

# Business Insurance

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## Administration unveils proposal capping liability for oil spills

WASHINGTON—President Bush last week sent to Congress legislation to establish a comprehensive liability and compensation system for oil spills by tankers and other sources.

Under the bill, tanker owners' liability for cleanup damages sought in federal courts would be capped at \$78 million, while oil terminal and oil platform operators' liability would be capped at \$75 million.

However, the legislation would allow  
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## AIG gets hotel for settling Dupont claims

By LINDA J. COLLINS

SAN JUAN, Puerto Rico—Corporate and individual owners, operators and alleged affiliates of the San Juan Dupont Plaza hotel and its liability insurer have reached a potential \$108 million out-of-court settlement with plaintiffs in litigation stemming from the devastating Dec. 31, 1986, fire at the hotel.

As part of the settlement, the liability insurer, New York-based American International Group Inc., will assume ownership of the still-shuttered 450-room hotel.

Two AIG units—American International Insurance Co. of Puerto Rico and Insurance Co. of the State of Pennsylvania—wrote a \$1 million occurrence-based liability policy for the Dupont Plaza and were named in the litigation.

In addition, several insurers that wrote directors and officers liability insurance for the hotel owners and operators and coverage for limited partnerships will contribute to the settlement.

Separately, Sheraton Corp., the hotel's former owner, has tentatively agreed to an estimated \$36 million settlement with the plaintiffs, which also includes a contribution from AIG. An AIG unit wrote excess liability insurance for Sheraton.

Despite these settlements, litigation over liability for the fire continues with about 80 other defendants who supplied materials and services to the hotel.

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

"To satisfy all of our plaintiffs' interests, we have to get better than \$300 million" in recoveries from defendants, said Wendell Gauthier, chairman of the Plaintiffs Steering Committee in San Juan, which represents more than 2,300 plaintiffs in the hotel fire litigation. "If we get what the plaintiffs really want and deserve, we have to actually get to about \$320 million."

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## California to review insurer rates by line

By GLENN HUNTLEY

SAN FRANCISCO—The California Insurance Department will individually examine—by line of coverage—insurers' requests for relief from Proposition 103-mandated rate rollbacks.

However, to obtain relief from the rollback, property/casualty insurers in California must file detailed applications with the Insurance Department by June 3, Insurance Commissioner Roxani Gillespie said at a Thursday news conference.

Most of the estimated 700 insurers that write insurance in California affected by Proposition 103's rate rollback provisions are expected to file rates exceeding the level mandated by Proposition 103. Some publicly held insurers may file relief requests if only to avoid potential lawsuits by stockholders, Ms. Gillespie said.

In other Proposition 103-related developments last week:

- Insurance industry observers and consumer advocates say the May 4 California Supreme Court ruling upholding most provisions of Proposition 103 will encourage similar reform efforts in other states (see story, page 44).

- Iowa is proposing rules to prevent insurers from raising rates in Iowa to make up for losses in California prompted by Proposition 103 (see story, page 47).

- One insurer—Aetna Life & Casualty Co.—stopped writing all new business in California pending the Insurance Department's guidelines for obtaining rate relief. Aetna had not resumed underwriting new business in California as of last Friday afternoon.

Proposition 103, approved by California voters in November, mandates that "charges" for most lines of property/casualty insurance be rolled back to at least 20% below November 1987 levels for one year, retroac-



Photo: Glenn Huntley

**Insurance Commissioner Roxani Gillespie explains Proposition 103 rate relief procedures.**

tive to November 1988.

Beginning in November 1989, all property/casualty insurance rates will be subject to prior approval by the Insurance Department.

In addition, Proposition 103, among other things,  
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## No end to insurer competition in sight

By LINDA J. COLLINS

Competition remains the buzzword during spring 1989 commercial property/casualty insurance renewals, with observers unanimously certain the market will not begin to turn until next year at the earliest.

Most insurers still are aggressively pursuing both property and excess liability business, and some are still hungry for primary casualty accounts, insurers, reinsurers, brokers and risk managers agree.

And, some observers note particularly heated competition in the aviation and marine insurance markets.

"There is no indication of a slowdown in competition," said John E. Boyne, director of property/casualty sales for Nationwide Insurance Co. in Columbus, Ohio.

"I don't think we'll see any improvement (before year-end), and when the smoke clears, it may even be worse by the end of this year," predicted Ward B. Gordon, chairman and chief executive officer of Intere Reinsurance Intermediaries Inc. in New York.

As usual, assessments of the current magnitude of competition vary considerably among insurers and brokers.

Some insurer executives say they have observed only minimal rate reductions during spring renewals and that competition is losing momentum.

"We continue to see the market dragging along at about where it has been for the last six or seven months," said Keith Like, executive vp of commercial lines for Kemper Corp. in Long Grove, Ill.

Excluding workers compensation and pollution liability coverages, most "insurers are renewing business at rates that are no higher than a year ago or five to 10 points less," Mr. Like estimated.

But, while Kemper is encouraging its producers to sell last year's premiums or seek slight rate increases to keep pace with loss cost trends, when producers "want us to come through on their most important ac-

counts, we'll certainly try our best to help them," he conceded.

Brokers, however, still report vigorous competition for nearly all types of property/casualty business.



Graphic: Amy Palmer

"There is no tightening, generally. The market continues to soften and I don't see anything on the horizon that indicates that will change this year or next year," said Thomas J. Rodell, deputy managing vp of Alexander & Alexander Inc.'s Chicago office.

While "we don't see blatant price cutting," property and casualty markets "continue to be competitive," said Lawrence L. Drake, managing director of Marsh & McLennan Cos. Inc. in New York.

And, Harold Lang, director of insurance and risk management for Kohler Co. in Kohler, Wis., said that when he renewed his worldwide umbrella insurance program this April, "I saw a continued softening of the

marketplace with increased availability and limits."

Reports vary on the types of coverage that are seeing the greatest amount of competition, with some insurers suggesting competition may have ebbed for their smaller accounts.

Others point out that competition is more vigorous in some regions than others, with the Midwest the site of some of the fiercest price cutting.

"We haven't seen further deterioration in the marketplace than what there was six months ago" for property/casualty accounts generating \$50,000 or less in annual premiums, according to Richard W. Wratten, president of Transamerica Insurance Co.'s commercial lines division based in Los Angeles.

For those smaller accounts, "pricing has leveled off" on the East and West Coasts, though a different story exists in the Midwest—particularly in Indiana and Ohio—with some insurers cutting rates by 20% to 30%, Mr. Wratten observed.

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## Update

## Bush seeks oil spill caps

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plaintiffs to sue under state law for economic losses above the liability limits. In addition, the liability caps would not apply if the proximate cause of an oil spill was caused by "willful misconduct."

The legislation also would establish a \$500 million oil pollution liability trust fund to cover cleanup costs and damages in excess of the liability limits. The fund would be financed with a fee of 1.3 cents per barrel on domestic and imported oil.

The proposal, a response to the Exxon Valdez oil spill in March (BI, April 3), "dramatically enhances our ability to compensate victims of major oil spills and to restore our fragile environment," said Transportation Secretary Samuel K. Skinner.

## Workers win benefit dispute

NEWARK, N.J.—Continental Can Co. Inc. developed a sophisticated computer program to enable the company to identify and dismiss longtime employees before they became eligible for special pension benefits, a federal judge ruled last week.

Continental Can developed a plan, "shrouded in secrecy and executed companywide," to save hundreds of millions of dollars in unfunded pension liabilities, said U.S. District Court Judge H. Lee Sarokin in Newark, N.J.

"The evidence of the plan, its secrecy and its execution comes from the files of the defendants themselves. The documents are more than a smoking gun; they are a fusillade," said Judge Sarokin, who appointed Yale University law professor George Priest to attempt to negotiate a settlement in the class-action suit.

However, Dan Carson, associate general counsel at Continental Can, denied any wrongdoing. He said any dismissals were the result of changing economic conditions and were not intended to deny workers benefits. He also said that estimates of damages ranging into the hundreds of millions of dollars "is a gross exaggeration." The company will "pursue all appropriate avenues to obtain vindication."

Attorneys for the plaintiffs, members of the United Steel Workers Union, argued that Continental Can, now a unit of Peter Kiewit Sons Inc., deliberately dismissed workers before they would have accumulated sufficient service entitling them to special pension benefits payable before normal retirement age in the event of a plant shutdown.

"The judge's decision is a confirmation of what we have contended for years: Continental had an illegal program to cheat employees of millions of dollars in benefits to which they would have been entitled," said plaintiffs' attorney Mark Plotkin, a senior partner with the Chicago law firm Plotkin & Jacobs.

The workers' suit did not specify the benefits the employees allegedly are owed.

## N.Y. guaranty fund assessment

NEW YORK—Property/casualty insurers in New York will pay at least an additional \$148 million in assessments to the state guaranty fund, according to the New York Insurance Department.

Insurers are scheduled to pay \$37 million in quarterly assessments to New York's guaranty fund by June 1; Aug. 15; Nov. 15; and Feb. 15, 1990, said a department spokesman, who would not say whether the assessments would continue throughout 1990.

The assessments, which began last year, are continuing because the fund's balance was \$138 million at year-end 1989. By law, assessments to prefund liabilities must be collected if the fund falls below \$150 million at the close of any calendar year. The fund is expected to pay out at least \$90 million in claims this year.

Insurers are paying the assessments under protest, noted a spokesman for the American Insurance Assn.

The assessments follow the siphoning of \$87 million from the Property/Casualty Insurance Security Fund by the Legislature in 1982. Insurers are appealing a state judge's dismissal of three suits seeking return of the funds (BI, Jan. 23; May 9, 1988).

## Coverage ordered for treatment

NEWARK, N.J.—Crum & Forster Inc. must pay for an experimental bone marrow cancer treatment for the spouse of one of its employees, a U.S. District Court judge says.

Judge Dickinson Debevoise ruled that Nicolae Dozsa, whose wife is a Crum & Forster employee, is entitled to the treatment, which is expected to cost between \$75,000 and \$125,000, said John Hoyt III, Mr. Dozsa's attorney.

Crum & Forster, which self-insures its health care benefits, and its third-party administrator, Prudential Insurance Co. of America, had argued that there was not enough statistical evidence to prove that the treatment would be successful.

Mr. Dozsa was seeking to undergo an autologous bone marrow transplant at Johns Hopkins University. The treatment involves removing bone marrow from the body, submitting the patient to high levels of chemotherapy, then reintroducing the purified bone marrow.

