona Beach, Fla., 32114; 904-252-2915.

*Edward B. Jobe*
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# Work comp PPOs can cut costs

NEW ORLEANS—Preferred provider organizations must be properly structured if they are to provide cost-effective medical treatment to injured workers, according to an official of a PPO.

A formal workers compensation PPO network should include inpatient and outpatient treatment centers as well as a panel of physicians, according to Robert Hofstadter, executive vp of Preferred Care Network Inc. in Lincolnwood, Ill.

In addition, a workers compensation PPO must deliver high-quality care, be geographically accessible, be cost-effective and have the computer capability to produce comprehensive management reports that permit a workers compensation insurer or self-insurer to assess the PPO's performance, according to Mr. Hofstadter.

He spoke at a recent workers compensation seminar in New Orleans sponsored by the International Workers Compensation Foundation Inc.

The workers compensation foundation is an educational and research affiliate of the International Assn. of Industrial Accident Boards & Commissions.

Many observers formerly believed that workers compensation PPOs were viable only in states that limited injured employees' choice of physicians and capped provider fees according to a fee schedule, according to Mr. Hofstadter. But Preferred Care has discovered that a properly implemented organization still can be effective in a state like Illinois, which neither limits employees' choice of physicians nor has instituted a fee schedule for providers, he said.

In addition, Mr. Hofstadter pointed out that:

- If more than 40% of the hospitals in an area are in a preferred provider organization, the employer will receive only a small discount because the hospitals will not be receiving a sufficient volume of cases to provide the larger discounts that can generate long-term savings.
- Establishing a preferred provider organization can create problems with a self-insurer's third-party administrator, whose compensation would be based on the employer's claims expenditures.

If a PPO is successful, claims costs will decrease, reducing the TPA's remuneration, he pointed out.

Dr. Christopher Brigham, president of Occupational Health Excellence Inc. in Falmouth, Maine, also spoke at the session.

The conference session was moderated by Judith Greenwood, research director for the West Virginia Workers' Compensation Fund.

*—By Meg Fletcher*

# New Texas regulator an outsider

**By MICHAEL BRADFORD**

AUSTIN, Texas—The new chairman of the Texas State Board of Insurance is coming into his new job with admittedly little insight into the ways of the insurance world.

James E. Saxton Jr., 49, currently vice chairman and director of Texas Commerce Bank in Austin, will assume the duties of Texas' top insurance regulator no later than April 2. Mr. Saxton replaces former Chairman Paul Wrotenberry, who resigned effective March 1 to work for reforms of the insurance department and insurance regulation as an outsider (*BI*, Nov. 20, 1989).

Mr. Saxton

Mr. Saxton—a 20-year veteran of the banking industry who has held several executive positions with Texas Commerce Bank since 1970—said the insurance business is something "brand new" to him.

Why, then, would a Texas banker take on a job as chairman of a regulatory agency that has been blistered by charges of mismanagement, suffered through legislative investigations, watched numerous staffers resign and regulates a complex industry he knows little about?

"Because it's something new and different," Mr. Saxton said.

The new chairman "is a capable and effective leader," said Gov. Bill Clements in appointing Mr. Saxton to the position. "He will make a valuable contribution to this vitally important board. I am pleased he has agreed to take on this demanding job."

Regarding the challenges of his new job, Mr. Saxton pointed first to the task of establishing insurance prices that are fair to buyers as well as insurers.

"I really speak as more of an outsider," Mr. Saxton said. "But there are a couple of things that we are all concerned about."

Consumers "should be able to get coverage at a reasonable price," he said.

"Also, the industry itself has to be able to bring in new products and price them in a way that will allow them to be profitable."

The image of the State Board of Insurance already on the mend after the investigations and charges of mismanagement that followed the collapse of Dallas-based National County Mutual Fire Insurance Co. in 1988 (*BI*, Nov. 7, 1988), according to the new chairman.

All three members of the State Board of Insurance left the board amid the controversy, as did the state insurance commissioner, who reports to the board.

However, "that was over a year ago," Mr. Saxton noted. "All those problems are behind us. We have a whole new board, a new chairman and new commissioner."

However, the National County failure does underscore the realization that insurer solvency and integrity must be monitored closely, Mr. Saxton stressed.

"One thing it does bring to mind, and something we have to focus on, is the quality and solvency of insurance companies and agents doing business in Texas," Mr. Saxton said.

"That was something that was brought to the forefront" with the collapse of National County, he said. ■


RIMS 1990

RIMS PREVIEW
PUBLISHING: APRIL 23
AD CLOSING: APRIL 10

The perfect kick-off for this year's Risk & Insurance Management Society Conference in Boston is BI's 'Take-Out' section.

BI readers will find last minute details and updated program and speaker changes at RIMS '90; a floor plan and list of exhibitors; a map of Conference hotels; and transportation info; a Boston entertainment and restaurant guide, and weather watch from BI editors; and updates on conference and other hospitality functions.

Additional copies of our RIMS Preview 'Take-Out' section will be available at BI's booth #1023-1025. You get extra exposure at no extra cost.

CAPTIVES/
RISK MANAGER OF THE YEAR
PUBLISHING: APRIL 30
AD CLOSING: APRIL 17

BI will be at RIMS distributing extra copies of the Captives feature issue, announcing BI's 13th annual Risk Manager of the Year and the Risk Management Honor Roll. This issue also includes BI's exclusive annual Directory of Captive Managers. A special issue wrap-around will list advertisers, their page, and booth if at RIMS.

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PUBLISHING: MAY 7
AD CLOSING: APRIL 24

This follow-up report on new perspectives and insights presented at RIMS is an outstanding reinforcement for those who attended the employee benefits sessions. For those who did not, BI editors detail all the vital information covered at the conference. BI's RIMS Report on Employee Benefits is a well-read issue, giving advertisers direct access to the purchasing influentials actively seeking information on employee benefits.

RIMS REPORT:
RISK MANAGEMENT
PUBLISHING: MAY 14
AD CLOSING: MAY 1

Business Insurance rounds up its coverage of the RIMS Conference with reports on the risk management sessions. Our editors will deliver an information-packed issue to over 155,000* readers. BI's final conference coverage of RIMS '90 gives you one more chance to emphasize, reinforce and direct your advertising message to the purchasing heavyweights who can make a difference on your bottom line.

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# What lies ahead for insurers?

## Industry should tell public of social factors affecting rates

By Gerald D. Stephens

Speaking out

LET ME START with a question: If you had the magic power to change the environment in which we operate and improve our ways of doing business, what would our industry look like five years from now and in the year 2000?

The '90s are upon us. If we're going to be an influence in this decade, now is the time to begin. But before we can take any intelligent action, we must understand ourselves as we are today—where we are and how we need to change. We must understand the economic and political environment in which we conduct our business—what needs to change before our vision can become reality.

In assessing ourselves, I would ask whether we are truly customer-driven, or whether we are merely reacting to forces we think are beyond our control.

What kind of communications job are we doing? Are we telling the insurance industry story in a way to forge a strong alliance with the public? Without our customers' support, no significant change in the business climate is possible.

Do the people we serve hear us? Do they believe we are on their side, or are we the enemy? We have a strong sense of mission. We see ourselves as taking the hurts of our customers upon our shoulders. We are there when they need us most. But do they know this? Do they realize how much we are doing about safety and other social issues that concern them?

There is no doubt we have problems that public opinion can't solve. One is overcapacity. There are 250 good-sized groups handling most of the business and thousands of others with only a small share.

In the political sphere, current regulation of the industry by individual states creates incredible confusion and delays, and runs up costs with little value added for the customer. The insurance industry is the only competitive U.S. industry subject to price controls in most states. In my opinion, price fixing amounts to the type of cartel prohibited by federal anti-trust laws. The price cartels are only legal because of the McCarran-Ferguson Act.

We'd like to see deregulation, but the alternatives as they appear at present are not very promising. The possible repeal of McCarran-Ferguson would be unlikely to bring relief, because new pro-regulation federal legislation may be introduced to continue protecting centralized control and price cartels, creating still more bureaucracy. There is a lingering threat of nationalizing insurance as an antidote to state controls.

We and the public have a major problem with the system of justice in this country. Court awards to plaintiffs in injury suits can be unreasonable and astronomical. Judges nullify policy exclusions they deem to be against public interest. Insurance as the science of uncertainty has been thrown out of balance. Huge awards and accident frequency have driven up liability premiums to the point where they are unaffordable for many people.

Auto insurance rates have risen because the repair and replacement parts market is protected by tariffs.

People blame the insurance companies for the high rates that juries, plaintiffs' lawyers and judges have brought upon them. Proposition 103 wins in California. The state Supreme Court ruling that gives insurance companies the right to fair and reasonable return provides only limited protection, and the industry faces threats from the consumer movement in other states.

These are the facts of life for our industry. What lies ahead in the next 10 years? Here are a few of my hopes.

First, I'd like to see our industry thought of not only as a good place to work, but as worthy of respect.

Next, I'd like to see a heightened awareness of our professionalism—an industry where professionals work together with a mission of service, providing security, advice and immediate help to loss victims. An industry where the participants compete mightily to provide "high touch" immediate service.

I would like to see a smoothing out of the radical swings from overcapacity and sensitivity to money rates, which give the industry an image of instability.

I would like to see an industry free of price controls and price fixing, where market rates prevail.

And in the legal and economic climates surrounding us, I would like to see a court system that is fair and equitable—that is ruled by law and common sense rather than emotion. A system that provides accident victims adequate compensation for expenses and actual damage, without considering every accident a crime that must be punished by punitive awards. Attorneys should be paid fairly for their work, but why give them a bonanza when they extract outrageous settlements on a contingent fee for the lucky few who happen to be injured in the presence of a "deep pocket?"

I'd like to see an auto manufacturing industry concerned about the ultimate costs of its products, including insurance. This would result in a return to realism in the cost of replacement parts and in labor rates for car repair.

If you share my vision, what can we do now that will make a difference? One thing is for sure: We must begin adequate training of our own people. At my company, we are putting training right up at the top of the agenda. This means training not only in the technical aspects of insurance, but education, such as the Chartered Property & Casualty Underwriter program, so that our people understand the social and economic conditions that confront us and are equipped to present our point of view.

Our own people need to be prepared to take aggressive stands on the issues that concern us—positions that are not based just on our desire to make a profit, but on the best interests of our customers and the public. We need to be *for* good things—not just against bad things. Here are positions I think we need to bring to the public's attention:

On the tort system—tell our policyholders that we can reduce their costs, if they will give up their rights to the great American lottery: the right to sue. The great majority are now picking up the tab for a conflict resolution system that is unfair and expensive. Many injured go without benefits while the lucky few win a jackpot. Real, high-limit, no-fault liability insurance is the only solution.

On auto insurance—abuses must end, or premiums will become prohibitive and insurers will withdraw from the business, and nationalization is not far behind. No-fault with its reliance upon first-party insurance for medical bills and loss of income is the only way to salvage casualty insurance. Pain and suffering awards and punitive damage awards must go. The alternative is socialized insurance, which has been a disaster wherever it has been tried.

On safety—we must continue to be activists, having pioneered seat belts, air bags, the Underwriters Lab and other safety measures. We should extend our activism into the area of auto repairs to make them more economical and *tell* our public what we're doing.

On the insurance cycle—the major players must try to manage the price underwriting cycle to rectify the unpredictable performance that has given the industry a black eye.

Above all, we must *tell* people what we are doing. CPCUs are on the firing line in this effort, because we have the education and ability to level honestly with our customers. So tell it the way it is.

First, let's consider the wide cyclical fluctuation in the prices we charge. I don't know of any other industry where the swings are so radical.

Next, think about the way insurance companies treat their stockholders. We provide consistent total return to shareholders. No ups and downs or fluctuations here. And dips in the price cycle are nicely filled in by investment income. More and more, we are required to include investment income as a basis for rate determination. This is why radical variations in interest rates cause the price of insurance to change, especially on long tail lines. Why not tell people to expect insurance rate changes when interest rates change?

Now look at the positive side of our story. We run our business with great efficiency, to our customers' benefit. No government insurance plan anywhere can provide our kind of service for anywhere near the price.

Because we run our operations so efficiently, what can be done about auto premium rates? Suppose we wanted to reduce them 20%. Where do we pare the fat? Not from our industry's share—it has already been cut to the bone. A 20% cut here would reduce insurance premiums only 5%. The answer has to come from cutting loss payouts. Half of the present auto premium dollar goes for physical damage. Part by part, a $15,000 car built in the United States costs $150,000! Why don't we tell the American public how much lower their insurance premiums would be if repair shops used lower-cost imported or used parts for replacements? What would happen if we lowered the tariff on car parts?

And then there's our tort system. The present tort system is tremendously expensive to the public. When tort costs—in the form of liability insurance premiums—become 20% to 40% of the price of all products manufactured in the United States, and when auto insurance premiums rise to $5,000 to $10,000, the rebellion that first surfaced in California will spread across the land.

As we peer into the '90s, we have to consider whether we will be *managing* or *managed*. With state regulation as it now stands, we are not free to manage our businesses competitively. We are a competitive industry, yet we are the only industry in the United States subject to price controls. So-called consumer advocates see a centralized, controlled environment as the way out of all the world's difficulties, but this just doesn't work.

It now takes a national insurance company six months to a year to get a form or rate approved in all the states. In an era of accelerated change, this system cannot endure.

The escape valve in state-controlled rates—surplus lines insurance—is driving billions of dollars in coverage overseas—mainly to England, where insurance is unregulated and a free insurance market truly exists. With the return of a free market in insurance here, this business could be bought back, and we wouldn't need surplus lines laws at all.

To sum up, the '90s are going to be a challenging time for all of us.

We must be on the consumer's side of the big issues in our society to remain an important factor and make certain we're still around in the year 2000 to serve our fellow citizens.

As professionals, we need to be deeply concerned about the welfare of our clients. In our industry, quality must be a given. Our employees must be well-trained, competent and friendly—delivering service in a manner that shows they really care.

Now is the time to start managing for the '90s. Speak out on the issues you feel are important. Carry your vision to your peers. Do this, and the next decade will bring you riches and satisfaction from a job well done. ■

*Gerald D. Stephens is chief executive officer of RLI Corp. of Peoria, Ill. Mr. Stephens, former president of the Society of Chartered Property & Casualty Underwriters, delivered the above article as a speech at the Society of CPCU's annual conference last October.*

# Dealing with disasters

**By John A. Love**

TWO NATURAL DISASTERS and a large explosion in a petrochemical plant in 1989 focused corporate America's attention on the need for disaster planning and loss control and prevention programs. As a result, top management will pay more attention to property protection in the coming years.

As the Southeast rebuilds from Hurricane Hugo and northern California from the earthquake, insurance companies and their policyholders confront massive costs. This alone will strengthen their realization that insurance policies are not enough. Policyholders and insurers realize they must also focus more on loss prevention and control. In addition to the money, there is the human cost of inadequate loss prevention.

This increased emphasis on corporate loss prevention leads to a more prominent and valued position for corporate risk managers. Their importance in protecting the company's assets—and its profits—gains appreciation every year. They, in turn, demand more engineering services from their insurance companies.

We forecast increased demand for these services:

- Counsel on loss prevention and control features for new facilities and additions to existing buildings.
- Surveys of existing facilities to determine earthquake resistance.
- Customized engineering services and research.
- Disaster planning.
- Commodity classification tests to determine fire hazards of new products.

Not only the disasters of 1989, but also certain business trends will make loss prevention and control more important than ever in 1990.

One such trend is mergers and acquisitions. The risk manager of a newly reconfigured company may be responsible for some facilities where loss prevention has traditionally been a high priority, and others where

## 1989 losses reinforce need for loss control

it has been ignored. Procedures, lines of responsibility, insurance companies and other factors may vary widely from one type of property to the next. This challenges the risk manager and the company's insurers to devise loss prevention plans to serve the merged company's interests.

The near future will witness another important change affecting our business. In 1992, when barriers among European Community countries fall, European standards may make it difficult for North American companies to compete in Europe. There will be pressure to have global standards to facilitate trading.

American research and testing facilities that create industry standards will have to work toward some cooperative efforts with the European community.

We also believe there will be a greater demand for expert systems to help solve problems quickly. One such system being developed will assist engineers in the assessment of the reliability of sprinkler systems.

The San Francisco Bay area earthquake focused attention on not only the West Coast's San Andreas fault, but also the New Madrid fault in the Midwest and the vulnerability of other areas of our country to this type of devastation. Earthquake planning will receive more attention in the '90s.

Corporate risk managers increasingly will demand loss protection and conservation measures specific to their industries and companies. What works in a pulp and paper mill can be irrelevant to a hospital.

Therefore, insurance companies' engineering and technical operations will have to tailor their services to satisfy the needs of various industries they insure.

Companies will also look to insurance companies' research and development services covering materials and conditions where they have a strong interest. This could include the flammability of non-woven fabrics or electrical cable insulation; high-rack storage fire protection; safe storage of grain, chemicals or pharmaceutical powders; and storage of flammable liquids in plastic containers.

The events of 1989 make obvious the need to think the unthinkable. We experienced increased demand in the fourth quarter of last year for training and assistance with disaster planning. As a result, we are designing a disaster preparedness training program and new training aids that will help businesses establish action plans to minimize the effects of natural disasters on business operations.

Although a natural disaster is one property loss that cannot be prevented, many steps can be taken to minimize its effect on business operations. With an action plan, businesses at least have a fighting chance to resume operations quickly.

On balance, the future trends are highly positive for experts in loss prevention and control. The need for loss control and prevention as a necessary ingredient in running a safe, responsible, profitable company is better recognized than ever. The need for objective, reliable knowledge in these areas will become greater. ■

*John A. Love is chairman, president and chief executive officer of Factory Mutual Engineering Assn., Factory Mutual Research Corp. and Factory Mutual Engineering Corp.*

# As AIDS spreads, work policies needed

EVEN BRIEF TIME spent reading the newspaper or watching television news reports should convince you that acquired immune deficiency syndrome is no longer simply a freak disease threatening only homosexuals and drug abusers. But if the media isn't persuasive enough, consider these statistics:

- Currently, it is estimated that 365,000 Americans will *have developed* AIDS or AIDS-related complex by 1991. That is up nearly 38% from the 265,000 the Centers for Disease Control projected in 1986 would be affected by the disease next year.
- As of August 1989, 69,000 cases of AIDS had been reported, nearly triple the number reported in 1986. It is currently estimated that 1 million to 2 million individuals are *infected* with the HIV virus, many of whom will eventually contract the disease.
- There presently is no cure for AIDS, and as many as 90% of people exposed to it may die from AIDS-related complications.

AIDS is an insidious disease, no less menacing than the Black Death during the Middle Ages, malaria at the turn of the century and polio before the mid-1950s. And people are afraid of AIDS, like anything potentially lethal and uncontrollable and not yet fully understood. But AIDS is too big and threatening a danger for anyone to ignore, from both a personal and professional standpoint.

In personal matters, the medical community advises caution regarding interpersonal relationships. But what can be done about the dangers of AIDS in the workplace?

In large part, the responsibility for a safe work environment falls on management. But what can management do about AIDS in the workplace?

The best answer is to establish an AIDS-specific, non-discrimination policy, which is no easy task. Before attempting such a policy, employers should become aware of the issues and options involved in hiring or continuing to employ AIDS victims.

The courts have determined that AIDS is a workplace issue and—through decisions that smack of contradiction—have determined that employers' responsibilities extend to both infected and non-infected workers; i.e., infected employees are protected against discrimination and non-infected employees have the right to a safe workplace. Understanding these facts is a crucial first step toward developing an effective corporate policy on AIDS, and what follows are other prerequisites to developing a formal corporate policy.

AIDS is considered a handicap under both federal and state laws that prohibit discrimination against the handicapped and the Employee Retirement Income Security Act, which protects AIDS victims' rights to medical coverage and long-term disability benefits. That means that an adverse employment decision on a person with an AIDS-related condition cannot be made unless the decision is strictly job-related.

Simply put, no action can be taken against an AIDS victim unless the disease has progressed to the extent that an employee is incapable of acceptable job performance. Thus, it is imperative that employers become informed and keep abreast of legislation concerning AIDS and employment rights. Individual state laws protecting AIDS victims vary greatly, so employers should check with their state unemployment agencies to ascertain how local legislation affects them.

Unfortunately, the minds of many people remain clouded by a host of misconceptions about how AIDS is contracted and spread. According to the best medical authorities, AIDS cannot be contracted or spread through casual contact. Thus, there is no medical reason to fear working with someone infected with the disease.

Employers that are educated to the facts are more likely to incorporate policies that establish proper protocol to follow while helping to eliminate the fears and misconceptions existent within their workforces. Therefore, employers should keep current on AIDS-related information from the medical community and share it with employees.

Some employers feel it's not their responsibility to educate employees about AIDS. Many would say that is the job of the medical community. Others might express concern over risks involved in educating workers on issues that may infringe on their rights to privacy. AIDS, after all, is transmitted through sexual activity and drug use, which are considered personal matters.

These are valid concerns and denying so would be foolish. Employers must take precautions in educating their employees. A major one is that employers make sure employees understand the education program is meant to inform and enlighten, not to pass judgment or intrude into personal matters.

And testimony from companies that have instituted educational programs indicates that educated employees are less likely to get caught up in the fear and hysteria many currently associate with AIDS.

The above are basic prerequisites to developing an effective policy to deal with AIDS in the workplace. But any company policy concerning AIDS will be subject to controversy. The issue remains too complex and sensitive to permit a simple, universal solution.