## Lloyd's won't allow LOCs

LONDON—Several Lloyd's of London syndicates may be forced to make massive cash calls on their members next year because of a Committee of Lloyd's decision to bar the use of letters of credit to cover members' U.S. dollar liabilities in the Lloyd's U.S. Trust Fund.

"Letters of credit will not be deemed acceptable assets for the U.S. dollar solvency test as at Dec. 31, 1989," said Lloyd's Deputy Chairman Colin Murray in a market bulletin sent to underwriting agents, auditors and financial institutions.

Several syndicates unable to close their underwriting accounts in recent years have used LOCs to cover members' U.S. liabilities.

The move puts syndicates with open underwriting years on an equal footing with syndicates that close their books on time and are forced to make cash calls to cover underwriting losses, Lloyd's Chief Executive Alan Lord explained last week.

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## Delta Re liquidator sues Reiss group, captives

By DOUGLAS McLEOD

NEW YORK—Delta America Re Insurance Co.'s liquidator is suing the reinsurer's former management company and several of its retrocessionaires to recover millions of dollars in reinsurance losses.

The lawsuit, filed in U.S. District Court in New York by Kentucky Insurance Commissioner Leroy Morgan, names former Delta America Re manager American Risk Management Inc., several ARM affiliates, and several officers of ARM and related companies, including founder Frederic M. Reiss.

Also named are 23 retrocessionaires—mainly offshore captive insurance companies managed by ARM affiliates—that also were shareholders in Delta America Re's parent company, Delta Holdings Inc.

The suit charges that the retrocessionaires have wrongfully refused to pay claims under 1984 and 1985 treaties with Delta America Re.

Although the complaint does not say how much the retrocessionaires allegedly owe, recoverables amount to roughly \$30 million, according to William Costigan, a partner with the New York law firm of Anderson Costigan, representing the liquidator.

The complaint also charges that Delta America Re's managers breached their fiduciary duties to the reinsurer and should be required to indemnify the liquidator if the retrocessionaires are ultimately able to rescind their treaty participations.

Officials of ARM and its affiliates could not be reached for comment concerning the lawsuit.

The liquidator's lawsuit is the latest offshoot in the thicket of litigation that grew out of the 1985 collapse of Louisville, Ky.-based Delta America Re.

Delta America Re—which entered rehabilitation in May 1985 and was ordered liquidated four months later—is estimated to be insolvent by \$150 million to \$175 million, according to James E. Dickinson, assistant to the special deputy insurance commissioner liquidating Delta America Re.

The Tillinghast division of Towers, Perrin, Forster & Crosby Inc. is preparing a report on the adequacy of the reinsurer's incurred-but-not-reported loss reserves, and an updated estimate of the size of the insolvency should be available soon, according to Mr. Dickinson, who would not say whether the number is likely to be higher or lower than the current estimate.

Delta America Re, formerly known as Elkhorn Re Insurance Co., was acquired from National Distillers & Chemical Corp. in 1983 by Delta Holdings, an insurance and reinsurance holding company formed by more than two dozen captive management clients of the former Reiss Organization, including National Distillers itself.

Delta America Re was to act as a U.S. fronting company for business ceded to the Reiss-managed captives, which were looking to expand their involvement in third-party underwriting.

The Reiss Organization's captive management units, including ARM and several affiliates, were sold to Swiss Reinsurance Co. in 1988. National Distillers has

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## Phillips may appeal denial of captive excise tax refund

By DOUGLAS McLEOD

WASHINGTON—Phillips Petroleum Co. is deciding what action to take in the wake of a U.S. Tax Court's refusal to hear its claim for recovery of \$685,259 in excise taxes it paid on premiums ceded to its Bermuda captive.

In a petition against the Internal Revenue Service, Phillips argued that it should be able to offset the excise tax payments against \$95.5 million in additional income taxes it owes as a result of the IRS disallowing deductions for premiums paid to Walton Insurance Ltd., Phillips' captive, between 1975 and 1978.

However, a Tax Court judge earlier this month ruled that the court does not have jurisdiction over the excise tax dispute and granted an IRS motion to dismiss the case.

Phillips has not decided whether to appeal the decision or pursue its excise tax claim in adminis-

trative proceedings with the IRS, said Joseph O'Toole, vp-taxes of Bartlesville, Okla.-based Phillips.

Phillips is discussing the matter with the IRS, Mr. O'Toole said.

In addition to insuring Phillips' risks, Walton started underwriting commercial reinsurance business in 1974 and subsequently suffered massive losses. Phillips took a \$65 million aftertax charge related to Walton losses in 1982 and pumped \$55 million into the insurer in October 1983. Walton ceased commercial underwriting in January 1983 and is now running off its business (BI, Jan. 31, 1983).

The excise tax dispute arose after the IRS in 1987 disallowed deductions Phillips had taken for premiums paid to Walton for the 1975 through 1978 tax years.

In line with other rulings on deductibility of captive premiums, the IRS found that coverage with Walton was not true insurance because it did not represent a real

transfer of risk, and that premiums were therefore not deductible as business expenses.

In a July 20, 1987, "notice of deficiency," the IRS informed Phillips that its income tax payments were deficient in the amount of \$3.8 million for 1975, \$14.7 million for 1976, \$31.1 million for 1977 and \$45.8 million for 1978.

In its petition in tax court, Phillips argued that the IRS "erroneously failed" to reduce the amount of additional taxes owed by the amount of excise taxes Phillips had already paid on the premiums ceded to Walton.

The excise taxes in question amounted to \$200,015 for 1975, \$145,168 for 1976, \$164,808 for 1977 and \$175,268 for 1978.

The IRS levies excise taxes on premiums paid to offshore companies at the rate of 4% on direct insurance premiums and 1% on reinsurance premiums.

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## Inside

✓ Four former Alexander Howden Group Ltd. executives used bogus reinsurance deals to misappropriate millions of dollars, prosecutors allege. **PAGE 7**

✓ The great consumer victory claimed by advocates of Prop. 103 in California likely will prove hollow in terms of the cost of insurance, says this week's editorial. **PAGE 8**

✓ X.L. Insurance Co. Ltd. is planning to transfer all operations to Bermuda early next year. **PAGE 12**

✓ A totally non-admitted program insuring foreign risks may result in adverse tax treatment of premiums and losses, explains Alexander & Alexander Inc.'s Thomas J. Drag in Speaking Out. **PAGE 27**

✓ Only by purchasing its own product liability insurance can a vendor obtain the broadest coverage available, says Consultant Henry Salfeld in Perspectives. **PAGE 28**

✓ The California Supreme Court's decision upholding most of Proposition 103 is giving a green light to similar efforts in other states, consumer activists and insurance industry representatives agree. **PAGE 44**

✓ At least one state—Iowa—is reacting to the Proposition 103 by attempting to protect insurers and policyholders from 'oppressive' regulation by other states. **PAGE 47**

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# Broker results show no end to competition

By LINDA J. COLLINS

The publicly held insurance brokers' first-quarter results are more proof that property/casualty insurance rate cutting marches on.

And, brokers and the financial analysts who track the brokers see no profit relief any time in 1989.

In a nutshell, "the cycle has not turned and is not about to turn, so you have flat to down earnings—end of story," observed analyst Michael A. Smith, vp of Shearson Lehman Hutton Inc. in New York.

"The good news is that the first quarter is over. The bad news is that underwriters show no signs of returning to sane pricing anytime soon," said analyst Thomas G. Rosencrants, senior vp of Interstate/Johanson Lane Inc. in Atlanta.

"This means that the question is no longer: 'Will 1989 be a tough year?' It now also looks like the first half of 1990 will be very difficult," Mr. Rosencrants added.

The property/casualty insurance market "is still very competitive, and we don't see any signs of abatement," agreed Robert P.

Cuthbert, vp and controller of Corroon & Black Corp. in New York. "We feel it will be a very difficult year and will (continue to) exert pressure on our profit margins."

Brokers "are all buckling down and expecting a tough year," noted analyst John E. Keefe, vp of research for Drexel Burnham Lambert Inc. in New York.

"Despite strong new business production, brokers are not seeing any revenue increase, because they are working harder for fewer dollars," Mr. Keefe explained.

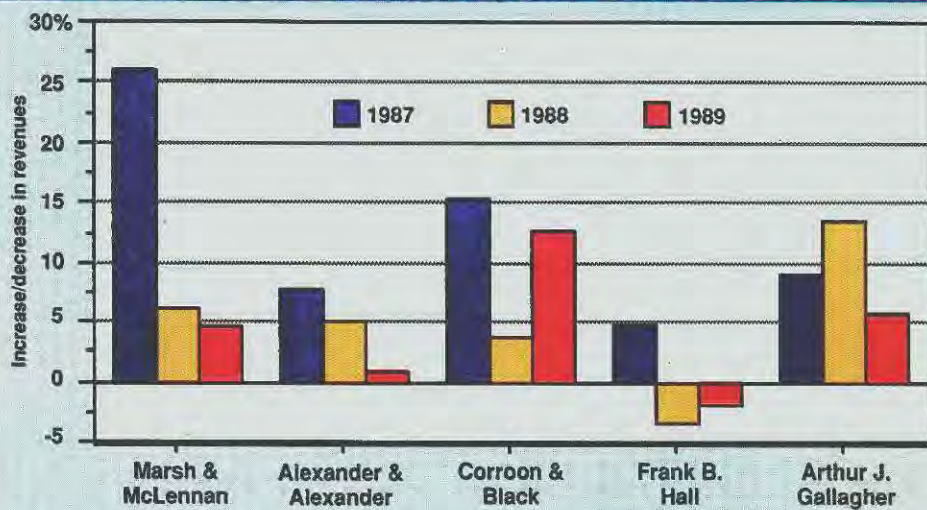
J. Michael Bischoff, vp of Marsh & McLennan Cos. Inc.'s Corporate Development Group, said the first quarter of 1989 "saw a continuation of what we were seeing through all of 1988: significant price reductions or premium rate declines, particularly in the U.S."

Brokers all cite aggregate first-quarter rate reductions of 15% to 20%, following similar rate reductions in 1988 and 1987.

"In the aggregate, rates declined 15%," Mr. Bischoff said.

"We're seeing, on average, 15% to 20%  
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## Brokers' first-quarter revenue growth tumbles



Source: Company reports

Chart: Holly E. Seguire

## U.S. tort system 'counterproductive,' study suggests

By STACY ADLER

WASHINGTON—Accident victims should rely more on private and social insurance—including health insurance, workers compensation and Social Security—for compensation because the U.S. tort system is "inefficient and counterproductive," a new study suggests.

Escalating legal fees, huge court awards and rising insurance costs make the tort system impractical for compensating victims, asserts the Committee for Economic Development, a group of more than 225 corporate executives and university presidents.

"The tort system is most effective where it provides both deterrence and compensation, but social insurance and private insurance are better for just compensating victims," said Patricia Danzon, professor of health care systems and insurance at the Wharton School of Business at the University of Pennsylvania and project director for the CED study.

"We are persuaded that the cost to society of using the tort system to compensate for injuries can be disproportionate to the injury," agreed CED President Robert C. Holland.

Furthermore, there are many indirect costs to society caused by the tort system such as higher prices for goods, the refusal by companies to introduce products because of liability fears and damage to U.S. international competitiveness, said Mr. Holland.

"The tort system is a very expensive way of compensating someone who has been injured," he said.

The CED—a non-profit, non-partisan group that dedicates itself to studying major economic problems affecting American businesses—spent three years and more than \$700,000 to develop a wide-ranging proposal for improving the way Americans compensate those who have been injured and to deter future injuries.

In its report titled, "Who Should be Liable? A Guide to Policy for Dealing with Risk," the CED calls for:

- Greater reliance on private insurance—specifically health

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## Illinois petitions court to liquidate Centaur

By STACY ADLER

CHICAGO—The Illinois Insurance Department is seeking to liquidate Centaur Insurance Co., which the department says is insolvent by at least \$120 million.

The failure of Schaumburg, Ill.-based Centaur, a unit of Borg-Warner Corp., could be the largest insurer insolvency in Illinois history, rivaling the 1979 failure of Reserve Insurance Co., which also is insolvent by more than \$120 million.

The Illinois Insurance Department believes Centaur's insolvency could climb to "possibly two to three times that much," according to a department spokesman. However, offsets could reduce the size of Centaur's deficit, he noted.

Centaur was placed into voluntary rehabilitation on Sept. 4, 1987, after a preliminary actuarial report found the insurer seriously underreserved for assumed reinsurance claims (BI, Sept. 7, 1987).

But new estimates of the size of Centaur's impairment makes rehabilitation impossible, said Illinois Insurance Director John Washburn.

Mr. Washburn filed a complaint seeking approval of Centaur's liquidation with the Cook County Circuit Court earlier this month. A status hearing on the complaint is scheduled for May 23.

Borg-Warner has not yet responded to Mr. Washburn's complaint and would not comment on whether it will oppose the liquidation.

Centaur stopped writing business in January 1986 after writing only \$6.9 million in gross written premiums in 1985, down from \$15.5 million in 1984 and \$55 million in 1983.

Half of Centaur's business was direct insurance, mostly commercial liability, umbrella and excess liability coverages. The remainder of Centaur's business was reinsurance, mostly quota-share treaties.

When Centaur was placed into rehabilitation, it was thought to be insolvent by only \$85.4 million. With a deficit of that size, the department believed that Centaur could be rehabilitated if some of Centaur's obligations could be commuted, the department spokesman said.

However, because the deficit now is estimated at \$120 million, liquidation is necessary, the spokesman said.

As of Dec. 31, 1988, Centaur had total assets of \$92.5 million and total liabilities of \$213 million, according to the complaint. The liabilities include \$56.4 million in direct insurance claims and expenses and \$152.9 million in reinsurance claims and expenses.

The reinsurance claims consist of \$51 million in reported claims; \$30.2 million in loss and expense reserves; and \$78.5 million in incurred-but-not-reported losses. This reinsurance liability is offset by \$6.9 million in ceded reserves, according to the complaint seeking Centaur's liquidation.

However, the accuracy of these balance sheet items is "suspect," according to the complaint, due to the uncertainty of the accuracy of Centaur books.

If Centaur is liquidated, direct policyholders should be paid in full, but insurers that ceded business to Centaur may only receive 10 cents on the dollar, according to the Insurance Department spokesman.

According to Illinois law regarding liquidations, administrative expenses are paid first; employees' claims are paid second; direct policyholder claims are paid third; and, general creditors, including ceding companies, are paid fourth.

Until the liquidation petition is approved, the Illinois Insurance Department will continue to pay direct policyholder claims and provide a defense for these claims.

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# Section 89 bill may cripple flex plans

By JERRY GEISEL

WASHINGTON—Section 89 reform legislation proposed by House Ways and Means Committee Chairman Daniel Rostenkowski, D-Ill., would spell disaster for many flexible benefit plans, experts say.

If the proposal, H.R. 1864, is enacted, highly compensated employees participating in a wide variety of flexible benefit plans could be taxed on all or part of the value of their health care coverage.

This harsh tax treatment would sharply reduce or even kill the attractiveness of many types of flexible benefit arrangements for highly compensated employees.

Among the types of flexible benefit plans that could be damaged by the legislation are programs that require employees to pay part of a health care premium with pretax dollars, allow employees to finance uncovered benefit expenses through flexible spending accounts or give employees a choice of taking cash in lieu of accepting certain benefit options.

Ironically, while the Rostenkowski legislation is intended to reduce employers' Section 89 compliance burdens, employers with flexible benefit plans fare much better under the current version of Section 89 than they would under the Rostenkowski proposal.

**'The very same flexible benefit plans that pass Section 89 non-discrimination testing with flying colors will flunk under the Rostenkowski legislation,' says Kevin Meehan of The Wyatt Co.**

"The very same flexible benefit plans that pass Section 89 non-discrimination testing with flying colors will flunk under the Rostenkowski legislation," said Kevin Meehan, an attorney and consultant in the Washington, D.C., office of The Wyatt Co.

"Participants in flexible benefit plans would face new taxes. Yet these plans are clearly non-discriminatory," Mr. Meehan added.

"Most cafeteria plans of which the ECFC is aware passed the majority of the current Section 89 rules. Others would pass with relatively minor adjustments. But just the reverse is true under" the Rostenkowski bill, said William Richardson, employee benefits manager for Valero Energy Corp. in San Antonio, Texas, in testimony submitted last week to the

Senate Finance Committee on behalf of the Employers Council on Flexible Compensation.

The problems that flex plans would face under the Rostenkowski bill in part result from the manner in which the bill treats highly compensated employees' pretax health care contributions made through salary reductions.

Problems also arise because of the definition the Internal Revenue Service has given "flex dollars" that can be taken in cash. The IRS has considered such arrangements to be equivalent to salary reduction.

Under the Rostenkowski legislation, all employers with health care plans—including health care plans that are part of a flexible benefit program—are required to run two non-discrimination tests.

These tests are:

- An eligibility test. Under this test, 90% of non-highly compensated employees must be eligible for health care coverage consisting primarily of "core"—or medical and hospital—benefits.

Annual employee contributions, either on a pretax or after-tax basis, could not exceed \$520 for individual coverage or \$1,300 for family coverage. These maximum contribution levels would be indexed to annual increases in wages.

The penalty for failing the 90% eligibility test is severe: The  
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## Dupont claims

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That means the plaintiffs are seeking at least another \$150 million from the remaining defendants if the Sheraton agreement is finalized.

A spokeswoman for AIG would not comment on the settlements except to say that they "would not have a material effect on our earnings."

AIG has already spent nearly \$35 million in defense costs in the litigation, *Business Insurance* learned. AIG also could have been forced to pay as much as \$136 million under the \$1 million occurrence-based liability policy under San Juan District Court Judge Raymond Acosta's interpretation of an occurrence under the policy.

Judge Acosta, who presides over the consolidated Dupont Plaza Hotel fire litigation, ruled that the AIG units were responsible for "each discrete act or omission, or series of acts or omissions," by the hotel that "caused damages to plaintiffs" (BI,

March 20).

Following Judge Acosta's policy interpretation ruling, the Plaintiffs Steering Committee filed a motion identifying as occurrences 88 "discrete acts or omissions committed by the San Juan Dupont Plaza Corp." and 48 other occurrences stemming from the hotel's selection and purchase of "unreasonably dangerous" products.

In addition to the \$1 million liability policy, AIG wrote about \$30 million in property and business interruption coverages for the hotel.

Judge Acosta last Friday confirmed that the settlement with what is known as the "hotel family" and its insurers will range from \$85 million to \$100 million.

The total potential settlement with the hotel family is \$108 million, according to Mr. Gauthier.

The settlement with the hotel's owners, operators and affiliates and AIG will provide plaintiffs "with \$85 million in guaranteed hard cash," said Mr. Gauthier, senior partner in

the law firm of Gauthier, Murphy, Sherman, Clehardy & Ellis in Metairie, La.

The remainder of the \$108 million settlement "will be collected from various insurance companies" that wrote directors and officers liability coverage for the "hotel family" defendants and policies covering "the participation of limited partners in various endeavors and activities," Mr. Gauthier added.

Those insurers include: Novato, Calif.-based Fireman's Fund Insurance Cos.; Hartford, Conn.-based Aetna Life & Casualty Co.; and Philadelphia-based Insurance Co. of North America, a unit of CIGNA Corp.

While CIGNA and Aetna confirmed their involvement in the pending portion of the settlement, Fireman's Fund would "neither confirm or deny its involvement."

The Plaintiffs Steering Committee brought suit against the intricate structure of individuals, corporations and limited partnerships in the

United States and Puerto Rico that make up what has commonly been referred to as the "hotel family."

According to Judge Acosta, 79 named defendants are part of the settlement.

Among these corporations and limited partnerships comprising the hotel family are: San Juan Dupont Plaza Corp., Holders Capital Corp., Hotel Systems International, HSI Reservations Hotel Equipment Leasing Associates, Dallas Asset Management Ltd. and Tertiary Inc.

Named individual defendants who owned or managed one or more of the corporations and limited partnerships at the time of the fire include: Brian Corbell, William Eberle, William Lyon and Dennis Jay.

The first phase of the four-phase trial, which began March 15, had been devoted to resolving questions pertaining to the ownership and management of the hotel. The plaintiffs had been attempting to pierce the corporate veil separating many members of the hotel family from di-

rect liability for losses resulting from the fire.

"We have maintained all along that they constitute just one party" for purposes of liability, explained Mr. Gauthier.

On Friday morning, Judge Acosta approved the hotel family settlement, but did not dismiss the jury because several contingent conditions still must be met. The judge asked the jury to return on July 14.