That fact notwithstanding, the issue has to be addressed, and a corporate AIDS policy that reflects an understanding of the law and of the disease, provides educational and counseling programs for employees, and expresses a genuine sensitivity to the concerns for all workers has the best chance of success. ■

*Richard D. Alaniz is a partner in the Houston law firm of Alaniz & Schraeder.*

# Work comp exposures can vary by state

**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.*

*The changes in loss exposures—specifically, workers compensation exposures—as a firm expands into several jurisdictions are the focus of this month's question and answer, which comes from a recent national examination in ARM 54, Essentials of Risk Financing.*

**Q:** The Ace Salvage Co., highly successful in its first two years of operation, is seeking to expand, principally by bidding for some additional projects. These projects would require Ace's employees to work for the first time outside Ace's home state. This work would take place on ships using navigable rivers or on wharves on the banks of these rivers.

- In its first year of operation, Ace's revenues were $6 million. Three years later, in its fourth year, Ace's revenues are projected to be $18 million.

## A.R.M. excercises

Explain how to compute, or give the formula for computing, the compound annual rate of growth in Ace's revenues over these three years.

- Identify and explain the significance of four factors Ace's risk management professional should consider in determining how operations in a second state would be likely to change Ace's workers compensation exposure.
- Ace's employees working on ships or on the banks of navigable rivers become subject to the federal Longshore and Harbor Workers Compensation Act. Explain how, if at all, Ace's obligations to employees who are injured while under the jurisdiction of this act are likely to differ from those owed to its employees injured while working under the jurisdiction of a state workers compensation act.

**A:** Beginning to operate beyond the borders of its home state increases both the number and the variety of loss exposures with which Ace's risk management program must deal:

- The compound annual rate of change (growth or decline) of any quantity is the nth root of the quotient formed by the ending value divided by the beginning value, after subtracting one from this root. In this formula, n is the number of annual periods, here three. Thus, in this example the compound rate of yearly growth is the third (cube) root of $18 million divided by $6 million, or the cube root of three, minus one. (Note that the question does not call for any further computations. For those who wonder, though, many calculators and math texts will show that the cube root of three is about 1.442, making the annual growth rate for Ace's revenues approximately 44.2% more than the previous three years.)
- Among other possibilities, four differences arising from operations in a second state may be:
  - ✔ A different definition of "covered employment" in the second state, which would significantly affect the eligibility of Ace's employees for workers compensation benefits.
  - ✔ A different level of income benefits for replacement of disabled employees' earnings, which could either raise or lower Ace's workers compensation costs.
  - ✔ The presence or absence of a state monopolistic workers compensation fund, which would affect the degree of competition among work comp insurers there.
  - ✔ Either tightened or loosened regulations on Ace's right to self-insure its workers comp obligations, which probably would affect both Ace's costs and its ability to control its work comp expenditures.
- Working under the jurisdiction of the Longshore and Harbor Workers Compensation Act entitles disabled employees to receive higher income benefits than those provided by most state workers compensation laws, thus increasing the amount of Ace's obligations to these employees. The federal act also excludes more employees from its coverage than does the typical state workers compensation act, thereby possibly reducing the extent of Ace's obligations. The administration of benefits to disabled employees protected by the federal act is, however, federally supervised, sometimes more stringently than states' supervision of these matters. ■

*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.*

# Physical injury caused by distress compensable

The Supreme Court of Arizona ruled that a physical injury caused by a worker's emotional response to being notified of his job displacement was an "accident arising out of and in the course of" employment and, thus, was compensable.

For 11 years, Kenneth Murphy worked in the tool crib section of Honeywell Inc. Prior to that, he had worked in a different department for eight years.

In 1985, Honeywell was forced to lay off many of its employees because of financial difficulties. Mr. Murphy and other employees were aware of the possibility they would be laid off. Mr. Murphy was concerned about his financial situation and, for about two months before the injury, experienced trouble sleeping.

In August 1985, Mr. Murphy's supervisor told him he would be transferred to the assembly crew with a one-third pay cut. Upon hearing the news, Mr. Murphy fell to the ground striking his head on the floor. He has been in a coma since the accident and is expected to permanently remain in a vegetative state.

A medical adviser stated that Mr. Murphy fell because of the emotional shock he suffered upon hearing the news of his displacement. Mr. Murphy's wife, as guardian, filed for workers compensation benefits. Her claim was denied.

The appellate court noted that workers compensation benefits were being sought for a *physical* injury that was a result of emotional stress and not for a mental injury, illness or condition.

According to the court, the fall caused Mr. Murphy's injury and the fall resulted from his reaction to the news about being displaced. Thus, the court said the external cause and the resulting injury were unexpected and constituted an accident that was work related. Compensation was awarded.

*Murphy vs. Industrial Commission of Arizona*, Supreme Court of Arizona, May 2, 1989 (*BI*/02/March-$10).

## Legal briefs

### Cover hinges on date of loss, not discovery

An Illinois appellate court ruled that the time that an insured company had to commence an action for a theft loss began from the time of the loss, not from the date the loss was discovered.

Wabash Power Equipment Co. purchased a boiler and auxiliary equipment in 1975. It dismantled the boiler and placed it and the auxiliary equipment in storage in Florida.

Unknown to Wabash, the boiler and equipment were stolen from storage in 1985, during the months of March and April. Wabash did not learn of the loss until July 1986.

On July 8, 1986, Wabash gave notice of the loss to its insurer, International Insurance Co. A proof of loss was filed on Aug. 8, 1986. International denied coverage.

Wabash filed suit in Nov. 21, 1986, seeking a declaration that coverage existed under the policy. The trial court dismissed Wabash's suit.

At issue on appeal was whether the policy required Wabash to file suit on a theft loss within one year of the date of loss or within one year from the date discovery of the loss. The court noted that the theft section of the policy specifically required Wabash to give notice within one year of the loss. The court rejected Wabash's argument that the date of loss must mean the date of discovery of the loss.

*Wabash Power Equipment vs. International Insurance Co.*, Appellate Court of Illinois, June 16, 1989 (*BI*/03/March-$10).

### Court denies forfeiture of jeweler's cover

A policyholder's breach of a warranty in a jewelers block insurance policy to keep 70% of the value of its merchandise in a safe after hours did not justify total forfeiture of coverage, according to a California appellate court.

Chainery Inc. owned and operated three retail jewelry stores. In 1985, Fireman's Fund Insurance Co. sold Chainery a jewelers block policy covering its inventory in all three stores against all risk of loss or damage. Coverage was limited to $70,000 with a deductible of $2,500. Attached to the policy and incorporated therein by reference was Chainery's application, which stated that 70% of the value of property on the premises would be in the store safe after store hours.

During the term of the policy, one of Chainery's stores was burglarized after hours, resulting in a loss of approximately $26,000. The target of the burglary was jewelry in six locked glass display cases inside the store. Nothing was removed from the store safe.

Chainery filed a claim for the entire loss. Fireman's Fund refused any recovery asserting Chainery had breached the warranty with regard to safe storage after hours. The trial court ruled for Fireman's Fund and denied Chainery any damages.

The appellate court concluded that the policy here did not provide for avoidance or termination of the policy for failure to strictly adhere to the safe storage provision. The court said that Chainery's promise to keep 70% of its inventory in a safe was material as to that part of the inventory only. Thus, the court said that the breach here did not justify total forfeiture of coverage under the policy.

The court said Fireman's was obligated to cover the loss of 30% of the inventory by value at the time of the burglary.

*Chainery Inc. vs. Fireman's Fund Insurance Co.*, California Court of Appeal, June 28, 1989 (*BI*/03/Feb.-$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.*

## At issue

### Will the Pepper Commission report increase the likelihood of mandated benefits?

**Gerald N. Cox**
Senior vp-human resources
**Crawford & Co.,**
**Atlanta**

The revenue required to fund this program and its effect on the deficit will help assure its demise. However, the issue of health care and the enormous costs associated with it will keep this topic active in Congress for the foreseeable future.

**Melvin L. Scott**
Manager-employee benefit programs
**Public Service Co. of Indiana Inc.,**
**Plainfield, Ind.**

No. The commission didn't propose any new ideas, they couldn't agree on a uniform solution and the final recommendation was only narrowly approved. Mandating benefits may be a quick fix, but it is really saying "one size fits all." Employers should have the flexibility to meet employee needs without jeopardizing their financial position.

**Nancy Pletcher**
Manager-employee benefits planning & development
**Armstrong World Industries Inc.,**
**Lancaster, Pa.**

No. The narrow margin of approval reflects the lack of consensus as to the best way to deal with access to health care. Gun-shy from recent repeals of benefits legislation, Congress will likely approach the issue of federally mandated benefits cautiously. However, state mandated benefits legislation will expand unless overridden by a federal mandate.

**Roger L. Boman**
Director-compensation, benefits & services
**Coors Brewing Co.,**
**Golden, Colo.**

Yes. I also believe that universal medical coverage is going to be a major issue of the 1990s. Unfortunately, this proposed response from Congress only serves to transfer the cost of medical care to U.S. workers and consumers, rather than addressing the bigger issue of skyrocketing medical costs and the affordability of health care for all Americans.

*Compiled by Christine Woolsey*


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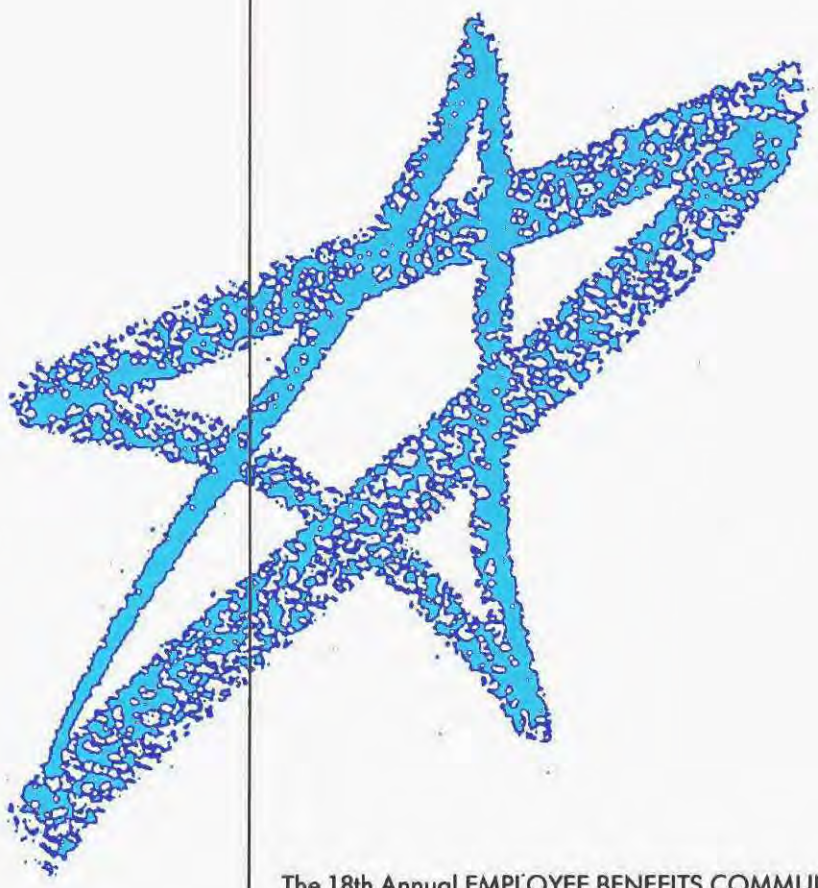

The 18th Annual EMPLOYEE BENEFITS COMMUNICATION AWARDS will be presented on August 13th during a luncheon, in Chicago, sponsored by Business Insurance, honoring excellence in communicating employee benefits.

The Competition is open to all companies in the U.S. and Canada, and has no restrictions as to the size of the company.

A panel of benefit managers and communication specialists will select winners from a variety of categories.

Entries will be accepted beginning April 2nd. No entry will be accepted after April 30th.

For Competition rules and entry forms, or for details and reservations for the Awards Luncheon, write to the EBC Registrar at the address below, or call (212)-210-0780.

Business Insurance
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EBC Awards/Business Insurance
Communication Services Department
220 East 42nd Street, New York, NY 10017


## Stolen art

*Continued from page 3*

hand-picked selection of 12 pieces of art, including paintings by Vermeer, Rembrandt, Degas and Manet.

Among the pieces stolen were:

- "The Concert" by Vermeer.
- Rembrandt's "The Storm on the Sea of Galilee."
- A Chinese bronze beaker dating from the Shang Dynasty, 1200-1100 B.C.
- Five works by Degas: "La Sortie du Paysage," "Cortege aux Environs de Florence," "Three Mounted Jockeys," "Program for an Artistic Soiree" and another less-completed work also called "Program for an Artistic Soiree."

"These masterpieces are of incomparable value," Mr. Block said.

Some experts are puzzled by the theft because the works cannot easily be resold.

"There is no market for these kinds of pictures," Mr. Block said.

"I don't know what these fellows had in mind."

Because the thieves took only Dutch and French works, leaving more valuable Renaissance pieces behind, some experts speculate that a private collector may have commissioned the theft.

**'There is no market for these kinds of pictures,' fine art broker Mr. Block says of the stolen works.**

The thieves also could demand a ransom from the museum, experts say.

The museum last week offered a $1 million reward for information leading to the recovery of the stolen art.

For other museums, the unlikelihood of losing an entire collection in a single event is one reason they do not fully insure collections or do not purchase any insurance.

For example, it would be very difficult for someone to steal a whole collection. And, fire walls are designed to prevent a complete loss in the event of a fire.

Many museums that purchase coverage try to calculate their maximum possible loss from a single theft or fire and generally insure about 25% of the value of a collection under an all-risk policy, according to brokers.

Annual premiums for $10 million in limits range from $10,000 to $50,000, according to Mr. Block, whose fine arts insurance brokerage is the nation's largest.

Premiums vary depending on the museum's size, location, security system, the value of the collection and "many other nuances," he said.

Brokers said a reported nationwide increase in the number of art thefts has had little effect on premiums.

However, the value of art has skyrocketed, which means the cost of fully insuring collections is soaring, according to nation's leading fine arts brokers.

"Policy limits are rising to cover the increasing value of the collections," said Patricia Flando, vp at Near North Insurance Agency in Chicago.

But, "many museums don't fully insure because they can't afford to fully insure," she said.

Another problem unique to the fine arts market is the mind-set of museum curators, many of whom consider it pointless to purchase coverage for their irreplaceable works.

It is very difficult to sell curators on the idea of insurance, Mr. Perkins said. "The standard curatorial mind-set is that 'if it's gone, it's gone." ■

# INTERNATIONAL

# Australians are divided over course of market

By KATE McILWAINE

BRISBANE, Australia—This highly competitive Australian property/casualty insurance market may be showing signs of hardening, some risk managers, underwriters and brokers say.

Following a slew of natural disasters in Australia and elsewhere last year, primary insurers are bracing for higher reinsurance costs. And some risk managers expect those costs to be passed on to them in June, when most Australian companies renew property/casualty insurance programs.

However, others doubt reinsurance price hikes will be sufficient to drive primary rates up in this historically competitive market.

Foremost among the catastrophes that hit Australian insurers last year was last year's Newcastle earthquake, which struck southeastern Australia in late December (*BI*, Jan. 1). Total insured losses are estimated at $700 million Australian ($536.2 million). One source said those quake losses were greater than all other 1989 property losses in Australia combined.

Rodney J. Adler, chief executive of Sydney-based FAI Insurance Ltd., said the Newcastle quake undoubtedly would force rates up.

While Mr. Adler said he could not say rate cutting would be totally absent from June renewals, he noted that Australian insurers have been hit hard by losses from the quake, recent bush fires in New South Wales and a severe storm that struck Brisbane on Dec. 24.

Most Australian corporations favor June renewals, which coincide with the end of their fiscal years, observers say.

Chris L. Meller, managing director of CIGNA Insurance Australia Ltd. in Sydney, a unit of CIGNA Corp., noted the market has become less volatile in recent years and said June renewal rates are likely to rise about 10%.

"It depends on the London market. . .but the severe losses worldwide will mean (reinsurance) treaties will go up," he said.

Mr. Meller said the Newcastle quake, which "jolted a lot of people," would lead to greater rate stability in the Australian market.

"I don't think we will see (severe rate cutting) again," he said.

Daryl Watson, risk and insurance manager for Rothmans of Pall Mall (Australia) Ltd. in Granville, New South Wales, said he expects repercussions in the now-tranquil Australian market from the Newcastle quake and other catastrophes around the world.

"Australia follows the rest of the world market, so I expect there will be changes," said Mr. Watson, who also is president of the Assn. of Risk & Insurance Managers in Australia.

Ken Gaunt, general manager-corporate risk management for Tooronga-based retailer Coles Myer Ltd., agreed that the Newcastle quake would affect the Australian market. But, he said, rising reinsurance rates following Hurricane Hugo, the San Francisco Bay area earthquake and the loss of the Piper Alpha drilling platform in 1988 would have more impact.

While Brendan M. Ryan, assistant risk manager for Melbourne-based aluminum producer ALCOA of Australia Ltd., a unit of Pittsburgh-based Aluminum Co. of America, said the market currently is still "relatively, but not overly, soft," he said he expects rising rates in the London reinsurance market to cause a "toughening up" when Australian renewals come due in June.

ALCOA is negotiating the April 1 renewal of its property insurance program, Mr. Ryan said, but it would be difficult to compare rates because ALCOA is seeking broader coverage. "ALCOA has always had coverage for fire and specified perils, but we are now going to an all-risks policy with increased deductibles," he explained.

John A. Unkles, executive director of the National Insurance Brokers Assn. of Australia, pointed out that big rate cuts were not evident at year-end renewals and that rates are currently holding steady.

However, he added, rates could increase sizably in June.

Paul Venning, assistant general manager-New South Wales for broker Alexander Stenhouse Ltd., agreed the market was steady through year-end renewals but said he has seen isolated cases of rates rising 5% to 10% for some large property accounts.

Wayne Richards, general manager-marketing of Sydney-based CIC General Insurance Holdings Ltd., agreed there was little change in rates at year-end renewals, but noted that June is always "the worst part of the year."

At the end of June 1989, insurers cut rates rampantly, with property/casualty rates falling 15% to 20%, analysts say. And that came on top of even more severe rate reductions the previous year.

Many observers say the Australian market has been highly competitive since the mid-1970s, when

*Continued on next page*

# EC charges six countries over directive

By DENISE CLAVELOUX

BRUSSELS, Belgium—The European Commission is proceeding with legal action against six European Community countries for failing to properly implement the EC's product liability directive.

Those countries are Belgium, France, Ireland, Italy, The Netherlands and the United Kingdom, said a commission spokesman.

The product liability directive, adopted in 1985, was due to be implemented throughout the EC by July 31, 1988. But so far, only seven countries—the United Kingdom, Denmark, Germany, Greece, Italy, Luxembourg and Portugal—have adopted it as national law.

The directive is intended to shift the burden of proof in product liability cases to the producer of a product from the consumer. Most EC nations had required victims of product-related accidents to prove negligence on the part of the producer to win compenstion.

Last year, the European Commission sent warning letters—the first step in the EC's three-stage legal procedure—to eight of the member states (*BI*, Jan. 9, 1989). The letters warned Belgium, Denmark, France, West Germany, Ireland and The Netherlands that legal proceedings would be pursued if they failed to implement the 1985 directive. Spain has not yet passed legislation incorporating the product liability directive, but the commission hasn't decided if it will take action against Spain.

Since last year, both Denmark and West Germany have implemented national laws, and the legal proceedings against them will be dropped.

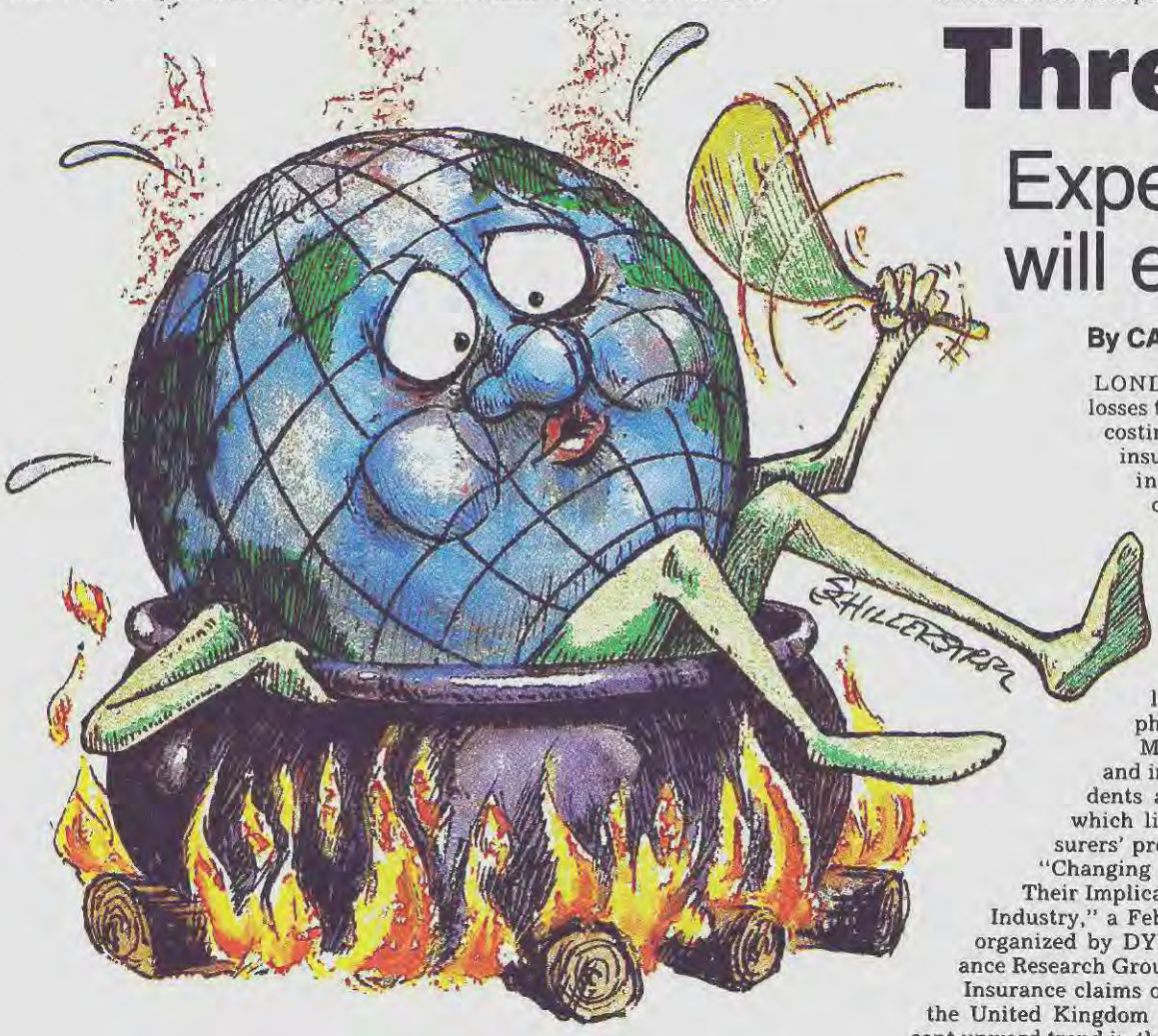
The other two countries to receive warning letters last year— Italy and the United Kingdom—were told that their national implementing legislation did not comply with the terms of the EC directive.