"I am pleased that it looks like it is over. It was an arduous, painstaking process and at times a frustrating one," Judge Acosta said Friday in response to questions from *Business Insurance*.

The settlement "benefits the process of the law in that it cuts expenses and it is more efficient. It frees me to work with other matters, not only regarding the next phases of this litigation, but also my regular case load," Judge Acosta added.

The judge said that a committee will be appointed to manage the funds from the settlement, which will be placed in interest-bearing accounts.

"It is not anticipated that the funds will be distributed" to plaintiffs until the trial involving all defendants is over, but that decision "is subject to change given special circumstances," Judge Acosta noted.

Philadelphia U.S. District Court Judge Louis C. Bechtel, who was brought into the case to coordinate settlement agreements, characterized the settlement as "just, wise and fair, and positive as respects those parties involved."

James L. Fetterly, a partner of Fetterly & Gordon in Minneapolis and attorney for the Dupont Plaza Corp., said: "My clients are first and foremost greatly relieved to have this experience behind them, particularly those individuals sued personally."

In addition, Mr. Fetterly said, the hotel family and its insurers might still pursue subrogation or direct claims against other defendants in the litigation.

Mr. Fetterly noted that the settlement was possible because Judge Acosta had structured the discovery proceedings and trial to determine damage issues concurrently with liability issues. As a result, defendants were much better able to assess and evaluate plaintiffs' damage claims and negotiate a reduced settlement.

Mr. Gauthier of the plaintiffs' committee said: "We are very excited and anxious to get on with the rest of the case."

Pending is a \$36 million settlement with Sheraton, which previously owned the hotel and held a lien on the property.

A clause in its mortgage contract said that in order to protect its investment, at any point in time Sheraton had the right to intervene and take over the hotel if it felt that the hotel was being mismanaged. The Plaintiffs Steering Committee has argued that Sheraton had the authority to make fire protection improvements at the hotel.

Jim Latham, an in-house counsel for Sheraton in Boston, said "parties are working quite hard to reach an agreement and considerable progress has been made, but the agreement does involve some confidentiality on the part of the parties."

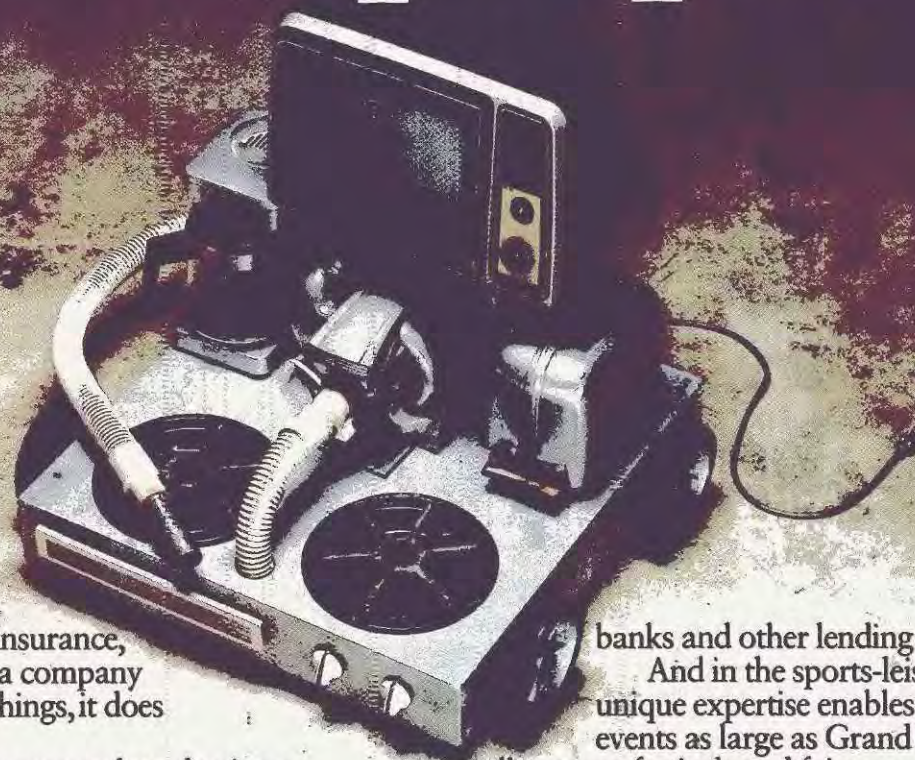
Mr. Gauthier pointed out that all parties are in agreement over the Sheraton settlement terms, but Judge Acosta and Judge Bechtel must approve the offer.

Mr. Gauthier would not comment on the amount of Sheraton's settlement offer, but he did say that it, combined with out-of-court settlements already reached with several other former defendants in the litigation, would bring plaintiffs about \$40 million in addition to the expected \$108 million settlement with the hotel family.

Settlements have been reached with Theodore Smyth, one of the owners of the hotel; Cerro Wire & Cable Corp., Phelps Dodge and

Continued on page 45

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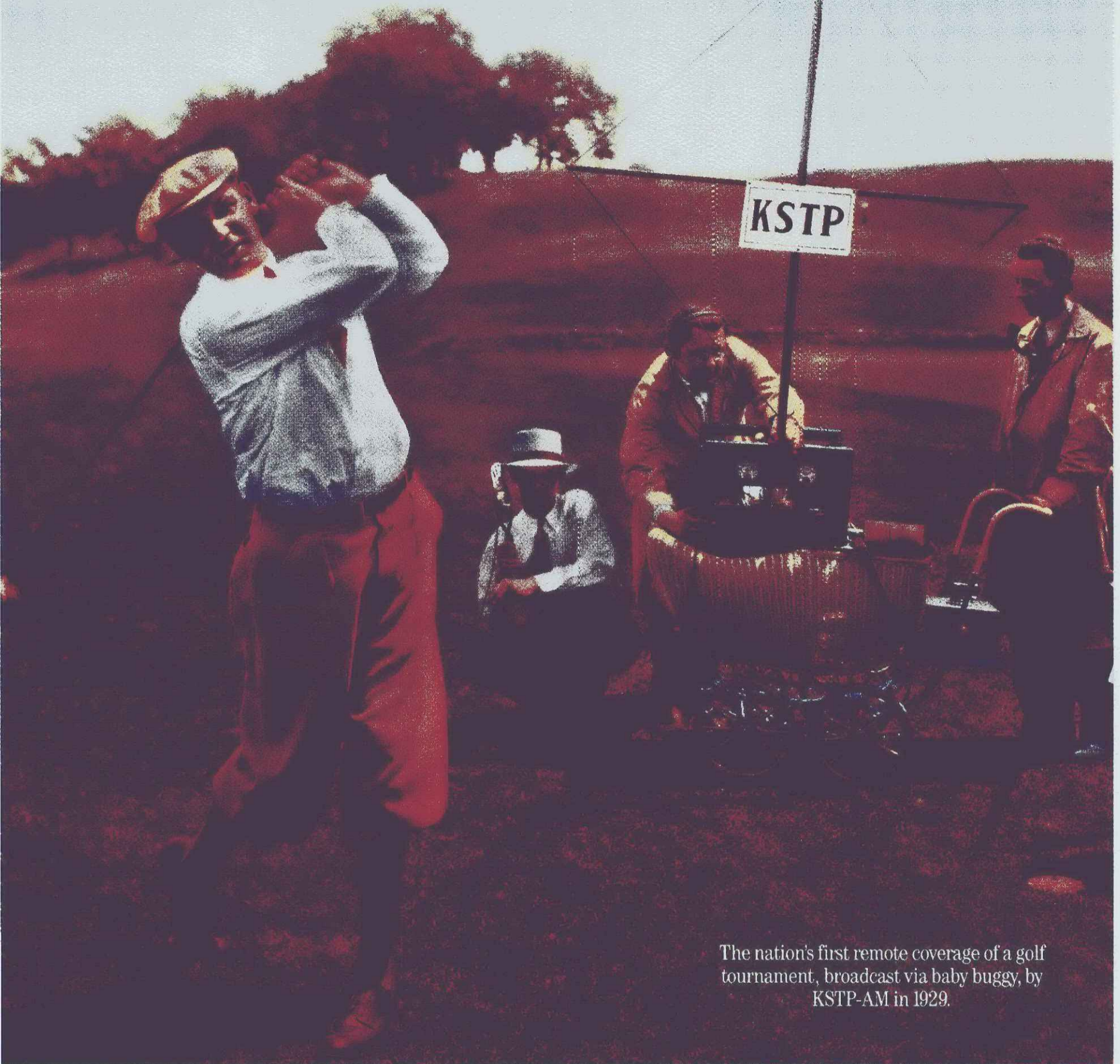
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# Maine forms group health plan for uninsured

By MICHAEL SCHACHNER

The Maine Legislature has set aside \$900,000 over the next two years to establish and help subsidize a group health insurance plan for uninsured workers at very small companies and self-employed workers in the greater Bath-Brunswick area.

Under the program, called MaineCare, employers and employees each pay 50% of the monthly health insurance premium. However, the state will subsidize low-income workers' premium contributions on a sliding scale.

The two-year pilot program was developed by the state Department of Human Services and the University of Southern Maine's Human Services Development Institute, with support from The Robert Wood Johnson Foundation, a health care philanthropic organization.

MaineCare began enrolling subscribers in December and 107 businesses have so far joined the project, representing 391 employees and dependents, said Ellen Schneider, director of MaineCare and director of special projects for the DHS in Augusta.

Ms. Schneider said the project stemmed from a 1986 state-funded study by the University of Southern Maine in Portland that showed about 13% of the state's population did not have health insurance and 66% of those uninsured held jobs.

MaineCare resulted because "there was a mood in the Legislature to address the problem," said Ms. Schneider.

The state has contracted with Healthsource Maine Inc., a Yarmouth-based health maintenance organization, to administer the

program and provide coverage to MaineCare enrollees, she said.

Under the contract, the state caps Healthsource's maximum loss on the program at a certain percentage of premium, while Healthsource agrees to return excess profits to the MaineCare program.

Premiums for MaineCare are determined according to Healthsource's community rate, said Ms. Schneider.

Currently, the monthly premium for an individual policy is \$79.75 and the premium for a family policy is \$238.46.

Group enrollees, with the exception of low-income workers, contribute 50% of the premium for single and family coverage. Employers contribute the remainder for their enrolled workers.

Low-income employees earning less than the state's individual poverty level—\$5,770—receive a state subsidy for the entire employee contribution. State subsidies continue on a sliding scale for workers earning up to \$8,655—or 150% of the poverty level.

Likewise, the state subsidizes employee contributions for family coverage. Employees earning less than or at the poverty level for a family of four—\$11,650—receive a state subsidy for the entire employee contribution. State subsidies continue on a sliding scale for employees earning up to \$20,388—or 175% of the poverty level for a family of four.

MaineCare also provides health care insurance to self-employed workers. The state,

rather than the self-employed person, pays 50% of the premium. In addition, low-income self-employed workers' premium contributions are eligible for state subsidies.

Certain employers—those whose total premium payments are more than 5% of gross annual revenues for the most recent fiscal year, or employers where all partners each have household incomes less than 200% of the federal median household income—also are eligible for state subsidies.

Of the \$900,000 provided by the Maine Legislature for the two-year project, \$350,000 has been allocated to reserves for excess losses, \$50,000 to marketing and \$500,000 for health care subsidization.

In addition, the state nearly matched an RWJ grant of \$409,000 during the project's development stage, said Ms. Schneider.

MaineCare features open enrollment to any small business that employs 15 or fewer full-time employees and has not provided group health coverage during the previous year.

However, for companies with fewer than 10 people, all eligible employees must participate. For firms with 10 to 15 workers, 80% must participate.

All applicants are subject to mandatory screening for pre-existing medical conditions, coverage for which is delayed for 90 days unless the lack of coverage would lead to greater medical expenses later. Workers with serious conditions such as cancer, heart disease, diabetes, acquired immune def-

ciency syndrome, severe and chronic mental illness and chemical dependency are referred to Maine's new High Risk Insurance Organization, a health insurance pool for those with eligibility problems.

MaineCare enrollees receive the same benefits offered to other individuals and their dependents participating in the Healthsource HMO, said Ms. Schneider.

MaineCare covers 100% of inpatient services rendered at the program's three participating hospitals, in addition to immunizations, X-rays, maternity care and a host of other services.

Copayments range from \$3 for prescriptions to \$5 for most ambulatory visits to 50% for additional mental health visits beyond the first 15 visits, which require only a \$5 copayment. Emergency care requires a \$25 copayment.

Ms. Schneider cautioned that "this is not being billed as a medical indigency program. It's a public/private partnership, which is a popular term right now."

In the fall MaineCare is expected to be expanded to cover those living in Somerset County, Maine, said Ms. Schneider.

The Maine program is the third in a series of RWJ-funded projects designed to provide health care insurance to those unable to afford individual coverage, or whose employers don't provide health care insurance. Last year, similar programs were implemented in Arizona and Michigan (*BI*, Aug. 22, 1988).

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

## Around the states

# Protection ♦ ♦ ♦

# Prosecutor outlines thefts from Howden

By STACY SHAPIRO

LONDON—Four former Alexander Howden Group Ltd. executives used a "confetti trail" of bogus reinsurance deals to misappropriate millions of dollars from Howden and Lloyd's of London syndicates between 1979 and 1982, prosecutors allege.

The reinsurance contracts were "used to move money" into a "secret empire" created by the four and to "fool the (Howden) auditors so they wouldn't go too deeply into what was really going on," alleges Crown Prosecutor Michael Hill.

However, the money was actually ceded into phony reinsurance companies, including Southern International Reinsurance in Panama, even though SIR never applied to become a reinsurer under Panamanian law and was described as a real estate company, Mr. Hill charged.

SIR was, in fact, owned and controlled by the four former Howden executives through various secret trusts and was capitalized with money misappropriated from Howden and Lloyd's syndicates, Mr. Hill alleged in the criminal trial of two of the executives, former Howden Chairman Kenneth V. Grob and former Director Jack Carpenter.

The Southwark Crown Court jury will have to decide, among other things, whether the failure to register SIR as a reinsurance company was the fatal "flaw" in the four former Howden executives' alleged conspiracy, Mr. Hill said.

Meanwhile, in the course of the alleged misappropriation of funds, the four former Howden executives, led by Mr. Grob, were able to make "black box payments" to themselves and others, Mr. Hill charges.

In addition, the executives and former Lloyd's underwriter Ian R. Posgate, who is also on trial, used the funds to secretly buy 51% of the Banque du Rhone et de la Tamise from Howden, Mr. Hill alleged.

Two of the four Howden executives that allegedly participated in setting up the "secret empire"—former Deputy Chairman Ronald Comery and former Director Allan Page—were dropped from the criminal proceedings. Mr. Comery died in a car accident in 1987, and charges against Mr. Page

were dropped last year during a pretrial hearing because he is terminally ill.

Messrs. Carpenter and Posgate face charges of conspiracy to defraud the Howden group, its subsidiary and members of Lloyd's syndicates. Mr. Grob faces 27 charges of theft, receipt of stolen goods and false accounting. His charges differ from the others because he could not have been extradited from France in July 1987 to face trial on conspiracy charges.

All three defendants pleaded not guilty to the charges when the trial began May 3 (BI, May 8).

The prosecution has given its opening statement and last week began calling witnesses. Three separate groups of barristers representing the defendants are cross-examining the witnesses, but they will not present arguments until after the prosecution has finished its case.

During his opening statement, Mr. Hill, the Crown prosecutor, told the jury how the Howden executives' alleged secret empire was uncovered.

The tale began in 1981 when Ian Dean—who is expected to be called as a witness soon—was recruited to join Howden underwriting subsidiary Sphere Drake Insurance Co. Ltd. Mr. Dean became managing director of Sphere Drake in January 1982 and joined the Howden board in March 1982, Mr. Hill said.

At the time he was employed, Mr. Dean was assured by Mr. Grob, then Howden's chairman, that Sphere Drake was fully reserved and funds were available to pay past liabilities, said Mr. Hill.

However, Mr. Dean "discovered a serious potential shortfall in (Sphere Drake's) reserves," said Mr. Hill. Mr. Dean calculated that the shortfall was likely to be 15 million pounds (\$24.9 million at current exchange rates), though the final figure proved to be 23 million pounds (\$38.2 million at current exchange rates), the prosecutor said.

Mr. Dean also discovered that the shortfall was related to reinsurance policies that were placed with Sphere Drake by Mr. Posgate's syndicates to cover computer leasing insurance losses between 1971 and 1978, said Mr. Hill. Lloyd's syndicates altogether lost \$450 million on computer leasing insur-

ance during the period and "Mr. Posgate had a share," the prosecutor said.

During a meeting, Mr. Dean asked Mr. Posgate where he had reinsured his syndicates' computer leasing coverage, according to Mr. Hill, who noted that Mr. Posgate then informed Mr. Dean that his syndicates reinsured the risk with Sphere Drake. This "disturbed" Mr. Dean because Mr. Grob had told him that the Posgate syndicates' quota-share reinsurance treaties were "reckoned to be profitable," Mr. Hill told the jury.

In early 1982, the four Howden executives—Messrs. Grob, Comery, Page and Carpenter—met with Mr. Dean to discuss the Sphere Drake reserve shortfall and how to reduce it, Mr. Hill said. Mr. Grob suggested that it be reduced by buying reinsurance from SIR, which he said was a reinsurance company with \$3 million of capital formed by Swiss companies, the prosecutor told the jury.

Mr. Grob told Mr. Dean that SIR was an "arms-length reinsurance company doing other business," such as writing quota-share reinsurance for Mr. Posgate's syndicates, the prosecutor said, remarking that the other Howden executives must have "sat back admiring how Mr. Grob" was describing a company the four actually owned.

Eventually, Mr. Dean was convinced that the reserve shortfall could be covered through reinsurance from SIR, the prosecutor said. According to Mr. Hill, a 15 million pound cover note that Sphere Drake obtained from SIR, dated Dec. 31, 1981, is a good illustration of:

- The Howden executives' use of SIR as a reinsurance company, when in fact it was not.

- Mr. Grob's approach to tackling problems encountered by Howden units.

"If you have a problem, reinsure it away and produce a document to show it," Mr. Hill said. "It also gets money across to a company you control."

- The way in which the former Howden executives used such reinsurance contracts to move money and to fool auditors.

Continued on page 37

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## Opinions

## Hollow victory

THE GREAT CONSUMER victory claimed by advocates of Proposition 103 in California following the state Supreme Court's decision upholding most of the law likely will prove hollow in terms of the cost of insurance.

California voters who approved the regulatory reform measure last fall clearly were voting primarily for one of the multitude of reforms included in the initiative: the 20% rollback and one-year freeze of most property/casualty insurance charges, especially personal auto insurance charges.

While the California Supreme Court upheld that provision of Proposition 103, the court also effectively rendered it meaningless by throwing out the requirement that only insurers facing insolvency could seek relief from the 20% rollback and freeze.

As we reported last week, insurers in California can seek relief from the rollback by showing the state Insurance Department that their rates are not excessive. Their rates will continue to be judged by the historic standard that they cannot be "excessive, inadequate or unfairly discriminatory."

Furthermore, the California Supreme Court decision may bolster insurers' arguments that their rates are not excessive because the court commented that insurers are entitled to a "fair and reasonable return" on doing business. According to Standard & Poor's Corp., insurers on average earn a paltry 3.1% return on personal auto insurance nationwide, and we'd be surprised if their California return was above the average.

However, Proposition 103 does require that insurers set their auto insurance rates based primarily on three factors, in descending order: the policyholder's driving record, the number of miles driven annually and number of years of driving experience. While this conceivably could result in lower auto rates for some, the initiative also allows the insurance commissioner to consider when evaluating the rates "such other factors as the commissioner may adopt by regulation that have a substantial relationship to the risk of loss."

Believing firmly as we do that competitive insurance markets guarantee consumers the lowest price, we believe that most auto insurance rates in California will meet these tests and that few insurers will be forced to roll back their rates this year.

And, in the commercial insurance market, there is no doubt that competitive pressures already have pushed rates below November 1987 levels.

We also don't expect to see Proposition 103 reduce rates in the years to come just because rates in California will be subject to prior approval by the Insurance Department and because the insurance commissioner will be elected.



Certainly, the Insurance Department could refuse to approve higher rates requested by insurers. But if the department refuses to approve the rates that insurers say they need to stay in business in California, they will simply leave the state. Witness the auto insurance mess in Massachusetts.