The commission charges the United Kingdom failed to properly implement the directive in its 1987 Consumer Protection Act, which enables manufacturers of unsafe products to avoid paying compensation to victims if they (manufacturers) can prove that they could not have known the products were dangerous.

The EC's product liability directive contains a much stricter development risks—or state-of-the-art defense—clause than that adopted under the British law. According to the EC version, producers of products must prove that no defects could have been discovered according to the highest state of scientific knowledge.

Within the next few weeks, the European Commission will issue reasoned opinions to Belgium, France, Ireland, Italy, The Netherlands and the United Kingdom. This is the second stage in the EC's legal procedure and allows the member state three months in which to explain why it has not yet complied with the legislation in question.

If the European Commission is satisfied with the reply, it can suspend legal proceedings. However, if it is not satisfied, it will take the member state to the European Court of Justice in Luxembourg.




Roger Schillerstrom

# Threatening skies

## Experts fear global warming will exacerbate storm losses

By CAROLYN ALDRED

LONDON—Weather-related losses throughout the world are costing the insurance and reinsurance industry escalating sums of money, underwriters agree.

Increasing property values, growing numbers of policyholders and increased claims consciousness all are contributing to larger and larger payouts following natural catastrophes, they claim.

Meanwhile, the frequency and intensity of weather incidents also seems to be rising, which likely will compound insurers' problems, said speakers at "Changing Weather Patterns—And Their Implications For The Insurance Industry," a Feb. 22 seminar in London organized by DYP Insurance & Reinsurance Research Group Ltd.

Insurance claims over the past 40 years in the United Kingdom "demonstrate a significant upward trend in the frequency and severity of weather incidents," said Graham Shearn, corporate planning manager for the Sun Alliance and London Insurance P.L.C.

And insurers likely will face even greater catastrophic losses in the future if theories supporting global warming prove accurate, agreed several speakers.

"It is now evident that the climate is warming, though there are significant local deviations, with Europe and North America in particular lagging behind," pointed out Andrew Dlugolecki, commercial insurance manager for Perth, Scotland-based General Accident Fire & Life Assurance Corp. P.L.C.

"The detailed impact of the greenhouse effect (heat trapped by gases in the earth's atmosphere) is not yet known, but it will certainly lead to more extremes occurring, due to the warmer ocean currents," said Mr. Dlugolecki.

According to some estimates, by 2030 the world will be warmer than at any time in the last 2 million years.

"The greenhouse effect and its repercussions on the earth's climate have been a subject of discussion for some time now—and not just among meteorologists and climatologists; the insurance industry has also expressed an interest in the topic," said Andreas Schraft, who works in the Catastrophe and Reinsurance Research Department for Swiss Reinsurance Co. in Zurich, Switzerland.

"It is accepted as certain that the climate will get

*Continued on next page*

## Global warming

*Continued from previous page*

warmer. It is, however, far less clear how the climate will vary from region to region and how specific elements, such as the wind patterns, will change," said Mr. Schraft.

Many research institutes and other organizations are studying likely effects of global warming on weather patterns.

For example, the British Meteorological Office in Bracknell, Berkshire, is producing a climatic model to predict the impact of increased greenhouse effect gases in the atmosphere over the next 100 years, said Martin Morris, assistant director of central forecasting services for the office.

The model already shows that increased levels of carbon dioxide in the atmosphere will lead to a greater frequency of tropical cyclones, said Mr. Morris.

Tropical cyclones—better known as hurricanes and typhoons—only occur when sea temperatures hit about 80 degrees and are formed at about 12 to 17 degrees latitude, he said. There are now about 80 tropical cyclones every year, a figure which has not increased markedly this century, with the greatest frequency occurring in the Northwest Pacific, around Indonesia and the Philippines.

However, increasing levels of carbon dioxide and other greenhouse gases in the atmosphere will raise sea temperatures and increase the frequency of tropical cyclones, some scientists predict.

An 50% increase in carbon dioxide levels would cause a 25% increase in the frequency of tropical cyclones, the Meteorological Office predicts.

The new storms, said Mr. Morris, would be concentrated in the Arabian Sea, the North Pacific and off the California coast.

Mr. Morris said he also sees "some indication that the peak winds of the cyclones will increase although the average wind strengths will stay the same."

Meanwhile, Swiss Re studies of claims data from the powerful October 1987 European windstorm, which caused $3 billion in damage, show that only slightly higher wind speeds can cause dramatic increases in damage (*BI*, Oct. 26, 1987).

Mr. Schraft painted a bleak picture for insurers on the assumption "that there will be a larger number of storms in Europe, and in these storms the recorded wind speeds will be higher."

"The wind speeds of the storm of October 16, 1987, were extreme. But in a warmer climate even more severe storms could occur in Europe," he said.

According to Swiss Re's Mr. Shraft, for a storm with maximum gusts of 95 knots—only 5 knots higher than the 1987 storm—"the event loss would be twice as large as that of 1987."

Maximum gusts of 10 knots above the 1987 peaks would make the event loss "almost three times as large," he added.

Both scenarios "are by all means conceivable as a result of the climate change brought about by the greenhouse effect," he warned.

**'In a warmer climate even more severe storms could occur in Europe,' says Mr. Schraft.**

Moreover, he said, his estimates are optimistic. "They do not take into account that if the storm had been more intense, the area affected would have been wider and that the storm could also have lasted longer," he said, adding also that "the 1987 storm was a 'dry' one. There was little rain either during or immediately after the event. If the storm had been combined with precipitation, the damage would have been significantly greater."

If predicted greenhouse changes actually occur, he said, "it might be that the 1987 storm gave us only a foretaste of what might be the rule in a few years or decades."

"Nevertheless, we should not overlook the fact that developments within the insurance industry itself. . . also have a great effect on the insurance cost of storms," said Mr. Schraft.

These include:

- A huge increase in the last 40 years in the number of people who buy insurance.
- The increasing scope of storm coverage in standard domestic and commercial policies. For example, many European countries now include flood insurance in standard policies.
- Replacement value coverage for damaged or lost property rather than coverge based on the insured property's current value. "Storm damage is often due to bad building maintenance. This can be taken into account if the insurance is on a current value basis. If the cover is based on replacement cost, however, the insurer will also pay for the maintenance and not just the storm damage," said Mr. Schraft.

"The increasing availability of cover and the higher sum insured exposure associated with full replacement cover have been accompanied by considerable changes in our lifestyle, which have significantly increased the cost of claims and the risk of water damage to our homes," said Mr. Shearn of Sun Alliance.

For example, most homes now have extensive indoor plumbing, central heating, fitted carpets and fitted kitchens, he noted.

- The inability of insurers to closely investigate as many claims as usual after a storm.

This leaves insurers and reinsurers more exposed to fraudulent or exaggerated claims, agreed those attending the seminar.

"In the short term (all) these developments have a greater effect on the insurance industry's loss burden from storm events than climatic changes occasioned by the greenhouse effect," said Mr. Schraft.

Mr. Shearn suggested that insurers could avoid massive rate hikes or reduced capacity for storm coverage by:

- Encouraging the use of risk management for personal policyholders as well as commercial policyholders.

For example, insurers can offer premium reductions for personal policyholders who take additional precautions like insulating water pipes to prevent freeze damage.

- Encouraging increased retentions by policyholders, which may discourage many fraudulent or inflated claims, said Mr. Shearn.
- Working with building regulatory authorities and companies to improve building standards.
- Increasing contact with water authorities and local municipal authorities to ensure coastal and river flood barriers are maintained. ■

# British insurers' '89 profits battered by weather losses

**By CAROLYN ALDRED**

LONDON—Weather-related losses are taking a heavy toll on British insurers' 1989 profits.

The 25% to 50% decline in profits at three of the major British insurance groups that have reported 1989 results reflect abnormal U.S. and U.K. weather losses last year, the companies report.

For example, 1989 profits were down 43.5% at London-based Royal Insurance Holdings P.L.C. to 126 million pounds ($202.9 million at year-end 1989 exchange rates) from 223 million pounds ($403.6 million at year-end 1988 exchange rate) in 1988.

Premium revenues, however, rose more than 19% last year to 4.74 billion pounds ($7.63 billion), and investment income increased 25% to 522 million pounds ($840.4 million), Royal reported.

"The second half of 1989 saw an unprecedented series of significant losses with Hurricane Hugo, earthquakes in San Francisco and Australia" and drought losses in the United Kingdom last summer, said Royal Group Chief Executive Ian Rushton.

However, "during 1989 the capital and reserves increased by 529 million pounds to 2.66 billion pounds ($4.28 billion), a rise of 25% after allowing for dividends to shareholders of 123 million pounds ($198 million). It is this underlying strength that enables us to cope with catastrophes," said Mr. Rushton.

At Perth, Scotland-based General Accident Fire & Life Assurance Corp. P.L.C. pretax profits were halved—to 147 million pounds ($236.7 million) from 294.1 million pounds ($532.3 million) a year earlier.

In a statement, General Accident attributed the decline mainly to losses from Hurricane Hugo and deteriorating U.K. loss experience in the fourth quarter.

Property/casualty premiums in 1989 increased 21% to 3.1 billion pounds ($4.99 billion) and investment earnings rose 31% to 462.7 million pounds ($744.9 million).

At Commercial Union Assurance Co. P.L.C. in London, a 25% profit drop in profits—to 150.5 million pounds ($242.3 million) in 1989, from 201.8 million pounds ($365.3 million) in 1988—was "largely due to exceptionally severe weather claims," said Chief Executive Tony Brend.

Premium income rose 18% to 3.5 billion pounds ($5.64 billion), Commercial Union reported.

"Hurricane Hugo caused severe damage in the United States and the Caribbean and cost the group approximately 20 million pounds ($32.2 million) in total. Other exceptional weather claims in the United States were 19 million pounds ($30.6 million) higher than in 1988, reflecting the highest level of catastrophe claims for the industry in 25 years," said Mr. Brend. ■

# Rising water seen as property threat

**By CAROLYN ALDRED**

LONDON—Rising water tables are threatening buildings and other construction in major cities throughout the world, an engineering executive warns.

Water levels in London, for example, are rising about 1.5 meters a year and at least one subway line already is below the water table, said Chris Payne, managing director of London-based Bridge Ironworks (Engineering) Ltd.

At that rate, water levels beneath London could rise to just 10 meters below the ground surface in 30 to 40 years, Mr. Payne told attendees of "Changing Weather Patterns—And Their Implications For The Insurance Industry," a seminar in London last month organized by DYP Insurance & Reinsurance Research Group Ltd.

Rising water levels pose a danger to buildings built in London and other cities when water levels were much lower, he warned insurers.

Research by construction companies shows buildings with shallow foundations will suffer from uplift pressures as water levels rise, according to Mr. Payne. And, buildings with deep foundations could be damaged by direct exposure to water, he said.

Also, tunnels and other underground structures in London are at risk of flooding, Mr. Payne said, noting that water is continually pumped out of the London subway's Picadilly Line, the deepest subway tunnel in the system.

The problem of rising water tables is not solely a problem for London, Mr. Payne warned. Many other major industrial cities have been built on aquifers, or layers of water-bearing rock, he said.

Aquifers enabled manufacturers to draw up their own water supply through bore holes driven down into the ground, Mr. Payne explained.

"The industrial revolution demanded an ever-increasing volume of water. Many industrial centers in the U.K. rested on large aquifers," he said. Dropping water levels due to increased consumption forced the construction of deeper and deeper wells.

The first deep wells—200 to 400 feet—were constructed in London at the end of the 18th century, Mr. Payne said.

By 1938, about 1,000 boreholes in London were pumping up more than 50 million gallons of water daily, he said.

The Bank of England—which still maintains its own private water supply through boreholes—built its first borehole in 1851 at a depth of 330 feet. By 1935, the bank constructed its 12th borehole at a depth of 670 feet, showing how far water levels had fallen due to water was being pumped out, said Mr. Payne.

During the years following the Industrial Revolution, many manufacturing industries moved out of city centers and water distribution pipes were constructed, Mr. Payne said.

At the same time, tunnels and subways, including much of London's subway system, were built in large cities, he noted.

Water distribution companies increasingly used water from above-ground reservoirs and the number of boreholes used to supply water dropped drastically in many cities, he said.

This has caused water tables to increase dramatically.

"I have watched a situation develop in the last 20 years which I have been powerless to do anything about," said Mr. Payne, whose engineering company drills and maintains boreholes.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INTERNATIONAL

# Aussie professional liability competition fierce

By KATE McILWAINE

SYDNEY, Australia—Professional liability insurers in Australia continue to heatedly compete for limited business, which will lead to a severely tightened market when losses begin to mount, brokers and underwriters say.

Competition has been fueled in part over the past four to five years since Australian states began to take over workers compensation and compulsory automobile liability coverages, forcing insurers to look for new business, brokers explain (*BI*, Oct. 17, 1988).

As a result, many insurers are increasing their professional liability underwriting, resulting in an "overdone" market of too much competition for too little business, said Frank Earl, managing director of broker Minet International Professional Indemnity Ltd. in Sydney.

"A number of insurers have looked to 'exotic' lines like PI when other areas have dried up," said Mr. Earl, referring to professional indemnity—or liability—insurance.

"I've never seen it as soft as it is now," he said. "Rates are at a non-economic level. It will stay soft for a while to come, but it's hard to see it getting any lower."

For example, professional liability insurance rates for accountants and major law firms have fallen 30% to 40% across the board, according to many brokers.

And, rates have plummeted as much as 50% in the last 18 months, said Ray Armstrong, manager of the professional and financial services division of Sydney-based broker Marsh & McLennan Ltd.

Underwriters are entering the professional liability insurance market "because they think there's money in there," observed Paul Muller, regional manager of financial services-Australasia for American Home Assurance Co.-Australia's branch in Melbourne, a unit of American International Group Inc. "With more players in the market, the main underwriters have no choice but to write the business down."

Mr. Muller explained that many insurers have been engaging in cash-flow underwriting and have a false sense of security because professional liability is a long-tail line of business.

Those underwriters are ruining the market "for those who are in it for the long haul and need the premium income," he said, noting that buyers are changing insurers for professional liability coverage more frequently than they are for other coverages.

But, some insurers may find themselves in trouble as claims begin mounting, Mr. Muller said.

Besides AIG, some of the largest professional liability insurers in Australia include FAI Insurances Ltd. in Sydney; Australian Mutual Provident Society in Sydney; and Chubb Insurance Co. of Australia Ltd. in Melbourne.

Observers do not expect the Australian professional liability insurance market to harden until at least until the end of 1990 and maybe not for several more years.

M&M's Mr. Armstrong expects the professional liability insurance market to turn when insurers start getting socked by claims.

Mr. Armstrong said that, like the 1985 professional liability insurance market, the current market could turn "overnight."

However, such a hardening is unlikely before late 1991, he predicted.

"I think it will take another 18 months to harden, but I hope I'm wrong," he said.

Marsh & McLennan clients include: The

*Continued on next page*

## Australian market

*Continued from page 27*

Cyclone Tracy hit the Northern Territory. Even when the U.S. and European property/casualty markets hardened dramatically in the mid-1980s, the Australian market did not follow suit, observers point out (*BI*, Oct. 17, 1988).

As a result, some question whether the Australian market is capable of hardening.

Rates are stabilizing, but a hard market is "wishful thinking," said Terry R. Herbert, general manager of Melbourne-based GRE Insurance Ltd., a unit of Guardian Royal Exchange Assurance Ltd. of London.

"The downward plunge has slowed," he said. "We're returning to firmness, but it's not a hard market yet."

Ray Kent, chief manager of insurance for Brisbane-based Suncorp Insurance & Finance, said he is concerned that the soft market may not have bottomed out. If that is the case, he warned, there will be some insurers that will "fall over, pull out or get taken over."

There is a "touch of sense" returning to the general liability market, he said, but property insurance is "still a big problem."

Mr. Kent also contended that the actions of reinsurers no longer have the same clout in the Australian market and could no longer prevent underwriters from indulging in rampant rate cutting.

John Priestley, international risk manager for Melbourne-based transport and security firm Mayne Nickless Ltd., said rates inevitably will harden, but the timing of a market turn remains unknown. "I don't see any huge changes."

Another Australian risk manager criticized insurers for an ongoing competitive market.

The Australian insurance market is "stupid, crazy and idiotic," said Ian C. Waters, manager of insurance and risk management for the Committee of Fruit Marketing in Brisbane and a vp of ARIMA.

The insurance market is chasing premium dollars and has an overabundance of capacity, he said.

While the Newcastle quake could contribute to a hardening in the market, Mr. Waters said it could "go either way" with some companies cutting rates further to generate premium to cover their earthquake losses.

Insurers are still quoting rates 15% to 20% lower than the expiring rates in a bid to boost premium income, he charged. "The end result will be a shaky industry," Mr. Waters warned, adding that some Australian insurers will become insolvent in the process.

Reserves have been eaten away increased losses, he said. Any increase in reinsurance rates will "knock a lot of smaller companies." ■


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# INTERNATIONAL

## Professional liability

*Continued from previous page*

Australian Institute of Chartered Accountants, the Australian Society of Accountants, Australia's National Insurance Broker's Assn., the Australian Stock Exchange, the Sydney Futures Exchange and three of the country's four largest law firms.

AIG's Mr. Muller said it is unlikely the soft Australian professional liability market has bottomed out and said he does not expect any hardening until late 1990 when reinsurance treaty renewals are due.

"Australia has to redefine the bottom each year," asserted Mr. Muller.

Minet's Mr. Earl predicted that the market will tighten when insurers have to "reach for the checkbooks" to pay professional liability insurance losses in the next two to three years.

Clients of Minet include the country's major accounting firms, most of which are subsidiaries of American accounting firms.

Mr. Earl said that neither the level of notifications of incidents nor the claims rate seems to have risen dramatically.

However, M&M's Mr. Armstrong said claims have jumped from one a day to three or four a day in the last 18 months.

Mr. Armstrong cited three possible reasons for the increase in claims:

- An economic downturn in Australia has left many companies "looking for a dollar," thus increasing the number of suits against professionals.
- The clients of professionals are better educated and more likely to take legal action if they feel someone has infringed upon their rights.
- Corporate collapses are triggering more suits.

For example, a Minet client, Ernst & Young of Melbourne, faces a suit in the Supreme Court of South Australia seeking $175 million Australian ($134 million) in damages.

The case is believed to be the country's largest professional indemnity case ever.

**Two reasons for more liability claims in Australia are an economic downtown that has left companies 'looking for a dollar,' and lawsuits triggered by bankruptcies, says Ray Armstrong of Marsh & McLennan.**

Ernst & Young is being sued by accounting firm Ferrier Hodgson, which is the liquidator for the Duke Group Ltd.

According to legal sources, Arthur Young & Co., before it merged with Ernst & Whinney, prepared a report for Duke on its 1988 takeover of a company called Kia Ora Gold Corp.

The liquidator alleges that Arthur Young made several errors and omissions in deciding the deal was fair and reasonable, according to court papers.

The suit also questions the independence of the accounting firm.

The liquidator alleges the takeover led to the Duke Group's collapse in mid-1989.

Ferrier Hodgson is seeking $42.5 million Australian ($32.5 million) to pay Duke's liabilities and $132 million Australian ($101.1 million) to indemnify shareholders for losses they sustained following the takeover.

Total damages could be higher if the court rules for Perrier Hodgson and orders the defendant to pay compound interest on the award.

In a landmark case in February 1989, the High Court of Australia ruled that defendants should be ordered to pay compound interest in connection with economic losses.

One source noted that it would "cost seven figures to fight" the claim against Arthur Young and expected the accounting firm to settle out of court.

The country's last big professional liability claim was a $145 million Australian ($111 million) claim against auditors of the collapsed Cambridge Credits Group.

The auditors agreed to pay a $19.5 million Australian ($14.93 million) settlement.

Insurers have been motivated to settle more professional liability claims out of court since the High Court's ruling on compound interest.

Brokers and underwriters expect corporate bankruptcies and liquidations stemming from the October 1987 stock market crash to lead to more claims against the firm's professional advisers.

Meanwhile, when the professional liability market does turn, risk managers who took advantage of the low rates may be worse off in the long run because of the uncertainty of the market, M&M's Mr. Armstrong warned.

Rates will "fluctuate wildly," making it difficult for companies to accurately budget professional liability insurance, Mr. Armstrong said.