No matter how broad the insurance commissioner's powers—and Proposition 103 gives the commissioner broad discretionary power—the commissioner does not have the power to reduce the underlying cost of losses.

Among the other reforms under Proposition 103, only a few offer hope of creating savings for consumers, and then we expect the savings will be minimal. Allowing individuals to band together to buy auto insurance as a group could result in some consumers getting better bargains. Allowing agents to rebate a portion of their commission could result in a few percentage points of savings. Having the Insurance Department furnish comparative price data could save policyholders some money. And, allowing state-chartered banks to sell insurance could result in some savings if banks can prove they are more efficient distributors of insurance than independent agents and direct writers.

But even combining all of these factors will not result in the substantial savings—presumably the 20% cited in Proposition 103—that consumers thought they would reap.

The only way to significantly reduce the cost of insurance is to reduce the underlying cost of losses. The only proven effective mechanism to reduce auto insurance costs, which is the real issue in California, is a strong no-fault auto insurance law.

## Letters

## Extensive discovery procedures exist in English law

To the editor: An unqualified statement in the article, "Needless Papers May Haunt Manufacturers" (BI, April 17), is not only wrong but indefensible.

Assuming that the reference to U.K. law was in fact to English law, it is quite clear that in both High Court litigation

and arbitration extensive procedures exist for discovery, including, in the Commercial Court, exchange of witness statements in lieu of evidence in chief.

The scope of discovery of documents may not be as wide ranging as found in certain jurisdictions in the United States,

but the English requirements are just as exacting. Indeed, if a document is not available or has been destroyed, a party must explain the circumstances as to how that document came to be missing or destroyed and when. The suggestion that seems to be implicit in the article that defendants subject to English jurisdiction can destroy or hide documentation to suit their own wishes is just not correct.

The major difference between English and American discovery is on the question of depositions. Generally, the English courts will not order deposition of witnesses except in limited and clear circumstances. It is an open question as to which of the two systems is correct.

David Farrington  
Lovell White Durrant  
New York

## Editorial writer wins award

Business Insurance Senior Editor Jerry Geisel captured third place in the editorial writing category in the annual awards competition sponsored by the Chicago Chapter of the American Society of Business Press Editors. Mr. Geisel, who is based in BI's

Washington, D.C., bureau, was recognized for his Jan. 18, 1988, editorial titled "Opening Pandora's Box." The editorial warned against relaxing rules governing self-funded multiple employer trusts providing health care coverage to small employers.

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## Delta America Re

Continued from page 2

since changed its name to Quantum Chemical Corp.

Soon after the acquisition, Delta America Re was found to be insolvent, and the insolvency spawned several lawsuits, including:

- A May 1985 complaint filed in U.S. District Court in New York by Delta Holdings against National Distillers. The suit, seeking to rescind the Delta America Re acquisition, charged that National Distillers fraudulently concealed the insurer's true financial condition during sale talks.

National Distillers denied the charges and later filed a third-party complaint against ARM, Mr. Reiss

and Peat Marwick, Mitchell & Co., which audited Delta America Re.

The trial ended last September.

- A lawsuit filed in Kentucky state court by the liquidator against Robert E. Norton, former president of Delta America Re and an officer of National Distillers. The suit seeks among other things to recover more than \$12 million in dividends alleged to have been wrongfully paid by the reinsurer to National Distillers.

- A suit the liquidator originally filed against National Distillers in Kentucky state court in 1986, seeking recovery of the \$12 million in allegedly illegal dividends.

The liquidator amended this suit last December to add as defendants 40 retrocessionaires that participated

on Delta America Re treaties prior to 1984, when Delta Holdings took over the reinsurer's operations and shifted retrocessions to the Reiss captives.

The 40 retrocessionaires are all alien companies and do not include any of the retrocessionaires named in the suit filed by the liquidator in the federal court in New York.

The amended complaint charges that the retrocessionaires have wrongfully refused to pay Delta America Re's claims and seeks a declaratory judgment of their duties under the pre-1984 treaties. If the retrocessionaires are able to rescind their treaty participations, the suit seeks indemnification from National Distillers and former directors and officers of Delta America Re.

The amended complaint does not say how much the 40 retrocessionaires allegedly owe, but recoverables amount to about \$30 million, not including \$8 million paid by the lead retrocessionaire, Dai-Tokyo Fire & Marine Insurance Co. Ltd., under a settlement agreement reached last December, said W. Henry Jernigan Jr., an attorney with the Lexington, Ky., firm of Jackson & Kelly, representing the liquidator.

Several of the retrocessionaires have filed answers denying the liquidator's contentions and have included cross-claims against National Distillers, according to Arnold Kideckel, a lawyer with Wilson, Elser, Moskowitz, Edelman & Dicker in New York, representing about 18 re-

trocessionaires.

Meanwhile, the proper venue for the litigation also is in dispute: The amended complaint was removed from the Kentucky state court in January to U.S. District Court in Frankfort, Ky., Mr. Jernigan said. Several retrocessionaires have since filed motions to have the suit moved again to U.S. District Court in New York, while the liquidator has filed a motion to have it remanded to the state court, he said.

The motions still are pending.

While these suits move ahead, the liquidator on May 2 filed a separate complaint in the New York federal court against ARM, the Reiss-managed retrocessionaires and others.

In addition to ARM and Mr. Reiss, the complaint names:

- International Risk Management Ltd. of Bermuda, European Risk Management Ltd. of the United Kingdom, Transnational Risk Management Ltd. of the Cayman Islands, Transnational Risk Management (Guernsey) Ltd. and Universal Management Ltd. of Ireland.

These former Reiss Organization captive management units have operated as units of Bermuda-based International Risk Management Group since the 1988 Swiss Re acquisition. The two Transnational units are now known as International Risk Management (Cayman) Ltd. and International Risk Management (Guernsey) Ltd.

- Mr. Norton and three other Delta America Re board members who also were Reiss Organization officers: John J. Ryan, Bryan D. Murphy and Arthur H. Deters.

- Twenty-three Reiss-managed retrocessionaires that also were shareholders of Delta Holdings. These include captive insurers owned by International Nickel Co., C.H. Robinson Paper Co., Thomas J. Lipton Inc., Petrofina (Belgium) S.A., Brunswick Corp., Sara Lee Corp., Rockwell International Corp., Eli Lilly International, Hoechst Celanese Corp., American Cyanamid Corp., Cargill Inc., Scott Paper Co., Genstar Ltd., Eaton Corp., Unisys, Aluminum Co. of America, Kellogg Co., Kaiser Aluminum & Chemical Co., Revco D.S. Inc., Weyerhaeuser Co. and Westburne International Industries.

Also named as defendants are Transnational Insurance Co. Ltd. and United Insurance Co. Ltd. of the Cayman Islands, two other Reiss-managed insurers.

The complaint charges ARM and other Reiss units breached their contractual duties by failing to supervise employees responsible for running the reinsurer and failing to maintain adequate loss reserves, establish underwriting guidelines and properly manage the retrocessional program.

The suit also charges that ARM and the individual defendants breached their fiduciary duties to Delta America Re by failing to supervise the reinsurer's operations and by "undertaking activities not for the benefit of Delta but, instead, to protect other business relationships in which they were involved."

The Reiss-managed retrocessionaires have refused to pay balances due to Delta America Re, citing wrongful acts by Reiss Organization units and employees, including failure to disclose information about the profitability of the business being ceded, the complaint says.

For the 1984 underwriting year alone, Delta America Re's losses total more than \$100 million, the suit notes. The retrocessionaires named in the suit are responsible for payments equaling 40% of this amount, though the \$40 million recoverable from the retrocessionaires has been reduced by some voluntary payments and letter of credit drawdowns, leaving a balance due of about \$30 million.

The complaint seeks a declaratory judgment of the retrocessionaires' duties under the treaty agreements. If the retrocessionaires are successful in rescinding their participations, the suit seeks indemnification from ARM, the other Reiss units and the individual defendants. ■

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**At issue**

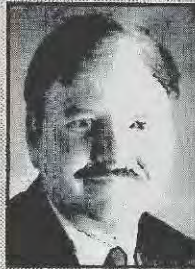
**Will Proposition 103 have a major impact on the California insurance market?**



**John W. Schaefer**  
corporate risk manager  
Raychem Corp.,  
Menlo Park, Calif.

The major changes from Proposition 103 will be long term as insurance companies will worry more about their image, competition from banks and an elected insurance commissioner. These issues will overshadow rate regulation since insureds and insurers will end up agreeing on a fair insurance price.

Compiled by Christine Woolsey



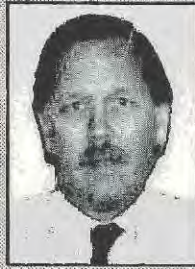
**Gary L. Secor**  
assistant treasurer/  
director- risk management  
Illinois Power Co.,  
Decatur, Ill.

Yes, it will have a major impact on California insurance markets and on markets outside California. Rates artificially lowered on some lines will result in increased rates for other lines and probably increased rates in other states. The additional expense for expansion of state insurance departments may appropriately be reflected in higher insurance premiums.



**Nancy Bellard**  
risk manager  
Alameda County,  
Oakland, Calif.

It's still a horse race, but I don't believe so. Based on the court ruling that insurance companies are entitled to a fair return on their investment and that being left up to the insurance commissioner, it would seem to lead to years of litigation on what "fair return" means. The decision might bring some stability to the market in California. Insurers won't be as quick to pull out of the state.



**Vincent A. Patterson**  
risk manager  
The Clorox Co.,  
Oakland, Calif.

No, I believe Proposition 103 will not have a material effect in controlling insurance rates. The bill lacks the depth necessary to regulate the major factors that are driving premiums higher: excessive settlements, increased medical expenses and higher property damage repair costs. In addition, Proposition 103 will increase insurers' administrative costs required to justify rates.

**Bermuda**

**X.L. plans to relocate in Bermuda**

By ROGER SCOTTON

HAMILTON, Bermuda—X.L. Insurance Co. Ltd., the Barbados-based excess liability insurer, is planning to transfer all operations to Bermuda early next year.

"X.L. Insurance Co. has petitioned the the Bermuda Legislature for the enactment of a private act enabling X.L. to be continued in Bermuda as a Bermuda company," a statement from the company said. "If such legislation is enacted, X.L. expects to migrate to Bermuda from Barbados in January 1990."

X.L.'s statement reflects the use of continuance provisions in X.L.'s corporate bylaws, provisions recognized in both countries that allow the company to set up in another domicile without having to go the lengthy and sometimes more costly route of seeking incorporation in a new jurisdiction.