At that point, insurance buyers should reduce limits, increase deductibles or both rather than pay significantly higher premiums, he suggested. ■

# Proposal to require greater disclosure by reinsurers fails

**By JOHN PARRY**

GENEVA, Switzerland—Western reinsurers do not have to disclose more information about their financial position to regulators in Third World countries and will not be subject to stricter regulatory controls following the failure of a proposal at a U.N. committee meeting in Geneva last month.

Third World countries are increasingly concerned about "uncollectible reinsurance" and want to ensure greater protection for domestic ceding insurers, explained Mohammed Rifash, an Egyptian delegate who presented the proposal on behalf of the "Group of 77"—a group of more than 100 Third World nations.

Under the group's proposal to a committee of the United Nations Committee on Trade and Development, reinsurers and brokers would be required to gain approval from UNCTAD and the insurance regulators in each member country before writing coverage for ceding companies in those nations.

However, Western nations voted down the proposal at the annual meeting of the UNCTAD Committee on Invisibles and Financing.

Adding extra layers of control to the ceding company-reinsurer relationship would not necessarily better protect Third World cedants, claimed John Kemp, a British trade official who acted as a spokesman for developed nations.

U.N. involvement would lead to only greater bureaucratic infighting and delays in the reinsurance process, he said.

But, Mr. Kemp agreed that brokers and reinsurers ought to voluntarily provide more financial information to regulators in developing nations to keep irresponsible "cowboys" out of the business.

A Soviet delegate generally advocated protective restrictions for Third World insurance companies.

The delegate, Stanislav Konshin, said Western reinsurers may have little interest in providing high-quality products for Third World insurers when they can write more profitably elsewhere.

Mr. Konshin said he favored leaving the development of reinsurance protection to Third World countries and not getting the U.N. involved.

In 1987, the latest year for which figures are available, Third World insurance companies wrote only $961 billion, or 4.6%, of the world's gross premium volume of $20.9 trillion, according to a U.N. report prepared for the meeting.

"Not only is demand for insurance in most developing countries insufficient, it exists mainly for low-expense coverages as automobile insurance and high-risk coverages such as aircraft insurance, which leaves the insurance companies with an unbalanced portfolio of risks," the report said.

As a result, Third World insurers have to rely heavily on a reinsurance market dominated by U.S., West German, Swiss, British and French companies, the U.N. report noted.

This system eventually has to be modified if poor nations are to turn their insurance industries into significant segments of their local economies, UNCTAD Secretary General Kenneth Dadrie told the meeting. ■

# New construction delay cover unveiled

**By CAROLYN ALDRED and STACY SHAPIRO**

## LONDON

LONDON—A new line slip will offer a new form of insurance to cover costs arising from the delayed completion of construction projects outside the United States.

Previously, major projects could only purchase business interruption coverage for losses from the delay of a project due to such perils as fire or explosion.

But the new "project completion risk" insurance, led in Lloyd's of London by underwriter Don Carey, will cover lost revenue and expenses that may arise from other "events beyond the (project owner's) control leading to delay," say the organizers of the coverage.

In addition to physical damage, the policy would be triggered by such events as delay in receipt of supplies, delays caused by weather or adverse ground conditions unforeseen at the time the construction was planned.

The coverage will indemnify policyholders for such liabilities as repayment to lenders; penalties to franchisers; fixed business costs; and contractors' compensation.

However, the policy excludes coverage for delay caused by illegal acts committed by the policyholder or others; breach of the contract by the policyholder; on-site disputes; bankruptcy; and a shortfall of resources.

Lloyd's syndicates underwrite 60% of the policy, other London insurance companies write 20%, and insurers outside London handle 20%.

Up to 50 million pounds ($80.7 million) of project completion coverage is available above a self-insured retention that is determined on an individual basis by the underwriters and contract owners, Mr. Carey explained.

Before insuring a project, underwriters require SPONSOR, a London risk management consultant, to analyze the construction schedule.

Once the inception date of the coverage is agreed, SPONSOR will monitor the progress of the project on behalf of the underwriters, the organizers say.

The coverage "is exciting in its potential," said Mr. Carey.

The new policy means that "projects will retain an extra tier of risk finance," added Tony South, a director of SPONSOR.

The new coverage is aimed at construction projects in the United Kingdom, Europe and British Commonwealth countries such as Canada and Australia that exceed 25 million pounds ($40.4 million) and last for less than five years, said Mr. Carey.

However, "there's no reason why it can't eventually be an international" policy also offered in the United States and other parts of the world, he said.

But for now, Mr. Carey said he and the other underwriters want to stick to offering the coverage in legal systems with which they are familiar.

The line slip was put together by Mr. Carey, SPONSOR and Lloyd's brokers Jardine Insurance Brokers International Ltd. and Bowring International Insurance Brokers Ltd., a unit of C.T. Bowring & Co. Ltd. However, the insurance is available from all Lloyd's brokers, Mr. Carey pointed out.

Underwriters are considering coverage for about four or five projects that have already gone through the risk analysis procedure, he said.

The main exposure the project owners are looking to insure is delay due to unforeseen ground conditions, according to Mr. Carey.

In one case, SPONSOR had to examine the geotechnical properties of the ground where an Italian project was going to be built and consider whether there would be a delay in construction if Roman ruins were found underneath the site and archeologists were brought in to excavate, he said.

## New Guernsey pool

A new aviation insurance underwriting pool has been formed in Guernsey by three Japanese and a Malaysian insurance companies.

Underwriting Management (Guernsey) Ltd. will write gross annual premiums of up to $25 million.

Nippon Fire & Marine Insurance Co. Ltd. of Tokyo will underwrite 40% of the syndicate's business; Fuji International Insurance Co. Ltd., a subsidiary of Fuji Fire & Marine Insurance Co. Ltd. of Osaka, Japan, also will underwrite 40%; Dowa Insurance Co. (U.K.) Ltd., a subsidiary of Dowa Fire & Marine Insurance Co. Ltd. of Tokyo, will underwrite 10%; and East West Insurance Co. Ltd., a unit of Kuala Lumpur, Malaysia-based East West Insurance Bhd, also will underwrite 10%.

The new syndicate will underwrite all types of aviation insurance and reinsurance. Most business initially will be risks previously written by several captives managed by Transglobe.

## Joint venture cover

American International Underwriters (UK) Ltd. is combining several of its existing insurance policies to provide investment and contract risk insurance for companies setting up joint ventures in the Soviet Union, China and Eastern Europe.

The combined coverage would protect investors against confiscation or expropriation of assets or the nationalization of operations. Other government actions, including actions that restrict transfer of earnings or capital, are also covered.

Political risk insurance traditionally covers two areas—investment coverage protects assets abroad and contract insurance protects financial loss caused by contract frustration.

AIU has decided to combine several of its existing policies because foreign joint ventures are exposed to both investment and contract risk, said Nicholas Hedley, assistant vp.

Capacity is available to cover most current joint venture risks, which generally require coverage from about $500,000 to about $5 million, according to AIU.

Contact Mr. Hedley, AIU (UK) Ltd., 120 Fenchurch St., London EC3 M5BP; 01-626-7866.

## Comings and goings

**John Morley** has been appointed general manager and finance director at London-based Guardian Royal Exchange P.L.C. Mr. Morley formerly was deputy chief executive and group finance director of car-rental company Avis Europe P.L.C.

**Chris Pearce** has been appointed assistant general manager of Tower Hill Services Ltd., the computer services subsidiary of English & American Group P.L.C. THS produces underwriting slip software systems and related products for the London insurance market.

Lloyd's of London broker D.G. Durham International Ltd. has promoted **Steve Willsmer** to associate director and **Alex Woodgate** to divisional director with overall responsibility for the claims department.

SBJ Marine Reinsurance Brokers Ltd. has appointed **David Williams** chairman; **Alistair Troughton** deputy chairman; and **Jeffrey Wright** managing director. **David Beresford Jones** is resigning as chairman but will remain a director.

**Alan Taylor** and **Andre White** have been appointed SBJ directors and **Clive Durham** has been appointed an associate director.

**David Williams** was appointed chairman of SBJ Marine Reinsurance Brokers Ltd., succeeding **David Beresford Jones**, who will continue as a director of the company. **Alistair Troughton** has been appointed deputy chairman and **Jeffrey Wright** has been named managing director.

**Bob Orriss** and **Nick Brown** have been appointed directors of London United Marine Agencies Ltd., a marine underwriting subsidiary of London United Investments P.L.C. that was formed last April. ■

# Summary of major property/casualty insurers' 1989 results

(All amounts in thousands of dollars) (Ranked by change in net income)

| Rank 1989 | Consolidated revenues 1989 | Net income 1989 | Percent increase (decline) 1988-1989 | Combined[1] ratio 1989 | Combined[1] ratio 1988 | Net premiums written 1989 | Percent increase (decrease) 1988-1989 | Pretax underwriting income (loss) 1989 | Percent increase (decline) 1988-1989 | Pretax investment income 1989 | Percent increase (decrease) 1988-1989 | Policyholders surplus 1989 | Percent increase (decrease) 1988-1989 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Corporate | | | Property/casualty operations | | | | | | | | | |
| 1 Continental Corp. | 6,078,600 | 153,100 | 16,911.1 | 115.0[2] | 108.1[2] | 4,775,200[2] | (5.5) | (680,000) | (55.3) | 727,200 | 20.8 | 2,163,800 | 14.2 |
| 2 Travelers Corp. | 12,523,200 | 455,100 | 730.5 | 116.1 | 106.8 | 4,589,900 | (9.5) | (688,700) | (138.0) | 741,200 | 16.4 | 2,212,400 | 21.3 |
| 3 Old Republic Int'l | 1,181,997 | 98,971 | 94.1 | 113.4 | 107.9 | 625,793 | 5.3 | (83,940) | (73.2) | 148,445 | 16.6 | 652,283 | 2.5 |
| 4 Lincoln National Corp. | 8,081,100 | 268,800 | 78.1 | 106.7[2] | 100.5[2] | 2,362,500 | 4.7 | (167,900) | (1,898.8) | 318,200 | 14.8 | 1,469,800 | 11.9 |
| 5 Royal Group (U.S. subs.)[2] | N/A | (42,900) | 35.0 | 121.5 | 117.2 | 2,229,400 | (0.7) | (470,000) | (37.9) | 301,000 | 6.2 | N/A | N/A |
| 6 CIGNA Corp. | 15,654,000 | 562,000 | 26.3 | 115.8 | 109.1 | 5,866,000 | (2.3) | (929,000) | (71.4) | 853,000 | 6.2 | N/A | N/A |
| 7 General Re Corp. | 2,771,300 | 598,500 | 24.7 | 99.6[2] | 99.1[2] | 1,898,000 | (0.3) | 28,300 | 253.7 | 673,300 | 18.2 | 2,683,600 | 15.7 |
| 8 Sentry Insurance Cos.[2] | 1,344,782 | 54,026 | 18.8 | 107.5 | 106.2 | 1,032,165 | 10.0 | (75,563) | (3.8) | 148,492 | 8.9 | 613,883 | 13.3 |
| 9 Chubb Corp. | 4,022,400 | 420,800 | 17.0 | 101.5[2] | 99.8[2] | 2,734,900 | (1.1) | (41,900) | (363.5) | 444,400 | 17.8 | 1,292,700 | (3.8) |
| 10 Fremont General Corp. | 466,547 | 17,551 | 15.7 | 105.1 | 105.6 | 326,553 | 19.0 | (16,754) | (7.7) | 60,783 | 28.6 | 201,430 | 44.2 |
| 11 American International Group | 14,150,024 | 1,367,475 | 13.1 | 100.0[2] | 99.2[2] | 8,940,427 | 5.5 | 57,084 | (33.4) | 954,867 | 14.5 | N/A | N/A |
| 12 CNA Financial Corp. | 9,084,000 | 613,500 | 12.3 | 116.0[2] | 108.8[2] | 5,639,000[2] | 8.9 | (923,400)[2] | (90.9) | 1,029,000[2] | 18.3 | 3,118,000 | 16.1 |
| 13 The St. Paul Cos. Inc. | 3,788,648 | 398,158 | 12.1 | 106.6 | 104.0 | 2,807,223 | 4.3 | (196,378) | (117.7) | 614,119 | 11.9 | 1,533,805 | 10.1 |
| 14 SAFECO Corp. | 2,934,379 | 300,217 | 11.8 | 103.3 | 100.3 | 1,595,512 | 5.1 | (52,243) | (927.6) | 263,415 | 19.5 | 1,069,758 | 26.5 |
| 15 Home Insurance Cos. | 3,526,400 | 96,200 | 9.9 | 109.0[2] | 108.7[2] | 2,044,900 | (1.1) | (198,100) | (6.6) | 359,500 | 2.4 | 840,100 | 1.4 |
| 16 Hartford Steam Boiler | 484,532 | 77,571 | 9.8 | 83.9 | 84.0 | 286,859 | (1.4) | 46,239 | (1.0) | 41,679 | 16.5 | 335,472 | 25.9 |
| 17 Crum & Forster Inc. | 4,595,600 | 308,000 | 6.0 | 117.6 | 108.8 | 3,348,700 | (1.6) | (588,300) | (107.0) | 606,900 | 11.2 | 1,530,800 | 10.1 |
| 18 Berkshire Hathaway Group | 637,877 | 201,383 | 2.4 | 106.5 | 101.9 | 296,091 | (38.9) | (24,401) | (120.2) | 243,599 | 5.3 | N/A | N/A |
| 19 Aetna Life & Casualty Co. | 19,671,400 | 676,400 | (5.2) | 114.9 | 109.7 | 6,549,300 | (3.6) | (972,600) | (48.1) | 1,024,900 | 9.7 | 6,692,900 | 4.3 |
| 20 Argonaut Insurance Co. | 467,768 | 70,988 | (6.6) | 103.5[2] | 113.7[2] | 369,564[2] | 27.2 | (15,337)[2] | 62.4 | 112,597[2] | (0.4) | 383,442 | 2.9 |
| 21 Reliance Ins. Co. & subs. | 3,857,169 | 121,763 | (14.9) | 107.1[2] | 103.9[2] | 1,794,142 | 7.0 | (149,438) | (151.4) | 229,172 | 14.3 | 668,428 | 11.2 |
| 22 Ohio Casualty Corp. | 1,577,091 | 101,544 | (20.7) | 103.7[2] | 100.8[2] | 1,377,599[2] | 1.8 | (62,584) | (284.9) | 187,669 | 10.6 | 531,561 | 17.6 |
| 23 Hartford Insurance Group | 8,688,633 | 271,360 | (31.3) | 107.7 | 103.9 | 6,107,682 | (2.1) | (523,454) | (74.7) | 883,321 | 14.9 | 2,566,773 | (2.3) |
| 24 Transamerica Ins. Group | 1,920,527 | 74,888 | (37.6) | 110.4 | 109.2 | 1,658,996 | 1.0 | (176,813) | (20.5) | 221,340 | 9.6 | 1,010,347 | 6.3 |
| 25 USF&G Corp. | 4,678,815 | 119,102 | (51.8) | 109.9[2] | 104.8[2] | 3,697,819[2] | (5.0) | (361,774) | (90.2) | 623,458 | 0.4 | 1,422,900 | 2.6 |
| 26 Fireman's Fund Ins. Cos. | 3,490,124 | 73,267 | (68.9) | 122.3 | 109.2 | 2,693,980 | (5.0) | (596,104) | (116.1) | 457,437 | 1.4 | 1,426,365 | (1.8) |
| — Nationwide Mutual Ins. Co.[2] | N/A | N/A | N/A | 108.2 | 106.1 | 5,794,860 | 5.6 | (368,953) | (33.3) | 696,125 | 11.3 | 2,942,576 | 12.3 |
| — Kemper National P/C Cos.[2] | N/A | N/A | N/A | 110.5 | 104.9 | 2,580,480 | 13.2 | (288,805) | (106.6) | 299,994 | 12.3 | 1,671,419 | (2.3) |
| — Commercial Union Ins. (U.S.)[2] | N/A | N/A | N/A | 112.0[3] | 106.7[3] | 1,242,600 | 3.2 | (155,300) | (69.4) | 162,600 | 8.0 | 598,300 | 7.3 |
| — Liberty Mutual Ins. Co.[2] | N/A | N/A | N/A | 115.5 | 113.7 | 6,261,094 | (5.5) | (791,866) | (43.3) | 1,012,401 | 10.6 | N/A | N/A |
| Cumulative | 135,676,913 | 7,457,764 | 12.7 | 110.7 | 106.3 | 91,527,239 | (0.2) | (9,467,984) | (75.1) | 14,440,113 | 11.8 | 39,632,842 | 6.7 |

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

# Insurer results

*Continued from page 1*

phe losses, 30 major property/casualty insurers surveyed by *Business Insurance* posted a 110.7% combined ratio for 1989, compared with 106.3% for 1988. The 1989 figure is the highest combined ratio for surveyed insurers since the 110.9% posted in the first quarter of 1986 (see chart, page 1).

The industry's combined ratio will be worse in 1990 than in 1989, said Dennis Busti, president of Reliance National Insurance Co. in New York, a unit of Reliance Group Holdings Inc.

"There's no question. Unequivocally. The dye is already cast," he said, predicting the 1990 combined ratio would be 112% or 113% or "even worse than that."

Most of insurers' 1990 underwriting results will be produced by actions taken in 1989, and "the pricing activity in 1989 is certainly not adequate to keep results from deteriorating further," agreed Robert A. Anker, president and chief executive officer of American States Insurance Co., a unit of Fort Wayne, Ind.-based Lincoln National Corp.

Underwriting results will improve in 1990 compared to 1989, but "that's mainly because I'm assuming catastrophe losses will return to a more normal level," said Jeffrey Cohen, senior analyst with Goldman Sachs & Co. in New York.

But David Seifer, vp with Donaldson, Lufkin & Jenrette Securities Corp. in New York, said: "I'm expecting underwriting experience in 1990 and 1991 to be worse even if the catastrophe levels in 1990 and '91 are nowhere near '89's." He predicted a 112.5% industrywide combined ratio in 1990 and a 113.5% combined ratio in 1991.

While the property/casualty insurance pricing cycle is now bottoming out, insurers still must withstand two more years of poor results because of the mistakes of 1987 to 1989, said Mr. Seifer.

Property/casualty insurers surveyed by *Business Insurance* also reported that:

- Underwriting losses increased a whopping 75.1% in 1989 to $9.5 billion. Insurers reported a 23.2% increase in underwriting losses in 1988 (*BI*, March 20, 1989).
- Net written premium volume actually fell by 0.2%, another indication of widespread rate cutting. Premium volume rose 1.6% in 1988.
- Investment income increased 11.8% in 1989 to $14.4 billion. The 1988 increase was 11.3%.
- Policyholder surplus among the 25 insurers reporting this data increased 6.7% to $39.6 billion in 1989. Policyholder surplus increased 12.8% the previous year.
- Net income among the surveyed insurers increased 12.7%, to $7.5 billion for the year. *BI* did not track insurers' net income until 1989.

Continental Corp. reported the largest percentage increase in net income last year, with a 16,911.1% increase to $153.1 million in 1989, from $900,000 in 1988.

New York-based Continental's 1988 profits were deflated by a $121.6 million loss from the sale of its life insurance operations, said a spokesman. Continental also reported $126.2 million in realized capital gains in 1989, compared with $400,000 in 1988, he explained.

Travelers Corp. of Hartford, Conn., reported that 1989 net income increased 730.5% compared with 1988 for a number of factors, including a major addition to real estate reserves in the second quarter of 1988 that significantly lowered last year's results.

Analysts and other observers generally say that low premium rates will continue to plague insurers this year and possibly for years to come.

While rates have stopped declining "there doesn't seem to be any momentum" to increase them, said Herbert Goodfriend, an analyst with Prudential/Bache Securities Inc. in New York.

Rates could begin to increase by mid-1990, but the market will not turn until the end of the year or perhaps even 1991, Mr. Goodfriend said. "I think the industry still has too much capacity, and that's an overriding consideration."

While prices have not declined "with a vengeance" for some time, current prices are still too low, said Barbara Stewart of Stewart Economics, an insurance industry analyst in New York.

Under these conditions, 1990 underwriting "results are likely to be worse than they were in '89," said Ms. Stewart.

Alan Levin, senior vp at Standard & Poor's Corp. in New York, noted that the rating agency in December had concluded "there was some cause for optimism" that prices would begin to increase and that property/casualty insurer's financial results could improve by late 1990.

S&P has not changed its forecast, but events and indications now "aren't very favorable," Mr. Levin acknowledged. Rates for year-end 1989 renewals were a "little worse than we expected," he said.

"It looks like the industry is being a little bit more competitive than it should be," Mr. Levin said, adding he is "somewhat concerned" about insurers' 1990 financial results.

"The rates are not going up as robustly as had been hoped from late last year," said Dick Paulsen of Boston-based Paulsen Securities. If rates in general rise 5% in the first half of 1990, "I would be pleasantly surprised."

If inflation remains at only 5%, insurers cannot force rate increases of two to three times the general inflation rate "with impunity," he pointed out.

While some observers disagree whether rates are still heading downward, "there certainly isn't any signs it's turned around," said Marvin Shulman, a senior analyst with Moody's Investors Service Inc. in New York. He predicted the market will not turn before mid-year.

As a result, said Mr. Shulman, there will not be a big change in 1990's financial results. "I don't think they're going to be any different," he said. "I think there's a good chance they won't worsen, but I don't think they're going to

*Continued on next page*


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Business Insurance a publication of Crain Communications Inc

# Insurers defend quality of investments

By JUDY GREENWALD

Multiline insurers say there is no need to be concerned about the quality of their assets.

Widespread publicity about the crises involving First Executive Corp.'s troubled junk bond portfolio and the Bank of New England's real estate mortgage losses has focused attention on the quality of insurers' assets as well.

"Everyone's looking at real estate and high-yield bond income investments," said Michael Lewis, first vp at Dean Witter Reynolds in New York.

"There's potentially some significant problems," especially if insurers are forced to write off some of these assets, Mr. Lewis said.

Junk bond investment is a "concern, but I don't know how significant it is," said Jeffrey Cohen, a senior analyst at Goldman Sachs & Co. in New York.

"Asset quality's become a major concern," agreed Gloria Vogel, associate director at Bear Stearns & Co. in New York. However, she added that "overall, the concerns for most of the major (insurers) have been overdone."

Earlier this year, First Executive Corp. of Los Angeles, a longtime client of Drexel Burnham Lambert Inc. and parent of First Executive Life Insurance Co., said it was taking a $515 million write-down on potential losses in its junk bond portfolio.

First Executive's problems in part have prompted Congress to question the security of workers' and retirees' pension benefits after companies terminate overfunded defined benefit pension plans. First Executive Life earlier this year had intended to sell annuities to a Kansas employer that is seeking to terminate its defined benefit plan (*BI*, Feb. 12).

Meanwhile, observers say Boston-based Bank of New England's $1.11 billion net loss in 1989 stemmed from aggressive lending during a mid-1980s real estate boom in the Northeast. Slumping prices subsequently caused lenders to default.

Insurers say the concern over asset quality is unwarranted for two reasons:

- Insurers' strategy in commercial real estate investments is very different from that used by Bank of New England and other banks.

For instance, insurers, unlike banks, generally make loans only in connection with completed projects. By making only rare construction loans, insurers are less likely to be stuck with losses if a new building is unable to attract tenants.

- Junk bonds often represent only a small portion of insurers' total invested assets (*BI*, Feb. 12).

Observers note that "pure" property/casualty insurers generally hold even fewer junk bonds than multiline insurers, whose bonds usually are held in their life insurance units' portfolios. Property/casualty insurers also have relatively few real estate investments.

Trouble in some banking institutions' commercial mortgage loan portfolios have led to similar concerns about insurers' investments. However, these fears have been "greatly overstated," said a spokesman for Aetna Life & Casualty Co. of Hartford, Conn.

As of year-end 1989, Aetna reported $23 billion in mortgage investments—$22 billion in commercial and $1 billion in residential mortgages.

The commercial mortgages are primarily on existing, well-leased properties like shopping centers and hotels, the spokesman said. Aetna does not make new construction loans, he said.

Problem loans—defined as those with payments more than 60 days overdue—constitute 1.7% of the outstanding mortgage principal balance owed. And Aetna's mortgage loan losses are not increasing significantly, according to the spokesman.

"We're seeing a lot of concern" about real estate investments, following the banks' problems, he said. "We don't think it's the most logical jump," he said, however.

"We're really as stodgy and conservative as investors want us to be. In this case, it's to our benefit," he said.

"We're in a totally different business" than banks, agreed a CIGNA Corp. spokesman. The Philadelphia-based insurer does not make construction loans, he said.

"Our so-called asset quality, we think, is reasonably good," said the CIGNA spokesman. Of its $10.24 billion mortgage loan portfolio, 3% or $311 million consists of delinquencies and foreclosures, he said.

Robert W. Crispin, executive vp and chief investment officer for Fort Wayne, Ind.-based Lincoln National Corp., said insurers have the expertise to invest in real estate projects.

"Our industry has been making these kinds of loans almost as long as the industry has existed," he said.

Savings and loans, conversely, began making commercial real estate loans in the early 1980s, sometimes led by residential real estate specialists who were inexperienced in commercial markets, Mr. Crispin said.

Commercial mortgage loans accounted for 17% of Lincoln National's $17 billion investment portfolio. At year-end 1989, 6.5% of its mortgage loans were defined as problem loans.

"We are not doing construction loans," Mr. Crispin noted. He added that the company will sometimes loan money to non-completed projects, but only if the loan is secured against either an escrow fund or a letter of credit, so Lincoln National is not bearing the risk of the property not being leased.

However, one multiline insurer, Hartford, Conn.-based Travelers Corp., has taken a hit to earnings because of real estate investment problems.

Travelers added $415 million to its real estate reserves during the second quarter of 1988 for unpaid principal and interest owed on mortgage loans (*BI*, Aug. 29, 1988). The provisions have proven to be adequate, and the portfolio is now performing well, said a spokesman.

Travelers Realty Investment Co., a Travelers Corp. unit that was reorganized in 1989, manages $19.1 billion in real estate and mortgages for both Travelers and its customers. Real estate accounts for 34% of Travelers Corp.'s total assets, said the spokesman.

Insurers and other observers also say there is little cause for concern about insurers' junk bond holdings.

"Very few companies actively made a practice of buying newly issued junk to beef up their investment income," said Charles Ronson, an analyst with Baird, Patrick & Co. in New

*Continued on next page*

## Property/casualty results

*Continued from previous page*

be significantly better, either."

"We see 1990 as kind of a blah year where the market kind of levels off," said Reliance's Mr. Busti. Overall rates, though, could could start to improve by the end of the year, he said.

But Mr. Busti, along with some other observers, warned against assuming that rates will rise in the coming months.

Competition also could again heat up, he said. If reinsurers begin to worry about falling premium volume, they could lower rates aggressively, which would be "like throwing a match into a can of gasoline," Mr. Busti warned.

The fact that primary property/casualty insurance rates may have stabilized for now does not mean there will be a saucer-shaped upturn, said David Wells, a vp with rating agency Fitch Investors Service in New York. The current stabilization could also turn out to be another ledge in a downward slope, he added.

Michael Morrissey, a principal with Firemark Consultants Inc. in Morristown, N.J., agreed that the underwriting environment could become worse for insurers before it gets better. "I don't think it's a foregone conclusion that the next inflection point in rates is going to be upwards."

Trends that have developed since World War II, he explained, indicate that when the pricing cycle is "bumping along the bottom"—as it is now—the next change in pricing would be down, rather than up, as insurers try to retain market share by lowering prices.

Mr. Morrissey said he expects the industry's combined ratio to rise three to four points in 1990, "with no significant firming of rates for at least another year."

Bob Riordan, director of investor relations for Novato, Calif.-based Fund American Cos., the parent of Fireman's Fund Insurance Co., observed that "for the moment, the market seems to have flattened out." However, "you're never really sure."

With only small rate increases now being introduced, the market could easily backslide, he said, noting that Fireman's Fund would be happy if it could introduce 8% to 10% rate increases by year-end.

Even insurers that are raising rates acknowledge that the increases are insufficient to offset rising loss costs.

"We are getting price increases. They are not yet at the level we need to be for adequate margins," however, said a spokesman for Philadelphia-based CIGNA Corp.

He said CIGNA has begun to increase rates by 5% for property/casualty lines, except workers compensation, where increases are 7% to 8% (*BI*, March 19). But, he added that "we need anywhere between 10% and 20%, depending on the line of business."

"We're prepared to lose business to get there," said the spokesman.

Kemper has been trying to raise rates 5% to 10% since January, said Gerald Maatman, president of the Kemper Group's national insurance companies in Long Grove, Ill.

"We are beginning to try to keep careful score on how well we're doing on renewals," he said. "Generally, it looks like were being successful on approximately one-third of our renewals."

Mr. Maatman cautioned, however, that "this is only on the basis of a month or two," and the insurer does not know if the rate increases ultimately will take hold. "Very definitely, we're committed to giving it our very best effort" and will not give up even if some business is lost, he said.

"Right now, the losses are increasing faster than the prices are increasing, but some of this is momentum," Mr. Maatman said, referring to business written at low rates last year that still is generating losses. Higher rates on business now being written will not be reflected in earned premium for another six to nine months, he noted.

SAFECO Corp. has been raising rates by about 6%, though it is trying to increase them about 10%, said George Yonker, assistant controller for the Seattle-based insurer. "About all we're doing at that level is holding our own," said Mr. Yonker of the 6% increase's effect on underwriting results.

Rates are up about 5%, but loss costs are up a "little more" so that "the industry is still treading water, if you will," said Gloria Vogel, associate director at Bear, Stearns & Co. Inc. in New York.

Although Ms. Vogel says rates now are creeping up, insurers' combined ratios will rise if loss costs increase faster than rates, she said.

Observers point out that the hopes expressed by some last fall that Hurricane Hugo, the California earthquake and other catastrophes would turn the market was merely wishful thinking, at least in part because of the large amount of capacity still available.

"There still seems to be a lot of capital sloshing around the marketplace," said Michael Lewis, first vp at Dean Witter Reynolds in New York. Many companies generated capital gains in 1989 that increased their policyholder surplus and helped offset the catastrophe losses, said Mr. Lewis.

"I just don't think the catastrophes took enough capital," said Mr. Wells. One question, he said, remains: If the catastrophes in the second half of 1989 were insufficient to turn the market around, what will?

"What is it going to take?" he asked. It is "kind of frightening" to think that as the insurance industry grows larger, it takes something of a much larger magnitude to turn the market around, Mr. Wells said.

Kemper's Mr. Maatman said the market likely did not harden following last fall's catastrophes "because it didn't have that much of an impact on the reinsurance market." When reinsurers did not hike primary insurers' reinsurance rates after the catastrophes, it told primary insurers they did not have to stiffen their prices either, he observed.

Many insurers also believe that, excluding the catastrophes, their 1989 underwriting "wasn't all that bad," said Goldman Sachs' Mr. Cohen. And because they considered the magnitude of last year's catastrophes unusual, "that hasn't scared them off" from low rates.

"People think the business is better than it really is," he said.

Moody's Mr. Shulman warned it is not necessarily safe to assume, as some observers do, that catastrophes will be less severe this year than in 1989.

"There are signs that catastrophe experience might be worsening," said Mr. Shulman. For instance, he noted that while a 1987 windstorm in England and France was described as a "once-in-a-lifetime" event at the time, windstorm losses in Europe so far in 1990 rival the 1987 losses (*BI*, Feb. 12; Oct. 26, 1987).

Other observers also say the devastating windstorms in Western Europe this year could be a signal of changing world weather patterns that could generate a large volume of claims against insurers and reinsurers worldwide (see story, page 27).

Meanwhile, insurers' reserving practices remain an ongoing concern among some observers.

Current pricing practices do "not make us feel good about the reserves situation" said S&P's Mr. Levin. "Price inadequacy generally translates into inadequate loss reserves."

Reserves did not grow as rapidly during the fourth quarter as they did earlier in the year, said Goldman Sachs' Mr. Cohen, who added that he believes reserve adequacy deteriorated during 1989. "That problem is going to have to be addressed someday."

Some insurers have either underreserved or slowed down rate increases "in a way that was troubling," said Joyce Culbert, vp of S.G. Warburg & Co. in New York.

Many companies now are underreserved by 10% to 20%, according to DLJ's Mr. Seifer.

Reserve strengthening is typically postponed when earnings are squeezed, said Ms. Stewart. "Reserves are the great unknown in the insurance business simply because the casualty problems are really unforecastable," she commented.

Mr. Paulsen, however, was more optimistic. "I think the earnings are going to get better because reserves are redundant because of changes in the legal system" that favor insurance companies, he said.

Insurers that put up reserves several years ago as a buffer are now able to release those now-redundant reserves into earnings, he explained. ■

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Business Insurance

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York.

While Mr. Crispin noted that the returns on higher-risk investments may fluctuate, junk bond problems have not had a significantly negative impact either on Lincoln National in particular or on the insurance industry overall, he said.

"It's not been a strategy that our industry has undertaken that would put it anywhere near the class of the S&Ls," he said.

About 5%—or $653 million—of Lincoln National's $17 billion portfolio is junk bonds, said Mr. Crispin. He added the company has no plans to change its strategy of investing in junk bonds.

But, he said, the company does not follow a "you bet your company" strategy. "We're just not going to take excessive risks of any kind."

The Aetna spokesman said the company has about $300 million invested in junk bonds—or about 1% of its $33 billion bond portfolio—as of Dec. 31.

The CIGNA spokesman said the company has $1.5 billion—or 7.2% of its $21.5 billion fixed-maturity portfolio—in securities that were either rated below investment-grade or non-rated.

Hartford Insurance Group of Hartford, Conn., has no junk bond investments, though in some cases investment-grade bonds in its portfolios have been downgraded. "Our policy precludes investing in junk bonds," said a spokesman.

The market value of USF&G Corp.'s junk bond holdings have declined only 5% as of the end of January compared to their original value despite the current weakness in the junk bond market, said a spokesman for the Baltimore-based insurer.

"We've done very well with the portfolio," he said. The bonds represent about 6.9% of the company's invested assets.

USF&G's junk bonds are intended to be held to maturity, the spokesman said. "It's very conservatively run," said the spokesman, who added the company has no plans to change its strategy.

A spokesman for Reliance Group Holdings Inc. in New York, whose estimated $2.6 billion in non-investment-grade and non-rated bonds account for 30% of its invested assets, said: "We have a successful track record as an investor in high-yield securities in the past."

Reliance took a $105 million third-quarter 1989 write-down on junk bonds that defaulted or were sold last year, but still reported pretax capital gains of $45 million in 1989, the spokesman said.

He also pointed out that the percentage of assets Reliance has invested in junk bonds has declined to 30% from 42% two years ago. Most of the bonds are in its life insurance portfolio, the spokesman added.

"We're very confident in the quality of our fixed-income portfolio right now, and expect to continue to produce excellent returns," he said.

The $560 million in junk bond investments in SAFECO Corp.'s life insurance company portfolio constitute about 14% to 15% of the company's life insurance invested assets and about 6% to 7% of the parent company's total invested assets, said Assistant Controller George Yonker.

Seattle-based SAFECO's strategy has been to buy junk bonds in conjunction with its life insurance unit's interest-sensitive products, he said. He noted, however, that because of the weakness of the junk bond market, SAFECO has not purchased any junk for six to nine months.

"There's been a lot of hooting and hollering about the junk bonds," said C. David Mencer, controller at Hamilton, Ohio-based Ohio Casualty Co., which has been in the junk bond business about 10 years.

As year-end 1989 Ohio Casualty held below-investment-grade bonds with a face value of $700 million and a $655 million market value, which translates into a $45 million unrealized loss.

However, Mr. Mencer defended junk bonds which provide interest rate adjustments and other kinds of protection that cannot be found with AAA-rated securities, he said.

In addition, he said Ohio Casualty's strategy is to spread its risk among varied types of investments and different industries so that it is not affected by the economic cycle. The company, "on balance, comes out ahead."

Unlike many other insurers, Ohio Casualty keeps most of its junk bonds in its property/casualty portfolio, which has $500 million of the company's $700 million in such investments. The remainder is in its life insurance company's portfolio. ■


1989/1990

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**IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS**
**COUNTY DEPARTMENT, CHANCERY DIVISION**

**IN THE MATTER OF THE LIQUIDATION OF THE PATRIOT LIFE INSURANCE COMPANY**
**NO.89 CH 9456**

**NOTICE OF CLAIMS DATE AND PROCEDURES**

PLEASE TAKE NOTICE that on August 23, 1989 an Order of Liquidation With a Finding of Insolvency was entered against Patriot Life Insurance Company ("Patriot") by the Circuit Court of Cook County, Illinois. Zack Stamp, Director of Insurance of the State of Illinois is the statutory and court affirmed Liquidator of Patriot.

TAKE FURTHER NOTICE that pursuant to the Order, all rights and liabilities of Patriot and its creditors, policyholders and all other persons interested in its assets are fixed as of August 23, 1989, unless otherwise provided in a subsequent order of the Court.

TAKE FURTHER NOTICE that on September 13, 1989 the Circuit Court of Cook County, Illinois entered an Order Fixing the time and procedure for the filing of claims. Pursuant to the terms of that order, any and all persons, partnerships, corporations, associations, estates, trusts and governmental units having or claiming to have any accounts, debts, claims or demands against Patriot, or claiming any right, title or interest in or to any funds or property of Patriot in the possession of the Liquidator are required to file a Proof of Claim with Liquidator, or the Florida Ancillary Receiver, on or before 4:30 p.m. Chicago Time, August 24, 1990.

TAKE FURTHER NOTICE that the form and required content of all proofs of claim are described in the Illinois Revised Statutes, 1987, 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, Patriot Life Insurance Company, in Liquidation, 446 East Ontario Street, Suite 700, Chicago, Illinois 60611 or the Florida Department of Insurance, Ancillary Receiver of Patriot life Insurance Company. Post Office Box 110, Tallahassee, Florida 32302. Filing shall occur upon receipt of Proof of Claim by the Liquidator or the Ancillary Receiver. The Liquidator reserves the right to require such additional information with respect to any claim as he may deem necessary. The Liquidator further reserves all rights to any and all defenses of Patriot concerning such claim(s). 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 CLAIMS WITH THE LIQUIDATOR OR THE ANCILLARY RECEIVER AT THE ABOVE MENTIONED OFFICES IS AUGUST 24, 1990 AT 4:30 P.M., CHICAGO TIME. NO ONE HAVING OR CLAIMING TO HAVE ANY CLAIMS AGAINST PATRIOT LIFE INSURANCE COMPANY SHALL PARTICIPATE IN ANY DISTRIBUTION OF THE ASSETS OF PATRIOT UNLESS SUCH CLAIMS ARE FILED WITH THE LIQUIDATOR OR THE ANCILLARY RECEIVER ON OR BEFORE AUGUST 24, 1990 AT 4:30 P.M.

James W. Schacht, Special Deputy Liquidator

### INVITATION TO BID

The Virgin Islands Housing Authority invites sealed bids for the procurement of insurance for Fire and Extended Coverage. The coverage is to become effective May 9, 1990. The bid closing date is April 24, 1990. For bid information and a copy of the Invitation for Bids, contact the **Property, Procurement & Maintenance Department, Virgin Islands Housing Authority, St.Thomas, VI, (809) 775-2741.**

### NOTICES

**IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS**
**COUNTY DEPARTMENT, CHANCERY DIVISION**

PEOPLE OF THE STATE OF ILLINOIS, ex rel.,
Zack Stamp, Director of insurance of the State of ILLINOIS,
plaintiffs,
NO: 89 CH 11201
V.
INTERCONTINENTAL INSURANCE COMPANY,
a Domestic Stock, Property and Casualty
Insurance Company,
Defendant.

**NOTICE OF CLAIMS DATE AND PROCEDURES**

PLEASE TAKE NOTICE, that on January 12, 1990 an Order of Liquidation With a Finding of Insolvency was entered against Intercontinental Insurance Company ("Intercontinental") by the Circuit Court of County, ILLINOIS, ("Liquidator") is the statutory and court affirmed Liquidator of Intercontinental.

TAKE FURTHER NOTICE, that on January 19, 1990, the Circuit Court of Cook County, Illinois, entered an Order Fixing the Time and Procedures of Filing of Claims ("Fixing Order"). Pursuant to the terms of the Fixing Order, all policies of insurance issued by Intercontinental is not licensed to do business and which do not have an applicable insurance guaranty association insureds of Intercontinental are cancelled as of 12:01 a.m. on January 12, 1990, unless the same had been cancelled or have expired prior to such date.

TAKE FURTHER NOTICE, that all rights and liabilities of Intercontinental, and its creditors, policyholders and stockholders, and all other persons interested in its assets, are fixed as of January 12, 1990, unless otherwise provided in a subsequent order of the Court.

TAKE FURTHER NOTICE, that all persons and entities, who have, or may have, claims, contingent or otherwise, against Intercontinental, or the property or assets of Intercontinental, shall have the right to present and file with the Liquidator, proper proofs of claim on or before 4:30 p.m., Central Daylight Time, on July 12, 1991, and all contingent claims filed by the insureds of Intercontinental, and persons having a cause of action against such insureds, must be fully liquidated on or before 4:30 p.m., Central Daylight Time, on July 13, 1992. Such contingent claims by insureds may be allowed if such claim is fully liquidated, and the insured presents evidence of the payment of such claim to the Liquidator, on or before such final date and such contingent claims by persons claiming against such insureds may be allowed if such persons demonstrate to the Liquidator that the proofs submitted to the Liquidator upon such claim satisfy the requirements of *ILLINOIS Revised Statutes*, 1987, Ch. 73, Para. 821 by such final date.

TAKE FURTHER NOTICE, that the form of, and required contents of, all proofs of claim are described in *ILLINOIS Revised Statutes*, 1987, Ch. 73, Para. 821. Proofs of Claim, together with supporting documents, if any, are to be filed with, and may be secured from, the Special Deputy Liquidator of Intercontinental Insurance Company, In Liquidation, 446 E. Ontario, Suite 700, Chicago, ILLINOIS 60611. Filing shall occur upon the receipt of the Proof of Claim by Liquidator. The Liquidator reserves the right to require such additional information with respect to any claim filed with him as he may deem necessary. The Liquidator further reserves any and all defenses available to Intercontinental upon all filed claims. All Proofs of Claim must be duly sworn to before an Officer authorized to take oaths.

THE LAST DATES FOR THE FILING OF PROOFS OF CLAIM WITH THE LIQUIDATOR AND THE LIQUIDATION OF ALL CONTINGENT CLAIMS, IS SET FORTH ABOVE. NO PERSONS HAVING OR CLAIMING TO HAVE ANY CLAIMS AGAINST INTERCONTINENTAL INSURANCE COMPANY, OR ITS INSUREDS, SHALL PARTICIPATE IN ANY DISTRIBUTION OF THE ASSETS OF THE COMPANY, UNLESS SUCH CLAIMS ARE PROPERLY FILED, AND IN THE CASE OF CONTINGENT CLAIMS PROPERLY LIQUIDATED, WITH THE LIQUIDATOR ON OR BEFORE THE ABOVE RESPECTIVE DATES.
James W. Schacht, Special Deputy Liquidator

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# Health insurers

*Continued from page 1*

higher than the true inflation rate of medical costs." Now, however, there has been a "fair amount of catch-up" which is being reflected in the medical cost rates, he explained.