X.L. Chairman and Chief Executive Officer Michael Kevany said last week that the move would allow for the consolidation of all X.L. operations in Bermuda and result in greater operational efficiencies. X.L.'s Cayman Islands-domiciled parent, EXEL Ltd., maintains its principal office and an underwriting and support staff of 17 persons in Bermuda.

Mr. Kevany said X.L.'s Barbados office—which handles all claims, administration and policy issuance—will close and that the Bermuda office will be staffed to cope with the additional work. He said that its employees will soon move to larger offices in Hamilton to allow for the expansion.

X.L.'s parent, however, will remain a Caymans-based entity, Mr. Kevany said.

X.L. was formed in 1986 at the height of the liability insurance crisis and set up in Barbados to take advantage of a tax treaty that, among other things, exempts Barbados insurers from the 4% U.S. excise tax on premiums paid to overseas insurers.

But, the U.S. Senate's ratification last October of a U.S.-Bermuda tax treaty that contains similar provisions to the Barbados treaty erased the advantage once held by Barbados.

Though Mr. Kevany is careful to point out that he would prefer not to have to compare the two domiciles, he concedes that "the Bermuda tax treaty certainly made our decision a lot easier."

In addition, the excise tax exemption in both treaties expires at the end of 1989.

Mr. Kevany said that although operating costs would be higher in Bermuda, the costs are partially offset by its proximity to the United States, resulting in reduced travel time and costs when compared to Barbados.

X.L. writes up to \$75 million in liability insurance limits in \$25 million increments excess of \$25 million, and \$50 million or \$75 million in limits excess of \$50 million or \$75 million (BI, April 10). It also writes \$25 million in limits for directors and officers liability excess of \$25 million or \$20 million in D&O limits excess of \$20 million. The D&O limits are offered in \$5 million increments.

X.L. also writes errors and omissions insurance for insurance brokers, insurance companies and attorneys, with a minimum limit of \$25 million excess of \$25 million to a maximum of \$50 million excess of \$50 million.

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## Spring renewals

Continued from page 1

John F. Donahue, vp of commercial lines for Hartford Insurance Group in Hartford, Conn., agreed that while he is currently seeing only single-digit, if any, rate reductions in mainstream property/casualty accounts in most parts of the country, "we find that in the central part of the country there seems to be more competition to the point where it becomes very difficult to write business."

But while Frank A. McDougald Jr., senior vp and national marketing director for Fred S. James & Co. Inc. in New York, also has observed a greater degree of rate competition in the Midwest, particularly in the South Central region, he believes "we still have a reactive market on the East and West coasts" as well.

And, unlike some insurer executives, Mr. McDougald cited "some substantial (rate) reductions" for small commercial accounts generating between \$10,000 and \$250,000, which he feels "suggests an overabundant supply of capacity."

According to Nationwide's Mr. Boyne, "a number of (insurers) are directing their sales efforts" toward niche markets such as small artisan contractors, retail stores and small service businesses.

For these target accounts, insurers "are using special policies with distinctive rating," offering reductions of "as much as 20%," Mr. Boyne added.

Samuel Alcorn, senior vp of operations for Bayly, Martin & Fay International Inc. in Fort Worth, Texas, contacted all of the brokerage's regional offices to get a feel for competition nationwide.

Each office reported continuing competition for most lines of business, with the frequent exceptions of workers compensation, financial guarantee, long-tail casualty coverages and commercial auto liability.

However, the intensity of competition for different types of risks varies from region to region, Mr. Alcorn explained. And he stressed that, at present, most insurers appear to be adhering to underwriting guidelines, though "they're being compelled to give a little on price for good accounts."

Insurers also note that they are attempting to maintain underwriting discipline.

For example, Mr. Wratten said that when Transamerica's competitors offer its clients unjustifiable rate decreases, its underwriters have been walking away from the business, rather than writing it at inadequate rates.

But, while "some carriers are saying, 'That's enough!' and are walking away from business, there are others there to take it and carriers are very competitive on new business," observed Richard A. Maxwell, senior vp and director of marketing and professional standards for broker Corroon & Black Corp. in New York.

However, "there are still some accounts for which insurers do not want to get involved in working layers," said John F. O'Sullivan, managing director of M&M in New York. Those include chemical, pharmaceutical, auto and other high-hazard product manufacturers; railroads; architects and engineers liability; and surety bonds.

And, "markets have behaved pretty responsibly in the directors and officers liability area, and in medical malpractice we don't see anything like the competitive conditions of 1982 to 1984. Pricing is much more sensible," added M&M's Mr. Drake.

"In the architects and engineers liability area, prices have gone up," Mr. Drake noted.

"For more troublesome coverage areas—like pollution liability and financial guarantee exposures—

**'Companies have learned the dangers of long-tail exposures and are very cautious, but once you get out of that field, they are swinging like mad,' says BMF's Mr. Alcorn.**



nothing has changed countrywide. Companies have learned the dangers of long-tail exposures and are very cautious, but once you get out of that field, they are swinging like mad," Bayly, Martin & Fay's Mr. Alcorn observed.

The excess/umbrella liability insurance market remains hotly competitive during the spring renewal season, most sources say.

In fact, aggressive competition for excess liability accounts has caused Schaumburg, Ill.-based Zurich-American Insurance Cos. to lose "the bulk of our business in that area, and we are not aggressi-

vely looking for" excess liability business, said Richard A. Manetta, senior vp of Zurich-American's insurance services division.

But Mr. Manetta added that the magnitude of excess liability rate reductions "varies by region and by who the competitors are" for a given account.

James R. Rabenstine, vp-inter-company and governmental relations for Liberty Mutual Insurance Co. in Boston, also sees "more dramatic differences in prices in the excess area," where quotes can be "all over the map."

"After 16 to 18 months of fierce

competition in the excess market, rates are already on a level that is dancing on the edge of danger," observed Hartford's Mr. Donahue. However, he believes that competition is now just beginning to subside for excess liability risks.

Risk managers say they are benefitting from this competition.

For example, Kohler's Mr. Lang saw rate decreases of 18% to 20% in the plumbing product manufacturer's worldwide umbrella program this spring renewal, while retaining all but one of its incumbent insurers. "A lot" of other insurers were interested in writing the business, he noted.

"We had higher limits offered to us, but we felt that what we have bought in the past was sufficient," Mr. Lang said.

Susan M. Werner, director of risk management for Hardee's Food System Inc. in Rocky Mount, N.C., said that the restaurant chain was able to renew its catastrophe liability coverage at a savings of

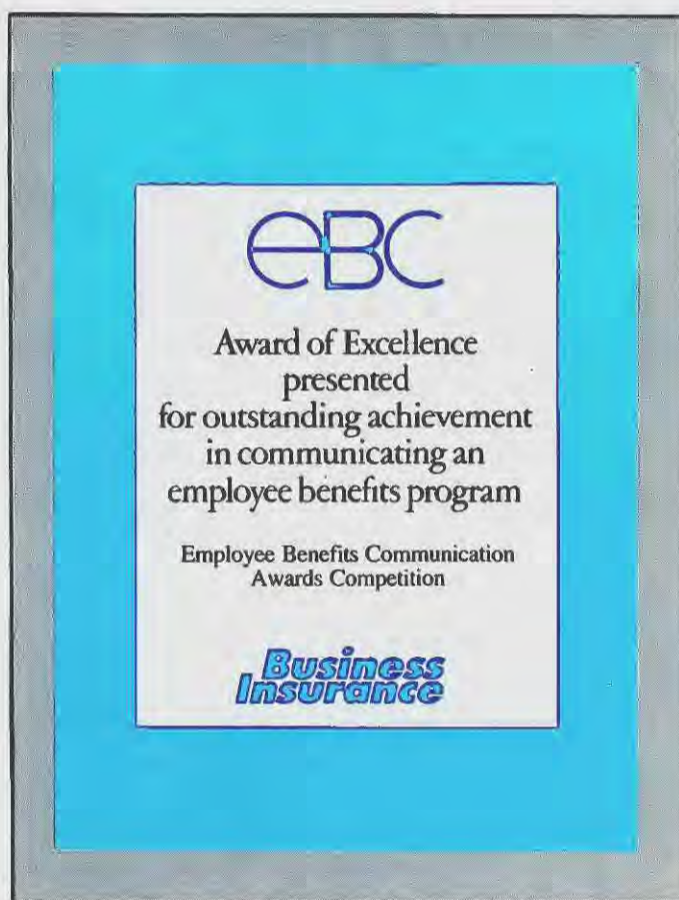
"about \$100,000 over last year's coverage," without any added coverage restrictions. In fact, she said she found that market "extremely soft" this year.

Edward G. Weiss, director of risk management and security for First of America Bank Corp. in Clawson, Mich., increased the bank's umbrella limits to \$35 million from \$25 million, though "the premium was considerably less," considering several acquisitions First of America made over the past 12 months, Mr. Weiss said.

"I had trouble choosing (between insurers) because the quotes were almost identical in the layers," Mr. Weiss said, adding that all three layers of the program were placed with domestic insurers.

Mr. Weiss also received rate reductions and/or more favorable terms on the bank's primary general liability and auto liability coverages that renewed in April.

First of America's commercial  
Continued on page 14



The 17th Annual EMPLOYEE BENEFITS COMMUNICATION AWARDS will be presented on August 7 during a luncheon, in New York City, 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 May 1st. No entry will be accepted after May 24th.

For Competition rules and entry forms, or for details and reservations for the Awards Luncheon, write to *Business Insurance* Communication Svcs. Dept., EBC Registrar, 220 E. 42nd St., New York, NY 10017.

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## Spring renewals

Continued from page 14

to be as much as half the (total) premium and rates are far too inadequate to make a profit," said Zurich-American's Mr. Manetta, adding that his company will not write monoline workers comp in a couple of states.

But, "as a large workers comp carrier, we see different situations regionally," said Liberty Mutual's Mr. Rabenstine, noting that while it is difficult to write workers compensation insurance on a profitable basis in some states, "there is some competition for that business in states where rates are considered adequate."

While competition generally is increasing in the reinsurance market, observers concur that reinsurers are not responsible for driving the current rate competition.

In fact, "caution relative to the reinsurance market is what tends to make this pricing cycle some-

what different" than the soft market of the early 1980s, which was driven by cheap and plentiful reinsurance, noted Willcox's Mr. King

He also pointed out that because primary insurers are retaining more risk, "their losses will not be passed off to reinsurers this time around."