As a result, premium increases for small-case indemnity accounts are rising by 30% to 35%. Medium-sized and larger accounts are experiencing premium increases of around 25%, he said, while HMO premiums are being raised 15% to 20%.

Overall, improving group health insurance results will aid multiline insurance companies, which are facing continuing deteriorating underwriting results in their property/casualty insurance operations (see story, page 1).

Better group health results "will certainly help the multilines," commented Jeffrey Cohen, senior analyst with Goldman, Sachs & Co. in New York.

But group health premium increases could be a "two-edged sword," said Michael Lewis, first vp at Dean Witter Reynolds Inc. in New York.

Mr. Lewis warns of a possible consumer "backlash" instigated by high health insurance premium costs and the growing portion of the country's gross national product claimed by medical costs.

Health insurance premium increases are easier targets for consumer activists than the more difficult underlying problems that are causing health care costs to rise, said Mr. Lewis.

"There is a tremendous outcry now for some form of controls on health costs," said Thomas G. Rosencrants, senior vp and director of research at Charlotte, N.C.-based Interstate/Johnson Lane Inc., a securities and futures brokerage service.

And William Caulfield, senior vp of group benefit services at John Hancock Mutual Life Insurance Co. in Boston, said that in addition to being concerned about increased federal and state regulation of group health care benefits, he also worries about the impact of overcapacity in the health insurance marketplace.

More and more companies are establishing health maintenance organizations and preferred provider organizations "without a helluva lot of thought," said Mr. Caulfield.

Meanwhile, however, observers say they are generally pleased with 1989 results and look forward to continued gains in 1990.

"The earnings should continue to improve, although the rate of increase should be substantially less pronounced than it was in 1989," said Mr. Rosencrants.

"The outlook for profits is quite good for the balance of 1990, and I think for all of 1991," Mr. Rosencrants commented.

"I think it'll be a good year" for group health insurers, said Tom Billet, who is a managing consultant for benefit consulting firm A. Foster Higgins & Co. Inc. in New York.

"I think the health insurance cycle generally is on an upswing right now because of the large rate increases they're passing through," he added.

"I expect they'll continue to do pretty well," agreed Lawrence B. Leisure, national health care practice leader of TPF&C, the benefit consulting division of Towers, Perrin, Forster & Crosby Inc. in New York.

"I think it looks brighter than it did this time last year," particularly for the major insurers, Mr. Leisure said.

"We have reasonable hopes for continued growth in our employee benefits area," said the CIGNA Corp. spokesman.

CIGNA's 1989 results exclude data from EQUICOR Inc., whose acquisition by CIGNA is expected to be completed within two to three months, according to the CIGNA spokesman (*BI*, Jan. 22).

**'Earnings should continue to improve, although the rate of increase should be substantially less pronounced,' Mr. Rosencrants says. 'The outlook for profits is quite good for the balance of 1990, and I think for all of 1991.'**

"So far, so good. It's a nice environment to be in," commented John P. Cole, executive vp and chief operating officer of Fort Wayne, Ind.-based Lincoln National Corp.'s managed health care group.

Lincoln National's employee life/health operations were profitable in 1989 for the first time since 1986, posting earnings of $4.6 million, compared with a $129 million loss in 1988, which included a $61.7 million charge for restructuring.

Insurers and other observers point to premium increases as the major influence on the improved results in 1989 and the bright outlook for this year.

"The rate increases are coming in, and the profit margins are rising, so the industry looks pretty healthy right now," commented Ken Abramowitz, an analyst with Sanford Bernstein & Co. in New York.

Many insurers note, however, that premium increases are expected to moderate this year. "Increases have slowed down," said Mr. Rosencrants.

"Clearly, there's a reduction in the increases in health insurance premiums that are being charged," agreed Leonard E. Wood, senior vp for national marketing for the Blue Cross/Blue Shield Assn. in Chicago.

Mr. Wood said last year's premium increases were 20% to 25%, while this year they will range from 10% to 20%, with 15% a "good average."

The lower premium increases are driven by two factors, said Mr. Wood:

- Renewal rates this year are more acceptable than they had been, so insurers' need to build reserves is less of a factor this year.
- Cost containment steps undertaken by Blue Cross/Blue Shield have had an impact on controlling health care costs, so there is less need for rate increases.

Mr. Wood said the Blue Cross/Blue Shield Assn., which is nonprofit organization, generated a $1.2 billion gain from operations in 1989, an "abrupt reversal" of a $1.1 billion loss the previous year. Its 1987 losses totaled $1.9 billion (*BI*, March 20, 1989).

Traditionally, the BC/BS Assn. posts three years of gains following three years of losses, Mr. Wood commented.

"We are hopeful we will show about a $2 billion gain" in 1990, Mr. Wood said.

Premium increases in 1990 will average about 15% to 20%, compared with 20% to 25% last year, said Charles T. Bell, a vp in the employee benefits department of Aetna Life & Casualty Co. in Hartford, Conn.

Aetna reported $263.8 million in group insurance earnings in 1989, a 90.3% increase from $138.6 million in 1988.

Meanwhile, many insurers report that results from HMO operations are improving, though they may not necessarily be profitable.

CIGNA's HMO operation, for instance, could be in the black as early as the first quarter, said Mr. Doerr.

CIGNA does not, however, expect its HMO operations in 1990 to reach "full profit margins," which it defines as 4% of revenues. Pretax profits of $80 million would be considered adequate on anticipated revenues of $2 billion, Mr. Doerr said.

Mr. Doerr said he also expects EQUICOR's HMO business—which reported a $10 million loss for 1989—to improve this year.

"We were really delighted with our HMO results last year," said Mr. Cole of Lincoln National, whose HMO losses dropped to $5.3 million in 1989 from $97.5 million loss a year earlier. And in the fourth quarter, Lincoln National's HMOs generated a $1.2 million profit, compared with a $5.3 million loss for the comparable period in 1988.

Mr. Cole said utilization review programs have helped reduce the number of hospital days, which in turn have cut costs.

"We're still very much in the investment stage of our HMO operations," said Jim Galasso, vp and actuary at Metropolitan Life Insurance Co. in New York.

He noted that losses at Met Life's HMO operations were cut in 1989 to $45 million from $73 million in 1988.

The company forecasts a $32 million HMO loss in 1990, although "we're hoping we can beat that significantly," explained Mr. Galasso.

However, Mr. Bell described Aetna's 1989 HMO losses of $57 million—up from $37 million in 1988—as disappointing.

Acquisition costs contributed to the increased HMO losses, an Aetna spokesman said.

"We look for an improvement of that in 1990," said Mr. Bell. Aetna has increased its HMO rates, but "it's not enough yet to put it in the black." ■


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* Source Business/Occupational breakdown of qualified circulation, May 29, 1989 issue, as submitted to BPA for June1989 BPA Publisher's Statement.

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**The World Bank**

# Solvency report

*Continued from page 2*

market value were relatively small until the early 1970s, but have widened as bond markets have become more volatile, he testified. Insurance companies with junk bond investments, for example, have seen market values plummet in the last six months (see story, page 32).

In the early 1980s insurers also began reporting growing volumes of reinsurance recoverables "that had no reasonable chance of being collected," Mr. Byrne said in written testimony.

Inadequate valuation of loss reserves has been another key factor in many insurer insolvencies, he noted. Assuming a standard ratio of loss reserves to surplus of 2.5-to-1, a 20% loss reserve deficiency can produce a 50% reduction of surplus, he said.

"A 40% deficiency, which is conceivable for long-tail liability lines, could possibly negate the entire surplus carried by a company," Mr. Byrne testified.

An even larger threat, he said, are deficiencies in loss adjustment expense reserves, which the Insurance Services Office has estimated to be 50% short industrywide, according to Mr. Byrne.

If industrywide loss adjustment expense reserves of about $30 billion are deficient by 50%, the industry is now overstating its surplus by $30 billion to $40 billion, he pointed out.

Correcting all these problems would have had a dramatic effect on the property/casualty insurance industry's reported surplus over the last decade, Mr. Byrne testified.

While U.S. property/casualty insurers reported that surplus grew to just more than $60 billion in 1984 from roughly $20 billion in 1972, real surplus would actually have fallen to $14 billion by 1984 if investments had been reported at market value rather than cost and if loss and loss adjustment expense reserve deficiencies were corrected, he said.

Mr. Byrne recommended several ways to improve solvency regulation:

- Insurers should be required to have their loss reserves certified by casualty actuaries, who should sign off on the insurers' statements.
- Independent auditors should be required to certify insurers' statutory financial statements.
- Insurers should report bond investments at market value.
- Discounting of loss reserves should be prohibited. Mr. Byrne complained that by allowing discounting of reserves for tax purposes, the Tax Reform Act of 1986 encouraged insurers to reserve improperly.
- State insurance commissioners should "get serious about solvency."

While the National Assn. of Insurance Commissioners has made solvency regulation a high priority, it hasn't been a top concern for many individual state insurance commissioners, according to Mr. Byrne, who said that many regulators are more concerned about rate regulation and other matters immediately affecting policyholders.

**Insurance companies have not been an attractive target for corporate raiders, says John J. Byrne, chairman and chief executive officer of Fund American Cos. Inc. 'We've got the ultimate poison pill—we're a terrible business.'**

During questioning by Ron Wyden, D-Ore., the acting subcommittee chairman, Mr. Byrne blamed "politics"—mainly insurance company lobbying—for many states failing to adopt NAIC model laws, including those requiring independent audits of insurers' financial statements and actuarial review of reserves.

Mr. Byrne recommended strengthening the NAIC's central office and said states should cede some regulatory authority to the NAIC.

"The reason the NAIC has no authority is that individual state insurance commissioners like it that way," he said.

In response to other questions, Mr. Byrne said leveraged buyouts of insurers should be discouraged because of the "onerous burden" of debt they place on insurers.

Insurance companies, he added, have not been an attractive target for corporate raiders. "We've got the ultimate poison pill—we're a terrible business."

Mr. Byrne also labeled state guaranty funds "an abomination," urging that commercial policyholders be excluded from guaranty fund protection.

While a federal takeover of insurance regulation is "a terrible idea," Mr. Byrne suggested that the federal government might consider establishing minimum solvency standards or offering insurers the option of being regulated by a federal agency.

The subcommittee also heard testimony from the National Assn. of Insurance Brokers, represented by Alan G. Page, senior vp and director of Johnson & Higgins in New York; Barbara A. Guernsey, executive vp with DSI Insurance Services in San Francisco; and John T. Sinnott, president of Marsh & McLennan Inc. in New York.

Mr. Page, who presented the NAIB's statement, noted that state insurance regulators typically delay findings of insolvency for various reasons.

Insurance regulators often take "heroic measures" to save insurers because an insolvency would be considered a regulatory failure, he said.

Such delays have worked in the past, when insurers did not have huge books of high-risk casualty business and where the cost of delaying an insolvency finding in an attempt to save the company was relatively minor, Mr. Page commented.

Now, however, "a regulatory policy of trying to save poorly managed companies through delay of insolvency will usually fail and compound the insolvency problem," Mr. Page said. "For the future, the regulatory priority should be to minimize harm done to the public by an insolvency. This can best be achieved by early detection of problems and prompt action to take the insurer out of the marketplace."

Mr. Page echoed Mr. Byrne's concerns about insurer accounting inadequacies, also calling for mandatory audits of insurer financial statements and actuarial certification of reserves.

Noting the subcommittee report's criticism of insurers overreliance on managing general agents, the NAIB statement observed that "a properly managed MGA is not an inherent threat to the solvency of an insurer."

Conceding that insurers that fail to monitor MGAs are open to abuse, the NAIB statement supported a model bill approved by the NAIC last year that gives insurers and regulators a tighter rein on MGAs' activities (*BI*, Sept. 25, 1989).

Mr. Page also differed with the subcommittee's report's suggestion that joint ownership of an insurer and a broker presents a conflict of interest.

"We do not believe the conflicts of interest are so inherently severe that there should be structural limits on broker ownership of insurers or insurer ownership of brokers," the NAIB statement said. "We do recommend that in the case of any multiservice financial institution, there be adequate fire walls to separate the various entities from one another."

Andre Maisonpierre, president of the Washington-based Reinsurance Assn. of America, and William D. Warren, chairman and president of National Reinsurance Corp. in Stamford, Conn., and current RAA chairman, also testified at Monday's hearing.

U.S. reinsurers are subject to the same degree of regulation as U.S. insurers, said Mr. Maisonpierre. The subcommittee report had asserted that reinsurance regulation is limited.

At the same time, Mr. Maisonpierre said that "it is sobering to note that probably 10% or more of the U.S. reinsurance premium is written by alien companies located in countries which are generally viewed as (tax) havens with lax regulation."

U.S. insurers maintain letters of credit securing balances owed by alien reinsurers, but these are only as good as the reserves set by the ceding insurers and used as a basis for the amount of LOCs required, he noted.

"LOCs do not fully substitute for sound regulation," he added. "When issued as security on behalf of well-managed, sound alien reinsurers, they are probably not even needed."

While the report concluded that reinsurance abuse was a key factor in the Mission, Transit and Anglo-American failures, Mr. Maisonpierre asserted that mismanagement and unaccountability were more to blame.

He also disputed the report's suggestion that increased U.S. regulation of the alien reinsurance market is required to enhance that market's security.

"Regulation cannot substitute for good management practices," Mr. Maisonpierre said. "The placement of reinsurance is a major responsibility of insurance management. It is a responsibility which cannot be substituted by regulation."

Anglo-American Insurance Co. of Insurance Co. of Louisiana is not connected with Anglo American Insurance Co. Ltd. in London, which participates on the line slip managed by H.S. Weavers (Underwriting) Agencies Ltd. ■

# Star Pool

*Continued from page 2*

municipal law prohibits interstate and some intrastate pooling of municipal risks, according to Deputy Insurance Superintendent Richard Hsia.

State insurance law also expressly prohibits claims-paid coverage, which Mr. Hsia said has "an immobilizing, lock-in effect" on participants.

Under the claims-paid police professional liability coverage issued by The Star Pool, claims were funded on a pay-as-you-go basis, and members that left the pool assumed responsibility for pending and incurred-but-not-reported claims.

The formation of AJIR, which offers more traditional claims-made coverage, resolved the claims-paid issue, but AJIR still violates New York municipal law prohibiting interstate pooling, Mr. Hsia has argued.

In response, the NSA and AJIR "have agreed, without further litigation, to cease from doing business in New York," Mr. Hsia said.

But, Mr. Dickman said AJIR has reserved its right "to challenge them at some future time."

In addition, AJIR and NSA representatives have "proposed to give New York participants the ability to extricate themselves from The Star Pool and the reconstituted AJIR," Mr. Hsia said.

Details are still being worked out, but the proposal would give New York members two options under which they could withdraw. Members could:

**The agreement 'would appear to be fair to members and also realistic,' Mr. Hsia says.**

- Take their accumulative reserve funds but assume responsibility for any unresolved or IBNR claims.
- Leave their accumulative reserve funds with AJIR, which would then pay all of their unresolved claims, as well as IBNR claims reported within one year from the time a member officially withdraws.

"This would appear to be fair to members and also realistic," Mr. Hsia said.

He noted that sheriffs' and police departments in New York can purchase police professional liability coverage through admitted insurers or through the New York Police Professional Market Assistance Program.

"We will help them find coverage," he stressed.

Insurance regulators are notifying all New York law enforcement agencies about the options, Mr. Hsia said.

Mr. Hsia also said he is seeking a formal opinion from the New York state attorney general supporting his contention that New York municipal law supersedes the federal Risk Retention Act and prohibits interstate pooling of municipal risks through a risk retention group. ■


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# PacTel network

*Continued from page 3*

care networks.

A managed care network involves contracting with health care providers to care for employees and encouraging employees to use network providers by imposing higher costs for using non-network providers.

"Employers wanted to wait and see. Now that results are coming in, companies will move in the network direction. It is the direction of the future," said Robert McGoldrick, vp of CIGNA's employee benefits division in Hartford, Conn.

In fact, about a dozen employers are discussing managed care networks with CIGNA, he said.

Nearly all so-called Baby Bells grappled with their unions last summer over efforts to hold down soaring health care costs. Workers went on strike over efforts to shift more health care costs to workers (*BI*, Aug. 14, 1989).

The 1989 collective bargaining agreement PacTel reached with its major labor unions—the Communications Workers of America and the International Brotherhood of Electrical Workers—called for the creation of a managed care network to replace indemnity plans (*BI*, Aug. 28, 1989).

Under the program, PacTel employees will enroll in open-ended HMOs operated by CIGNA Healthplans Inc. in California and Nevada. Coverage levels will be sharply reduced for employees seeking indemnity benefits outside the network.

By 1991, the CIGNA managed care network is expected to be available to about 90% of PacTel and subsidiaries' 70,000 employees and their dependents.

Participating subsidiaries include Nevada Bell and Pacific Bell Directory.

However, PacTel's managed care network will differ from Allied-Signal's pioneering program in several ways.

For example, under a "risk contract," CIGNA guaranteed to hold cost increases for Allied-Signal below 10% in each of the program's first two years and to 6% to 7% during the third year.

CIGNA, which says the Allied-Signal program is profitable for the insurer so far, must absorb any costs over that amount.

PacTel's program has no risk contract, though CIGNA made certain undisclosed performance guarantees.

In addition, unlike Allied-Signal, PacTel plans to continue offering several other HMOs.

"We want to provide employees with additional choices," Pacific Bell's Mr. Austin said.

And while Allied-Signal has gradually extended its managed care network to its union employees, PacTel from the start will offer its program to both salaried and union employees.

A common factor in the two programs is that employees using the network receive far better benefits than those going outside it.

PacTel employees, for example, will be enrolled in the managed care plan and select a primary care physician—or gatekeeper—just as HMO enrollees do.

**'Employers wanted to wait and see. Now that results are coming in, companies will move in the network direction. It is the direction of the future,' says Robert McGoldrick, vp of CIGNA's employee benefits division.**

To receive benefits, employees will first have to contact their network physician who will coordinate their health care. Employees using the network will not have to file claims.

But, out-of-pocket expenses will be much higher for employees that choose to receive care from non-network providers.

For example, employees using network providers will pay no deductibles, while those using non-network providers will pay deductibles tied to their salary.

For non-network care, employees with base annual salaries less than $28,000 will pay a $150 deductible for individual coverage and $450 for family coverage.

And for those whose base annual salary exceeds $28,000, the individual deductible will be $300 and the family deductible $600.

Employees using the network will pay fixed-dollar copayments on some services, including a $10 charge per physician office visit, while hospital charges will be fully covered and a limited number of other health care services, such as X-rays, will be 90% covered.

By contrast, employees going outside the network must pay a copayment for health care services up to an annual limit.

For employees earning less than $28,000, the copayment is 20% of expenses up to $1,000 for an individual and $4,000 per family. For higher-paid workers, the copayment is 30% up to $1,500 per individual and $4,500 per family.

For workers who live in areas not served by the CIGNA network, PacTel plans to establish a special indemnity plan, which will be the company's only indemnity plan after Jan. 1, 1991.

Under that plan, workers who earn less than $28,000 will pay a $150 annual deductible for individual coverage and $450 for family coverage. Higher-paid workers will pay individual deductibles of $300 and family deductibles of $600. The special indemnity plan will then pay 90% to 100% of incurred expenses, depending on the type of services.

PacTel also is establishing a dental maintenance organization, administered by Prudential Life Insurance Co. of America in Newark, N.J.

And, PacTel will offer a new mental health and substance abuse network, administered by U.S. Behavioral Health in Emeryville, Calif., that will offer higher benefits if network providers are used.

For example, the network plan offers 100% coverage for the first five outpatient psychiatric counseling visits.

For the next 15 visits, patients would pay a $15 per-visit copayment, and a $30 copayment for all subsequent visits.

For non-network mental health services, the company will pay 50% of usual and customary expenses after a $400 deductible is met.

The San Francisco office of benefit consultant William M. Mercer Meidinger Hansen Inc. worked with PacTel on developing the managed care network. ■

# Asbestos coverage ruling

*Continued from page 1*

tained are triggered is considered one of the most important asbestos property damage coverage rulings.

The litigation stemmed from a dispute between the company and Texas school districts over asbestos present in 600 school buildings.

In 1984, the school districts sued Grace in U.S. District Court for the Eastern District of Texas, seeking $175 million in compensatory damages and $525 million in punitive damages to pay for removing the asbestos.

In 1987, Grace brought many of its comprehensive general liability insurers from 1978 to 1985 into the litigation as third-party defendants under the theory that if Grace were held liable to the schools, the insurers would be liable to Grace.

Among the insurers were Continental Casualty Co., a unit of CNA Financial Corp. that wrote primary liability coverage for Grace from 1978 to 1985, and a group of excess insurers including:

- AIU Insurance Co., Lexington Insurance Co., National Union Fire Insurance Co. of Pittsburgh, Pa., Granite State Insurance Co. and Birmingham Fire Insurance Co., all units of New York-based American International Group Inc.
- Allstate Insurance Co of Northbrook, Ill., as successor to Northbrook Excess & Surplus Insurance Co.
- Bermuda Fire & Marine Insurance Co. Ltd. of Hamilton, Bermuda.
- Gerling Konsern Allegmeine Versicherungsaktiengesellschaft of Cologne, West Germany.
- Guarantee Insurance Co. in Wilmington, Del., a unit of Scottish & York Inc.
- Hartford Accident & Indemnity Co. of Hartford, Conn., a Hartford Insurance Group unit.
- Lloyd's of London syndicates and various London market insurance companies.

These insurers wrote combined limits of approximately $75 million annually for Grace between 1978 and 1985. Grace also had other liability coverage excess of the policies at issue in the case.

Grace eventually settled its dispute with the schools for an undisclosed sum. An attorney who asked not to be identified said in 1988 that the settlement totaled $50 million to $75 million.

After the settlement, the only question pending before the Texas federal court was whether the insurers had a duty to indemnify Grace for the settlement.

Insurers appealed U. S. District Court Judge Joe J. Fisher's ruling that they had to indemnify Grace, arguing, among other things, that the federal court did not have jurisdiction to decide the coverage dispute.

The 5th Circuit reversed the lower court's ruling, reasoning that once Grace settled its dispute with the Texas school districts, the U.S. District Court no longer had jurisdiction over the coverage litigation.

While the rules of diversity jurisdiction gave the federal court authority over the case between New York-based Grace and the Texas school districts, the appellate court said there was no diversity in the coverage litigation because both plaintiff Grace and the defendant AIG subsidiaries are based in New York.

A plaintiff cannot sue a defendant based in the same state in federal court under diversity jurisdiction, even if other defendants are located in different states.

The lower court based its jurisdiction on a theory known as ancillary jurisdiction. Since the coverage dispute was ancillary to the dispute between Grace and the schools, jurisdiction over both lawsuits was proper, the lower court reasoned.

However, the appellate court disagreed, holding that the trial court abused its discretion in retaining ancillary jurisdiction over the case.

"Once the main action has reached settlement prior to trial, there is generally little that can be gained in the way of judicial efficiency and economy by continuing to adjudicate ancillary state-law claims" in federal court, the 5th Circuit said.

Once Grace settled with the school district, the litigation "was reduced to a dispute between a New York company and its New York insurers, where the governing law would be the law of New York," the appellate court said, referring to the AIG units.

**The 5th Circuit decision, 'insofar as it wipes away a precedent applying the continuous trigger, is disappointing but not apocalyptic,' says policyholder attorney William Greaney.**

"It is important that neither Texas nor the school districts have any interest in whether the settlement is paid by Grace or, instead, by its insurers," the appellate court said. "Their only interest is in being paid, and they have been."

Thus, the court reasoned: "It is New York, not Texas, that has the greater interest in and the most significant relationship to the questions of insurance law that decide this dispute."

Even though the 5th Circuit reversed the lower court ruling, the impact of the appellate court's decision on Grace may be negligible, according to Mr. Oshinsky.

Should the company prevail in another coverage suit with its insurers now pending in federal court in New York, the insurers would still indemnify Grace for the Texas settlement.

However, looking at the broader implications of the 5th Circuit's decision, the ruling removes from the books an important pro-policyholder ruling that espouses the continuous trigger theory in asbestos property damage cases, insurer attorneys say.

"This decision takes a very adverse precedent off the table," said Thomas J. Quinn of Mendes & Mount in New York, who represents Lloyd's syndicates.

"The district court's decision was widely cited by policyholders in both asbestos and hazardous waste cases," said insurer attorney Thomas Brunner of Wiley, Rein & Fielding in Washington, D.C. "At a minimum, the appellate court's decision wipes out this widely cited decision."

In addition, the appellate court's ruling casts doubt on the viability of the continuous trigger theory in both asbestos property damage and pollution coverage disputes, Mr. Brunner said.

Looking at New York law, the 5th Circuit "has serious doubts if the continuous trigger should apply," Mr. Quinn agreed.

However, policyholder attorney William Greaney of Covington & Burling in Washington, D.C., said that because the appellate court reversed on procedural grounds rather than on the merits of the case, damage to policyholders will not be great.

"The decision, insofar as it wipes away a precedent applying the continuous trigger, is disappointing but not apocalyptic," he said.

"The substantive reasoning of the (trial court) decision is in no sense impaired," Mr. Greaney said.

Policyholder attorney John Heintz of Popham, Haik, Schnobrich & Kaufman in Washington, D.C., agreed: "Because the decision was vacated for lack of jurisdiction, it is not as significant as if they ruled on the merits."

Mr. Greaney also noted that while one important decision supporting the continuous trigger theory has been removed, at least five federal and state court decisions in the last six months have adopted the continuous trigger in various types of coverage disputes.

"The continuous trigger is not only the most viable theory, but it is becoming the majority view," he said.

However, Mr. Brunner said that "the continuous trigger theory is in general retreat."

Attorneys also predict the 5th Circuit's ruling could make it harder for policyholders to sue their insurers in federal court because one avenue of federal jurisdiction has been narrowed.

"In the asbestos context, policyholders prefer to be in federal court," Mr. Greaney said. Federal courts have been more sympathetic to policyholders in asbestos coverage disputes and offer faster relief than state courts, according to Mr. Greaney.

Policyholders suing many insurers, however, find it very difficult to forge diversity jurisdiction, since at least one insurer defendant is likely to be from the same state as the policyholder, he said.

As a result, policyholders use the doctrine of ancillary jurisdiction to bring their insurers into federal court, attorneys say.

But the 5th Circuit's decision "makes its clear that ancillary jurisdiction is to be invoked with caution and in a prudent fashion," Mr. Greaney said.

Other attorneys point out that the issue of state vs. federal jurisdiction "cuts both ways," explaining that insurers, too, often prefer federal proceedings.

The 5th Circuit decision also could help policyholders litigate massive coverage disputes on a comprehensive basis, since the appellate ruling moves the dispute to New York, Grace's home state, rather than Texas, where the asbestos damage was alleged.

Some insurers argue that coverage disputes are fact-sensitive and, thus, should be decided on an individual basis. For example, in cases over coverage for hazardous waste cleanups, these insurers argue that the coverage litigation should be heard separately in each state in which a waste site is located.

Policyholders counter that single, comprehensive actions more efficiently resolve massive coverage disputes.

The 5th Circuit's decision "sends a message that the way to resolve these disputes is through comprehensive litigation," said Mr. Quinn, the attorney who represents the Lloyd's syndicates.

Policyholder attorney Mr. Greaney agreed: "The decision is an endorsement of comprehensive coverage actions not only in the asbestos context but in the environmental context."

"This decision can easily be used by policyholders arguing in favor of comprehensive litigation," he said.

●

*W.R. Grace & Co. vs. Continental Casualty Co. et al.; U.S. Court of Appeals for the 5th Circuit, No. 88-2902 and 88-6164.*

# Update

## FDIC sues failed S&L's lawyers

DALLAS—The Federal Deposit Insurance Corp. is seeking up to $1.1 billion in damages from six former partners in a Dallas law firm that counseled a local failed savings and loan.

Five former Jenkens & Gilchrist partners and the estate of a deceased former partner are named as defendants in the FDIC suit. One defendant is in prison for an unrelated fraud conviction.

Mark Rosen, FDIC deputy counsel, said the suit seeks compensatory damages of $200 million to $1.1 billion.

The lawsuit, filed last week in U.S. District Court in Dallas, alleges that all partners are jointly liable for allowing Dallas-based Vernon Savings & Loan Assn. to make illegal transactions.

Defendant Scott Bradley pointed out that the suit does not specifically accuse individual defendants of wrongdoing. "I never worked for Vernon, never closed a Vernon loan," he said. "I don't know what relevance the suit has to us."

He said regulators want to tap the current professional liability insurance policies of the defendants, three of whom have a combined total of $20 million in coverage written by National Union Fire Insurance Co. of Pittsburgh, Pa., a unit of American International Group Inc.

Jenkens & Gilchrist and its professional liability insurer, Texas Lawyers Insurance Exchange in Austin, last year agreed to pay a nearly $20 million settlement to the Federal Savings & Loan Insurance Corp. (*BI*, Aug. 14, 1989). That case involved a former Jenkens & Gilchrist attorney who allegedly gave faulty advice to two institutions that later failed.

## Morrell to pay huge OSHA fine

WASHINGTON—In one of the largest settlements ever of proposed Labor Department penalties for workplace safety violations, John Morrell & Co. has agreed to pay $1.25 million in fines and grants for research on ergonomic hazards.

The amount consists of a $990,000 penalty for ergonomic hazards at its Sioux Fall, S.D., meatpacking plant and a $260,000 grant to the National Institute for Occupational Safety and Health in Washington, D.C., for continued research.

In addition, the company, a unit of United Brands Co., must determine which jobs pose cumulative trauma disorder hazards, eliminate the hazards and teach proper techniques and safety procedures to prevent the disorders, which are caused by repeated awkward or forceful hand, arm or body motion.

The Occupational Safety and Health Administration originally proposed $4.3 million in fines in October 1988, the third-largest proposed fine ever (*BI*, Oct. 31, 1988).

Morrell denies all allegations of OSHA violations but cannot contest them under the agreement.

## Firm agrees to D&O settlement

IRVINE, Calif.—National Education Corp. has agreed in principle to pay $11.9 million out of its own pocket to settle a class-action suit against it and several present and former officers and directors after its D&O insurer refused to contribute to the settlement.

However, the Irvine, Calif.-based company will pursue a claim for recovery against the insurer, said Jeffrey Brill, National Education's general counsel.

The company plans to give the insurer, which Mr. Brill would not identify, about a month to settle out of court.

In the initial suit filed last June, a National Education shareholder sought $25 million in damages, alleging the company made misleading statements about the financial condition of its Applied Learning unit to prevent a drop in stock price. That suit was consolidated with two similar suits in August and another class-action suit filed in October, Mr. Brill said.

The settlement is subject to approval by a federal court in Santa Ana, Calif., which could take several months.

National Education has taken a $23.4 million charge against its fourth-quarter earnings in part to pay for the settlement, Mr. Brill said.

National Education provides training courses and educational materials and operates a chain of 53 vocational and training schools.

## Briefly noted

Wind, hail, tornadoes and flooding caused an estimated **$100 million in insured property damage** March 13 to 17, according to the Property Claim Services Division of the American Insurance Services Group. The severe weather, assigned Catastrophe No. 28, hit portions of the Midwest and Southeastern United States. . . .Insured losses from a freak storm that pelted Sydney, Australia, last week with **baseball-sized hailstones** could top $200 million Australian ($153.2 million), the Insurance Council of Australia estimates. Car dealerships suffered the brunt of losses. . . .Liberty Mutual Insurance Co., Continental Insurance Co. and Aetna Casualty & Surety Co. have filed separate suits over the New Jersey Insurance Department's effort to recover funds it claims 15 servicing insurers in the state's **automobile joint underwriting association** should refund to the JUA (*BI*, Feb. 26). . . .A Fulton County Superior Court judge in Atlanta last week issued a temporary restraining order against a private passenger **auto insurance rate and premium freeze** approved by Georgia Insurance Commissioner Warren D. Evans in February. Eleven insurers had filed a lawsuit charging the freeze exceeded Mr. Evans' authority. . . .The Illinois Supreme Court refused to hear an appeal of an appellate court order barring the city of Chicago from increasing 16,000 municipal **retirees' health care contributions**. Higher fees were to have been collected beginning March 1 under an agreement between the city and its four retiree pension funds (*BI*, Jan. 29; Dec. 25, 1989). . . .Rep. Jim Slattery, D-Kan., introduced legislation last week that would overhaul the federal Risk Retention Act. The legislation, H.R. 4351, is similar to a measure proposed in the Senate last year that would allow only officials in the state in which a purchasing group maintains its principal place of business to regulate rates and policy forms used by the purchasing group insurer (*BI*, Nov. 27, 1989).

# Reinsurance rates

*Continued from page 1*

sign of the times," said John Parton, assistant general manager of Guardian Royal Exchange Assurance P.L.C. in London and former chairman of the Institute of London Underwriters.

"It's a total reflection of the fact that the experience has been so bad, all participants will have to take part" in rate increases, including American ceding companies, he said.

"London reinsurers would hope that (the Japanese premium hikes) are a trend with increases happening across the board," agreed William Neave, executive director of Lloyd's broker Willis Faber & Dumas Ltd.

For example, "those looking for retrocessional cover and high-layer catastrophe and rig protections will find it more expensive," Mr. Neave said.

London reinsurance underwriters say they must generate more premiums to pay for the billions of dollars of catastrophe claims rolling in worldwide. And, they will have to pay additional premiums to reinstate their own reinsurance protection following the rash of European storms that could cost up to $8 billion (see story, page 39).

Reinsurance contracts commonly offer ceding companies coverage for one event with one or two automatic reinstatements at a prenegotiated charge. Additional reinstatements must be negotiated.

"Since the (European) storms, ceding companies have had a difficult time buying additional reinsurance reinstatements," said Bill Mackay, managing director and chief executive of the non-marine reinsurance division of Lloyd's of London broker Alexander Howden Reinsurance Brokers Ltd.

"We've never experienced such a loss pattern in the past. So the underwriters feel they have to correct the market, not only for themselves but also to pay for the additional reinstatements."

July 1 reinsurance renewals "will be a lot worse," said James Vickers, executive director of Willis Faber & Dumas Ltd.

For example, most Australian insurers, which renew their reinsurance programs July 1, will face a hardening market and a re-examination of earthquake insurance rates following the Newcastle earthquake late last year, Mr. Vickers said (see story, page 27).

July 1 is also a major date for U.S. ceding companies to renew their reinsurance programs; for U.S. corporate policyholders to renew their insurance programs; and for the renewal of offshore oil rig insurance and reinsurance programs (*BI*, July 10, 1989).

Despite long, laborious negotiations during April 1 renewals, Japanese insurers' rates for cargo catastrophe reinsurance programs will be more than doubled in some cases, while premiums—if not rates—for non-marine catastrophe reinsurance also will rise.

Generally, the Japanese market is the largest market that renews its marine and non-marine reinsurance programs on April 1.

The Japanese are furious about the increases since the Japanese market has not been touched by the host of natural and man-made disasters that has plagued the rest of the world.

"Our results for non-marine reinsurance are good," said Mr. Kuzuhara in Tokyo. "There is an earthquake exposure," but Japan has not been hit by a major temblor in years, he added.

"We don't want to be the victims of a series of losses" that were not covered by Japanese insurers, he said.

"The London underwriters suffer, but not from our business. But we have to be partners with big carriers (so) we have to suffer together. But, if we are pushed too much. . . ."

Japan is the second-largest insurance market in the world after the United States. The country's 14 largest insurers together wrote more than 4.7 trillion yen ($35.44 billion at appropriate exchange rates) in net premiums for the year ending March 31, 1989, according to stock analyst County NatWest Japan in London.

Four companies dominate the Japanese market, together writing 47% of total net written premiums, Natwest reports. They are: Tokio Marine & Fire Insurance Co. Ltd.; Yasuda Fire & Marine Insurance Co. Ltd.; Taisho Marine & Fire Insurance Co. Ltd.; and Sumitomo Marine & Fire Insurance Co. Ltd.

Although NatWest estimates the Japanese cargo insurance market in Japan only accounts for about 1.6% of Japanese insurers' total net premium volume, they have been making substantial profits on this class, said a London marine reinsurer.

As of the third quarter of 1989, the Japanese companies had posted a loss ratio of less than 52% on cargo insurance business, according to the marine reinsurer.

As a result of their excellent loss experience—coupled with a soft worldwide cargo reinsurance market—Japanese ceding companies historically have been paying less and less for their catastrophe reinsurance over the years, London sources explain.

As of last year, many Japanese companies were paying as little as 0.4% of total cargo insurance limits—known as "rate on line"—for their catastrophe reinsurance, estimated Howden's Mr. Mackay.

For example, an insurer would pay $4,000 in premium per $1 million in reinsurance protection.

"Quite a lot of Japanese and other companies have been paying less than 1% on line," said Mr. Parton of GRE.

In fact, no one can remember when rates have ever increased for Japanese insurers' cargo catastrophe reinsurance, which has been placed in the London market for only the past 20 years.

"I don't remember" any increases, Mr. Parton said.

"I don't think they've ever seen an increase," said Mr. Neave of Willis Faber, which handles 50% of all Japanese reinsurance placed by London brokers.

Nevertheless, the Japanese ceding companies now are being charged about a 1% rate on line for their cargo catastrophe reinsurance coverage, brokers and underwriters agree.

"In every case, the cost of the (Japanese) excess-of-loss cargo reinsurance program has been substantially more," a London reinsurer said.

"The increases that have been paid on the Japanese renewals this year are mainly on the catastrophe end (of reinsurance)," said Mr. Parton of GRE, meaning the upper layers of reinsurance coverage. "Their results are good, but the catastrophe reinsurance portfolio bears on the whole of the world."

Mr. Parton admitted that the Japanese market has not been socked with a major disaster in 60 years while the rest of the world has become accustomed to one major disaster every 12 months.

However, the pace of disasters has considerably increased, he noted, explaining that since the devastating October 1987 European windstorm, disasters seemingly have struck every three months and that premiums worldwide must reflect this record.

As a result, the increases have varied but "most everyone (in Japan) is now paying a minimum of 1% on line," he said.

"The catastrophe market in London has suffered a considerable number of losses and has paid an increasing amount in their own excess-of-loss reinsurance protections, forcing London underwriters to look at their aggregate accumulations in different parts of the world and decide what should be charged for catastrophe cover," said Mr. Neave of Willis Faber.

He said London is particularly nervous about "the jitters in San Francisco" as well as the earthquake that hit New South Wales, Australia late last year.

Those temblors "have made underwriters particularly nervous" about the possibility of an earthquake in Japan, which sits on some of the earth's major faults, Mr. Neave said.

Although Japanese cedants are paying more for their cargo catastrophe coverage, they are not increasing their retentions or otherwise changing their cargo catastrophe reinsurance programs, he noted.

"Some of the companies have altered their protections, but for the most part, there has not been much change in retentions and limits," he said. "It's just the cost which is different."

"London is the only place to get the capacity for the coverage, and we're only putting the prices back up to what they were a few years ago," a reinsurer said.

The Japanese ceding companies also renew non-marine catastrophe reinsurance programs on April 1, but rates are virtually unchanged for these programs, London sources agree.

NatWest estimates that net written property insurance premiums among the 14 largest Japanese insurers totaled 680 billion yen ($5.13 billion) for the 12 months ending March 31, 1989, or around 14% of total net written premiums written by Japanese insurers.

London underwriters originally tried to increase rates on line for the non-marine reinsurance programs by 7% to 12%.

"There was pressure to increase (non-marine reinsurance) premium levels," Mr. Kuzuhara confirmed. "The increases were asked for all to start with."

However, the Japanese "thought they they would get rate reductions to start with," said Mr. Vickers of Willis Faber, who handled the non-marine reinsurance placements for the company's Japanese clients.

"We thought early in January that rate reductions could be achieved. However, the European windstorms didn't help that situation. The underwriters after the storms were looking to claw back rate reductions which were given over the last few years. That wasn't well received in Japan, because they didn't feel they should pay for losses they weren't involved in."

Following "very tough" negotiations, the rate for non-marine catastrophe reinsurance—around 1% on line—is staying virtually the same for the Japanese companies, said Mr. Mackay of Howden, which placed non-marine reinsurance for four Japanese ceding companies.

"At the end of the day, rates have renewed as they were before, although it's the first time there hasn't been a rate reduction since 1986," Mr. Vickers said.

However, the amount of premiums ceded by Japanese companies to reinsurers will automatically increase because the companies' own premium volume is expanding. Overall non-marine premium volume paid to London reinsurers will increase by about 10%, Mr. Mackay noted.

Rates generally are increasing in the London non-marine retrocessional market, Mr. Mackay said, while capacity is declining. "This should reflect on what's going on with the indigenous business," he said. "We will see a tighter market overall at year-end and there will be pressure on terms and certain reductions in capacity," he said. ■

# Storm losses curb underwriting

By STACY SHAPIRO

LONDON—Several London catastrophe reinsurers are taking a breather from underwriting until the extent of their losses from European windstorms earlier this year is better known.

Overall insured losses from the January and February storms are estimated at about $8 billion, but reinsurers won't know how much they have lost until underwriters establish how many "events" the series of storms constituted.

In addition, some reinsurers have stopped underwriting because increased rates for London market retrocessional coverage have already pushed them close to their premium income limits for this year.

However, most of the underwriters say they will be able to write selected reinsurance renewals later this year for overseas cedants, though rates may be increased (see story, page 1).

Property reinsurance contracts usually cover ceding companies for one "event," which is defined as losses occurring within a specified period of time, typically 72 hours. However, the contracts usually allow for one or two automatic reinstatements of the full limits of the contract at a prenegotiated charge. After automatic reinstatements are exhausted, new coverage must be negotiated.

Because reinsurers are uncertain how many events the series of storms comprised, they are unsure whether their losses will exceed the limits of their retrocessional protection and use up their automatic reinstatements.

The European storms have so far been listed as four separate events by the Lloyd's of London Underwriters' Non-Marine Claims Office (*BI*, March 5), and late February storm losses in Belgium are expected to constitute a fifth event.

In the London market, the storms have been designated:

- 90A, which hit Jan. 25 and 26, which caused more than 2.2 billion pounds ($3.51 billion) in insured damage across Europe, including 1.5 billion pounds ($2.39 billion) in the United Kingdom alone.
- 90C on Jan. 27, which caused 300 million pounds ($478.5 million) of insured damage in the United Kingdom and Ireland.
- 90D on Feb. 3 and 4, which caused 600 million pounds ($957 million) in insured damage in France and Belgium.
- 90G on Feb. 26, which cost nearly 1.8 billion pounds ($2.87 billion) in insured damage across Europe, including 700 million ($1.23 billion) in the United Kingdom and Ireland.

The storms that hit Belgium on Feb. 28, which have not yet been assigned a designation, are estimated to have caused 200 million pounds ($319 million) in insured damage.

Some underwriters have their own ideas of how many events the storms triggered.

"There were eight separate weather events," contends one Lloyd's non-marine underwriter. "Of those, three are big and might pop the bottom of reinsurance programs three times."

"The January and February storms are two separate events in the U.K.," said a spokesman for Royal Insurance (U.K.) Ltd. Royal's catastrophe reinsurance was depleted by the January storms, though an automatic reinsurance reinstatement has not yet been totally exhausted by the second storm, the spokesman said.

Royal's continental European losses are covered under a separate reinsurance program, he added.

"I don't know whether we'll need another reinstatement," the spokesman said.

"The non-marine boys don't know how many insurance events there have been" so they don't know whether they have sufficient reinsurance to cover the losses, said a major British reinsurer.

Confusion over the number of events and the number of reinsurance reinstatements that ceding companies may need has London underwriters wondering if they have enough retrocessional protection in place to write additional business this year.

The British reinsurer, for example, said his company recently tried to buy additional reinsurance reinstatements to bolster its capacity, but only 30% of the program was placed because "there is no market."

"We have stopped writing retrocessions for the moment basically because there has been so little information on the number of losses and how they have affected reinsurance programs," said another reinsurer, John Threadgold, non-marine underwriter for Charter Reinsurance Co. Ltd.

"It's a temporary move" to stop underwriting, he added, noting the moratorium will be reviewed in April.

"A lot of people like myself don't know if they have any reinsurance in place (to write new business), so they are not doing much at the moment," said Lloyd's of London non-marine underwriter Derek Walker, a leading excess-of-loss retrocessional underwriter. Mr. Walker has temporarily pulled out of the market because he has little capacity remaining to write coverage for the rest of the year.

"It's a difficult time," he said. "There's a certain amount of confusion whether underwriters are covered or not" for the European storms.

Reinsurers have temporarily stopped underwriting London market retrocessional coverage because they want to save what little capacity they have left for the "three or four international reinsurance renewal seasons they have to cope with this year," added another major U.K. reinsurer.

He said his company has restricted the amount of reinstatements it will write so it has enough capacity for April 1 and July 1 reinsurance renewals.

Meanwhile, at least one Lloyd's underwriter has temporarily stopped underwriting because he has reached a self-imposed limit of 85% of his 1990 premium income due to higher rates charged for London market retrocessions.

"I'm resting at the moment," said Terry Green, marine underwriter for Lloyd's syndicate 321, managed by Gresham Underwriting Agencies Ltd. "But I expect to start up again" when drilling rig excess-of-loss reinsurance renewals come due in June.

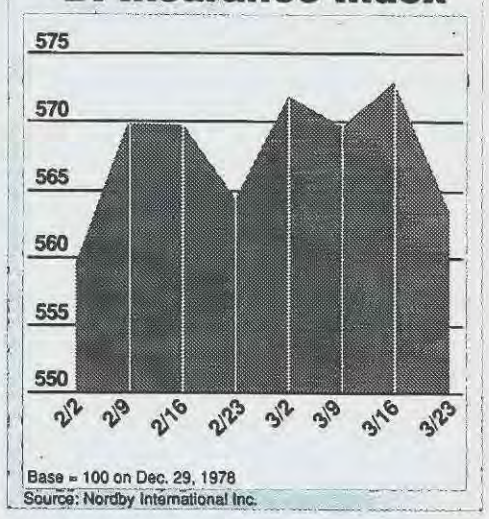
Mr. Green met with Lloyd's members' agents earlier this month to explain that he had notified Lloyd's he would not write any new or renewal business "until further notice."

Mr. Green explained that he agreed with Lloyd's last year that he would not exceed 85% of his premium income limit in 1989 and that he renewed that agreement for 1990.

However, because rates have increased by as much as 150% for London market retrocessions, Mr. Green is collecting much more premium than he did last year for the same business. As a result, he is reaching his limit much earlier than in 1989.

"It's an incredible irony," Mr. Green said. "When rates are weak, we in Lloyd's accept liability upon liability and we still don't reach our premium income limits. But when rates are hard, we reach premium income limits that much sooner." ■

## *BI* Insurance Index




**Insurance industry stocks took a downward turn last week, as the *Business Insurance Index* fell 9.5 points to 563.5 on March 23, from 573.0 on March 16. Advancing issues were led by Nobel Insurance Ltd., up 18.8%; Frank B. Hall & Co. Inc., up 18.5%; and Lawrence Insurance Group, up 14.1%. Declining issues followed HMO America Inc., down 14.3%; Sears, Roebuck & Co. (Allstate), down 8.4%; and Trenwick Group Inc., down 6.8%. The most active issue during the week was Sears, 3.1 million shares traded. The *BI* Index dropped 1.7%; the Standard & Poor's 500 lost 1.37%; the Dow Jones 30 Industrials fell 1.35%; and the new York Stock Exchange composite dropped 1.31%.**

## British Issues

| March 22 Companies | Price pence | P/E | Div. pence | Yield % | 1 Week High—Low pence | pence |
|---|---|---|---|---|---|---|
| Commi Union | 467 | 21.5 | 28.7 | 6.1 | 467—463 | |
| Genl Accident | 1047 | 16.0 | 66.7 | 6.4 | 1047—1030 | |
| Gdn Royal Exch | 221 | 20.5 | 15.3 | 6.9 | 221—220 | |
| Royal | 474 | 25.5 | 34.0 | 7.2 | 474—458 | |
| Sun Alliance | 287 | 10.6 | 17.0 | 5.9 | 288—286 | |
| **Brokers** | | | | | | |
| Bradstock | 248 | 17.5 | 10.0 | 4.0 | 248—247 | |
| CE Heath | 531 | 15.0 | 34.5 | 6.5 | 532—530 | |
| Hogg Robinson | 149 | 10.4 | 9.7 | 6.4 | 149—149 | |
| Lloyd Thompson | 269 | 17.9 | 9.3 | 3.5 | 269—268 | |
| PWS Holdings | 58 | 9.1 | 3.3 | 5.7 | 59—58 | |
| Sedgwick Grp | 252 | 16.3 | 16.0 | 6.9 | 259—252 | |
| Steel Brrl Jones | 289 | 17.6 | 14.7 | 5.1 | 289—287 | |
| Willis Faber | 242 | 17.0 | 15.3 | 6.3 | 248—242 | |

Source: Philip Olsen/Paul Hodges, Insurance Industry Specialists Kitcat & Aitken Stockbrokers, London

# *BI* Industry Stock Report

**MARCH 19, 1990 THROUGH MARCH 23, 1990**

| | | Price | Weekly % change | Year to Date % change | Annual High | Annual Low | Vol.(000) | $ Div. | % Yield | P/E | Book value | Mkt/Bk. value |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **BROKERS** | | | | | | | | | | | | |
| Alexander & Alexander | NYS | 25.88 | -4.17 | -17.86 | 34.00 | 24.00 | 380 | 1.00 | 3.86 | 18 | 9.18 | 2.82 |
| Corroon & Black | NYS | 32.50 | -4.06 | -15.03 | 41.00 | 31.00 | 137 | 1.36 | 4.18 | 15 | 12.73 | 2.55 |
| Gallagher Arthur J. & Co. | NYS | 24.25 | -1.52 | -2.02 | 26.50 | 17.63 | 15 | 0.60 | 2.47 | 17 | 5.33 | 4.55 |
| Frank B. Hall | NYS | 4.00 | 18.52 | 33.33 | 4.50 | 2.50 | 441 | 0.00 | 0.00 | -2 | -2.80 | -1.43 |
| Hilb, Rogal & Hamilton | OTC | 15.25 | 0.00 | -18.12 | 20.63 | 11.25 | 50 | 0.28 | 1.84 | 20 | 4.60 | 3.32 |
| Marsh & McLennan | NYS | 68.63 | -2.14 | -12.02 | 89.75 | 59.00 | 799 | 2.48 | 3.61 | 17 | 10.56 | 6.50 |
| Poe & Associates | OTC | 13.00 | 0.00 | -1.89 | 13.00 | 8.00 | 7 | 0.40 | 3.08 | 16 | 1.89 | 6.88 |
| BROKERS | AVERAGE | | 0.9 | -4.8 | | | | | 2.7 | 14 | | |
| **CONGLOMERATES & HOLDING COMPANIES** | | | | | | | | | | | | |
| Berkley W.R. Co'p. | OTC | 37.00 | -1.99 | -11.11 | 46.50 | 29.25 | 221 | 0.44 | 1.19 | 8 | 25.06 | 1.48 |
| Berkshire Hathaway Inc. | NYS | 7100.00 | 0.00 | -17.68 | 8900.00 | 4625.00 | 1 | 0.00 | 0.00 | 27 | 2869.00 | 2.47 |
| ITT (Hartford Group) | NYS | 52.25 | -2.56 | -12.73 | 64.50 | 51.13 | 1510 | 1.60 | 3.06 | 8 | 56.33 | 0.93 |
| Sears (Allstate) | NYS | 38.38 | -8.36 | -0.97 | 48.13 | 36.50 | 3142 | 2.00 | 5.21 | 9 | 37.75 | 1.02 |
| CONGLOMERATES | AVERAGE | | -3.2 | -10.6 | | | | | 2.4 | 13 | | |
| **INSURERS/REINSURERS** | | | | | | | | | | | | |
| Aetna Life & Casualty | NYS | 48.50 | -4.20 | -16.38 | 62.50 | 48.50 | 843 | 2.76 | 5.69 | 9 | 58.11 | 0.83 |
| Ambase Corp. | NYS | 7.13 | -6.56 | -43.56 | 16.38 | 7.13 | 513 | 0.20 | 2.81 | 3 | 29.08 | 0.25 |
| American General | NYS | 31.63 | 0.40 | -3.44 | 38.50 | 28.13 | 1061 | 1.56 | 4.93 | 10 | 34.68 | 0.91 |
| American Heritage | NYS | 22.88 | -1.61 | -19.74 | 24.63 | 19.50 | 9 | 0.92 | 4.02 | 12 | 22.60 | 1.01 |
| American Indemnity/Fin'l | OTC | 6.75 | 0.00 | -15.63 | 13.00 | 6.75 | 5 | 0.56 | 8.30 | -2 | 17.38 | 0.39 |
| American International | NYS | 93.25 | -2.10 | -11.61 | 112.00 | 76.38 | 1332 | 0.48 | 0.51 | 11 | 41.92 | 2.22 |
| Aon Corp. | NYS | 35.25 | -4.08 | -16.81 | 43.25 | 29.13 | 213 | 1.52 | 4.31 | 10 | 19.62 | 1.80 |
| Argonaut Group | OTC | 70.00 | 0.36 | 1.63 | 71.50 | 51.25 | 58 | 1.60 | 2.29 | 8 | 36.83 | 1.90 |
| AVEMCO Corp. | NYS | 23.88 | -1.04 | -2.05 | 27.50 | 20.38 | 11 | 0.40 | 1.68 | 16 | 9.52 | 2.51 |
| Baldwin & Lyons Inc. | OTC | 20.50 | -1.20 | -4.65 | 24.00 | 15.75 | 43 | 0.28 | 1.37 | 7 | 20.80 | 0.99 |
| Belvedere Corp. | ASE | 4.63 | -2.63 | -15.91 | 6.38 | 4.25 | 3 | 0.04 | 0.86 | -6 | 8.03 | 0.58 |
| Chandler Insurance | OTC | 9.50 | -1.30 | -19.15 | 13.25 | 7.00 | 114 | 0.00 | 0.00 | 5 | 9.53 | 1.00 |
| Chubb Corp. | NYS | 98.13 | -2.73 | 2.35 | 102.75 | 64.00 | 479 | 2.64 | 2.69 | 10 | 55.49 | 1.77 |
| CIGNA Corp. | NYS | 49.75 | -3.40 | -17.43 | 66.75 | 45.25 | 567 | 3.04 | 6.11 | 11 | 66.64 | 0.75 |
| CNA Financial Corp. | NYS | 73.13 | -2.99 | -26.88 | 108.75 | 59.38 | 120 | 0.00 | 0.00 | -8 | 54.87 | 1.33 |
| Continental Corp. | NYS | 29.75 | -2.86 | -5.18 | 38.63 | 25.75 | 375 | 2.60 | 8.74 | 11 | 41.36 | 0.72 |
| Durham Corp. | OTC | 31.00 | 3.33 | 0.81 | 34.75 | 29.00 | 2 | 0.92 | 2.97 | 15 | 26.32 | 1.18 |
| Fireman's Fund | NYS | 31.50 | -2.33 | -10.64 | 40.75 | 30.00 | 1302 | 0.68 | 2.16 | 46 | 32.74 | 0.96 |
| Fremont General Corp. | OTC | 19.88 | -3.64 | -1.24 | 22.50 | 14.38 | 120 | 0.80 | 4.03 | 9 | 19.09 | 1.04 |
| Frontier Insurance Group | NYS | 20.25 | 4.52 | 9.46 | 21.75 | 11.63 | 96 | 0.00 | 0.00 | 9 | 7.29 | 2.78 |
| General RE Corp. | NYS | 82.25 | -2.81 | -8.61 | 96.25 | 62.25 | 659 | 1.52 | 1.85 | 13 | 29.04 | 2.83 |
| Hanover Insurance Co. | OTC | 29.00 | -1.69 | -4.92 | 33.00 | 25.75 | 33 | 0.44 | 1.52 | 7 | 32.03 | 0.91 |
| Harleysville Group | OTC | 23.50 | -4.57 | -14.55 | 28.75 | 19.50 | 37 | 0.60 | 2.55 | 8 | 18.94 | 1.24 |
| Hartford Steam Boiler | OTC | 56.25 | 0.00 | 3.69 | 59.25 | 38.50 | 133 | 1.60 | 2.84 | 15 | 18.94 | 2.97 |
| Kansas City Life Ins. | OTC | 35.75 | 0.00 | -0.35 | 36.00 | 33.25 | 2 | 1.12 | 3.13 | 10 | 39.22 | 0.91 |
| Kemper Corp. | NYS | 37.75 | -1.95 | -20.11 | 51.88 | 31.00 | 346 | 0.92 | 2.44 | 9 | 29.97 | 1.26 |
| Lawrence Insurance Group | ASE | 9.13 | 14.06 | 28.07 | 9.13 | 6.50 | 11 | 0.28 | 3.07 | 17 | 3.29 | 2.77 |
| Liberty Corp. | NYS | 47.50 | -0.26 | 11.76 | 48.00 | 32.50 | 7 | 0.92 | 1.94 | 18 | 31.82 | 1.49 |
| Lincoln National | NYS | 53.38 | -2.95 | -12.50 | 62.88 | 46.75 | 255 | 2.60 | 4.87 | 9 | 49.19 | 1.09 |
| NAC Re Corp. | OTC | 32.25 | -1.15 | -11.03 | 41.00 | 23.88 | 221 | 0.20 | 0.62 | 13 | 22.81 | 1.41 |
| Navigators Group | OTC | 30.50 | -3.17 | 10.91 | 31.50 | 21.75 | 3 | 0.00 | 0.00 | 11 | 15.22 | 2.00 |
| Nobel Insurance LTD. | OTC | 2.38 | 18.75 | 18.75 | 3.00 | 1.50 | 78 | 0.00 | 0.00 | - | 7.76 | 0.31 |
| NWNL Companies | OTC | 29.13 | -6.05 | -26.27 | 44.13 | 26.50 | 732 | 1.20 | 4.12 | 6 | 37.50 | 0.78 |
| Ohio Casualty Corp. | OTC | 47.25 | -4.55 | -1.05 | 52.50 | 34.75 | 541 | 2.32 | 4.91 | 10 | 33.30 | 1.42 |
| Old Republic Int'l | OTC | 23.63 | -2.07 | -7.80 | 30.38 | 22.50 | 158 | 0.72 | 3.05 | 5 | 30.70 | 0.77 |
| Orion Capital Corp. | NYS | 19.00 | -3.80 | -18.28 | 28.50 | 18.50 | 112 | 0.84 | 4.42 | 5 | 19.72 | 0.96 |
| Phoenix RE Corp. | OTC | 10.75 | -6.52 | -17.31 | 15.50 | 8.75 | 123 | 0.20 | 1.86 | 83 | 12.99 | 0.83 |
| Protective Life Corp. | OTC | 13.75 | -3.51 | -3.51 | 16.25 | 10.88 | 85 | 0.68 | 4.95 | 9 | 14.54 | 0.95 |
| Provident Life | OTC | 22.63 | -2.16 | -12.56 | 30.13 | 20.25 | 256 | 0.80 | 3.54 | 7 | 23.24 | 0.97 |
| Re Capital Corp. | ASE | 12.50 | -0.99 | -13.79 | 15.25 | 9.75 | 36 | 0.00 | 0.00 | 11 | 12.60 | 0.99 |
| RLI Insurance Corp. | NYS | 9.75 | -2.50 | 9.86 | 10.38 | 6.88 | 26 | 0.40 | 4.10 | 7 | 10.71 | 0.91 |
| St. Paul Companies | OTC | 60.75 | -1.22 | 1.25 | 63.50 | 47.50 | 1349 | 2.40 | 3.95 | 7 | 43.47 | 1.40 |
| SAFECO Corp. | OTC | 36.13 | -1.70 | -9.12 | 42.38 | 25.63 | 604 | 1.20 | 3.32 | 8 | 24.87 | 1.45 |
| SCOR U.S. Corp. | NYS | 11.50 | -3.16 | -19.30 | 14.50 | 8.25 | 19 | 0.20 | 1.74 | 15 | 10.61 | 1.08 |
| Seibels Bruce Group | OTC | 10.25 | -3.53 | -5.75 | 13.63 | 8.75 | 11 | 0.80 | 7.80 | -2 | 13.75 | 0.75 |
| Selective Ins. Group | OTC | 18.00 | -2.70 | -5.88 | 20.25 | 15.50 | 252 | 0.96 | 5.33 | 6 | 15.72 | 1.15 |
| Statesman Group Inc. | OTC | 2.13 | -5.56 | -22.73 | 3.63 | 1.88 | 81 | 0.16 | 7.53 | 6 | 4.19 | 0.51 |
| Tokio Marine & Fire | OTC | 50.75 | -6.45 | -32.67 | 82.00 | 50.75 | 18 | 0.92 | 1.81 | 22 | 70.93 | 0.72 |
| Torchmark Corp. | NYS | 47.88 | -4.96 | -16.38 | 58.75 | 32.00 | 306 | 1.40 | 2.92 | 12 | 13.23 | 3.62 |
| Transamerica | NYS | 39.00 | -0.95 | -12.61 | 48.00 | 33.00 | 318 | 1.92 | 4.92 | 9 | 34.63 | 1.13 |
| Travelers Corp. | NYS | 32.63 | -5.09 | -11.53 | 45.00 | 32.00 | 804 | 2.40 | 7.36 | 5 | 44.85 | - |
| Trenwick Group Inc. | OTC | 19.00 | -6.75 | -22.05 | 26.88 | 13.75 | 562 | 0.36 | 1.89 | 15 | 16.91 | 1.12 |
| United Fire & Casualty | OTC | 31.00 | 0.81 | -6.06 | 34.50 | 29.00 | 34 | 1.20 | 3.87 | 9 | 22.56 | 1.37 |
| USF&G Corp. | NYS | 28.63 | -4.58 | -3.38 | 34.00 | 26.88 | 569 | 2.92 | 10.20 | 37 | 22.87 | 1.25 |
| UNUM Corp. | NYS | 44.25 | -3.28 | -7.33 | 51.38 | 29.50 | 377 | 0.60 | 1.36 | 10 | 31.20 | 1.42 |
| USLIFE Corp. | NYS | 38.00 | -3.18 | -16.02 | 48.13 | 38.00 | 248 | 1.48 | 3.89 | 5 | 54.34 | 0.70 |
| Washington National | NYS | 22.63 | -6.22 | -19.91 | 29.13 | 22.63 | 49 | 1.08 | 4.77 | 26 | 32.90 | 0.69 |
| USLICO Corp. | NYS | 22.63 | 0.56 | -4.74 | 25.38 | 21.00 | 45 | 1.00 | 4.42 | 6 | 27.73 | 0.82 |
| Zenith National Ins. | NYS | 16.75 | 0.75 | -10.67 | 21.50 | 14.00 | 28 | 0.84 | 5.01 | - | 13.81 | 1.21 |
| INSURERS/REINSURERS | AVERAGE | | -1.9 | -9.3 | | | | | 3.5 | 11.7 | | |
| **HEALTH MAINTENANCE ORGANIZATIONS** | | | | | | | | | | | | |
| FHP International | OTC | 17.00 | -5.56 | -20.00 | 26.38 | 10.88 | 730 | 0.00 | 0.00 | 5 | 3.54 | 4.80 |
| HMO America Inc. | OTC | 5.25 | -14.29 | -32.26 | 10.63 | 1.38 | 780 | 0.00 | 0.00 | -98 | 1.12 | 4.69 |
| Pacificare Health Sys. | OTC | 22.50 | 3.45 | -13.46 | 30.38 | 10.75 | 177 | 0.00 | 0.00 | 6 | 6.35 | 3.54 |
| Safeguard Health Enter. | OTC | 6.63 | -3.64 | -22.06 | 12.50 | 5.13 | 21 | 0.00 | 0.00 | 12 | 2.99 | 2.22 |
| Sierra Health Services | ASE | 8.00 | 8.47 | -9.86 | 9.63 | 2.38 | 72 | 0.00 | 0.00 | 20 | 0.62 | 12.90 |
| United Healthcare Corp. | OTC | 9.50 | -2.56 | -22.45 | 12.63 | 6.38 | 1089 | 0.00 | 0.00 | 12 | 0.34 | 27.94 |
| United Medical Corp. | ASE | 7.63 | -1.61 | 27.08 | 8.25 | 5.38 | 13 | 0.00 | 0.00 | 23 | 5.70 | 1.34 |
| U.S. Healthcare | OTC | 11.50 | -6.12 | -19.30 | 15.50 | 9.00 | 0 | 0.28 | 2.43 | - | 3.07 | 3.75 |
| HMOs | AVERAGE | | -2.7 | -14.0 | | | | | 0.3 | -2 | | |
| ALL COMPANIES | AVERAGE | | -1.8 | -9.5 | | | | | 3.0 | 10.4 | | |

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