However, industry sources note that many reinsurers—particularly facultative reinsurers—have a greater appetite for business and are also willing to make some concessions, primarily in terms and to a lesser degree in pricing.

"The reinsurance market is pretty soft now and is probably getting softer, both for treaty and facultative business, and foreign reinsurers are more involved now than they



Mr. King

were. Terms and language are a little broader and price is a little softer," said Zurich-American's Mr. Manetta.

"We've had some success with dealing with reinsurers that wouldn't even talk to us a couple of years ago, mostly for treaty business," noted Nationwide's Mr. Boyre.

But observers stress that reinsurers have been compelled to respond to conditions in the primary market in an attempt to recover some of the business they've lost because of increased ceding company retentions and the lower base of ceded premiums over the past couple of years.

"Primary market competition is the biggest factor. It continues to be very competitive and is indeed having an impact on the revenues of reinsurers and reinsurance brokers," explained Michael W. Cashman, president and managing partner of E.W. Blanch Co. in Minneapolis.

"Any sort of downtrend in prices (in the primary market) affects the environment of the reinsurers, rather than their wanting to compete. The base has shrunk in buyer retentions and deterioration of prices," said Paul H. Inderbitzin, executive vp of American Re-Insurance Co. in New York.

And, as most primary rates continue to drop, most insurers also continue to retain much of their business, reinsurers and reinsurance brokers note.

"There has been little or no movement toward reversing the trend of higher retentions," said Mark D. Mosca, vp and manager of the treaty department of NAC Re Corp. in Greenwich, Conn.

Mr. Mosca also noted that primary insurers "seem to be loosening their standards; they're hungrier," although he doesn't see massive rate cutting.

But, Thomas A. Lynch, senior vp of Metropolitan Reinsurance Co. in New York, said that due to the in-

tense competition in the primary casualty insurance market, "we find ourselves having to withdraw applications" because the buyer expects a lower price than reinsurers are willing to give.

In fact, "reinsurers are so concerned about primary rates that we're even seeing some conditions tying future capacity to future rate increases," said one reinsurance brokerage official who asked not to be identified.

In these instances, reinsurers have accepted the business on the condition that there will be no further rate reductions when clients renew current accounts, the broker explained.

And, while Kemper Reinsurance Co. is "trying to maintain as much continuity with our clients as possible," it is also closely monitoring the rates charged by its ceding insurers to make sure "that they'll stand the test of time and won't go through any drastic problems," commented Michael R. Pinter, Kemper Re's executive vp in Long Grove, Ill.

But because many major reinsurers have seen substantial reductions in their premium volumes over the past two years, "you'd better believe that they are going to get out there and fight for their accounts," said Bayly, Martin & Fay's Mr. Alcorn, noting that he already has seen "every indication that reinsurers have kicked in and are contributing to the cycle."

Facultative reinsurers, which lost the most business to higher insurer retentions, are more aggressive than treaty reinsurers, although both are more interested this year in business than they were last year, sources observe.

While Paul Ingrey, president of F&G Re Inc. in Morristown, N.J., has not seen a lot of interest in pure facultative reinsurance, things are getting "wild and woolly" in the semi-automatic facultative area, with reinsurers approaching the ceding companies to cut deals by market segment, he said.

Mr. Ingrey also noted that terms are becoming more lenient and capacity is increasing in the casualty treaty marketplace.

And, "in the treaty area (reinsurers) want property business. They want property working programs, either on a pro rata or excess basis," said Blanch's Mr. Cashman. He also cited a "slightly greater appetite" for treaty casualty business.

Some brokers have observed a new twist in the reinsurance marketplace: Direct-writing reinsurers are contacting retail brokers to offer to reinsure a particular account.

"One or two direct writer reinsurers have set up operations to go after (primary) brokers as another source of business," said A&A's Mr. Jones.

"Major reinsurance companies are becoming far more of a factor on the retail side of the business. That's a new market on the direct side," James' Mr. McDougald agreed.

These reinsurers are mostly interested in large primary programs, noted Michael E. Rothpletz, executive vp and chief operating officer of Hodson.

A couple of brokers predicted that the rating posture that reinsurers decide to take in the next few months may be the deciding factor in how long the current competitive market lasts.

M&M's Mr. O'Sullivan said it will be interesting to see how long reinsurers "are willing to sit on the sidelines. If there isn't an upturn in the marketplace soon, they may be forced into the game."

"A lot of facultative reinsurers haven't really jumped back" into the marketplace, noted A&A's Mr. Jones, adding: "If and when they do, we can expect longer competition."

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Associate Editor Laura Mazzuca in Chicago contributed to this report.

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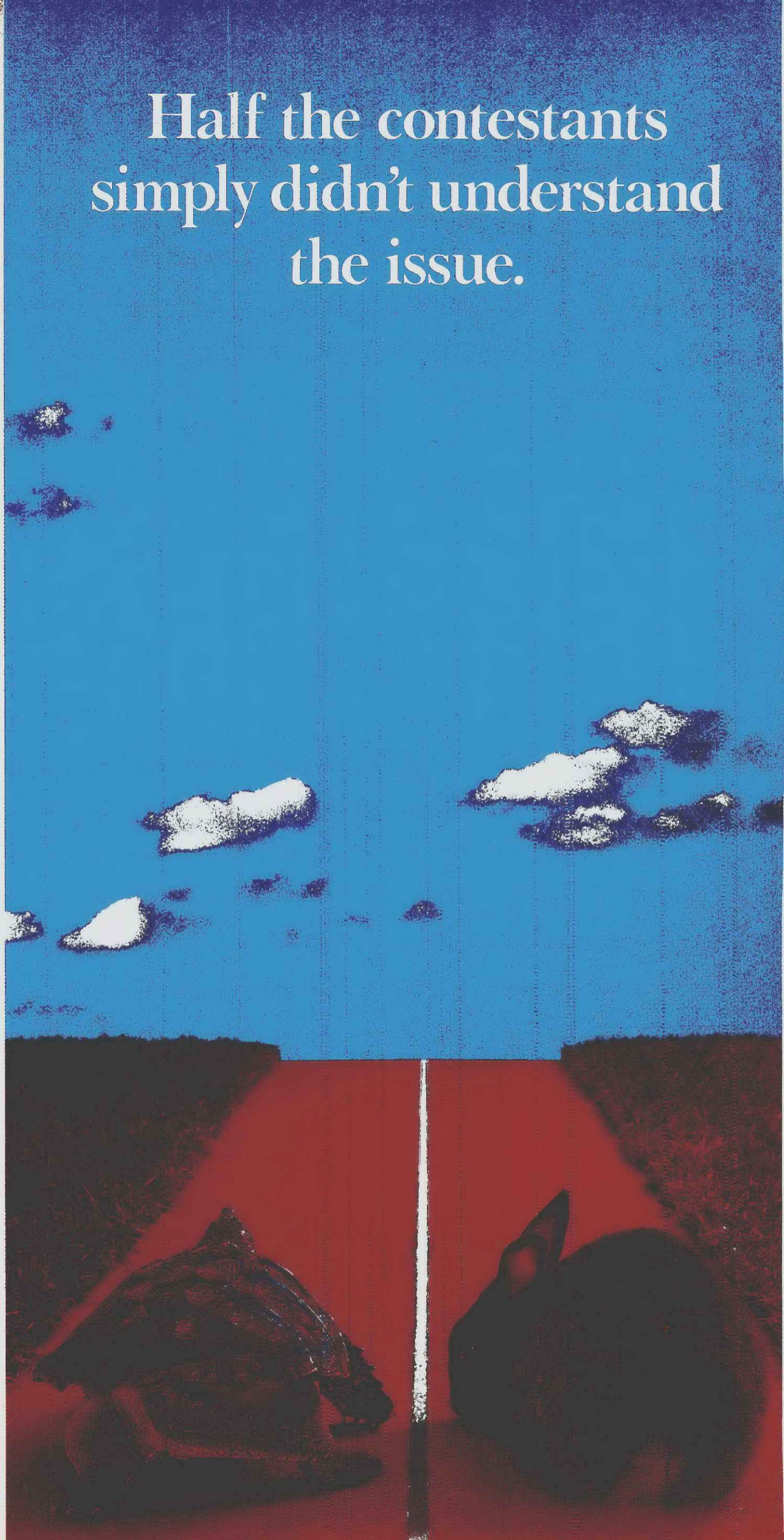
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# Greyhound names Rodriguez vp-insurance

**Arthur L. Rodriguez**, 55, named corporate vp-insurance at The Greyhound Corp. in Phoenix, Ariz. In this newly created position, he oversees risk management, property/casualty insurance, claims and loss control activities for the multi-industry conglomerate and assists Greyhound subsidiaries with these functions. He reports to L. Gene Lemon, vp and general counsel. Previously, Mr. Rodriguez served as director of U.K. operations for Greyhound subsidiary Pine Top Insurance Co. Ltd. in London. Prior to that he was a director of the British National Group in London. Mr. Rodriguez holds a bachelor of arts degree from the University of Florida in Gainesville and a doctor of law degree from Cumberland College of Tennessee in Lebanon.



**Mr. Rodriguez**

\*\*\*

**Terrell G. Womack**, 38, promoted to vp-benefits at Champion International Corp. in Stamford, Conn. In this newly created position, he is responsible for the design and administration of the paper products company's employee benefits. He reports to William Gray, senior vp-human resources. Mr. Womack joined Champion in 1979 as manager for forest products planning and held several positions prior to his most recent assignment as director of benefits. He holds a bachelor of science degree in forestry from Louisiana State University in Baton Rouge and a master of business administration degree from Vanderbilt University in Nashville, Tenn.



**Mr. Womack**

\*\*\*

**David M. Soden** named benefits manager of Katy Industries Inc. in Elgin, Ill. In this newly created position, Mr. Soden administers employee benefit programs for Katy and its subsidiaries. He reports to J. Russell Jones, treasurer. Prior to joining Katy—which is a diversified corporation with holdings in consumer products, industrial machinery and components and energy resources—Mr. Soden was benefits manager at Carson Pirie Scott Corp. in Chicago. Prior



**Mr. Soden**

## Storm damage totals \$95 million

Wind, hail, tornadoes and flooding caused an estimated \$95 million in insured property damage in portions of Arkansas, Missouri, Illinois, Indiana, Alabama, Georgia and South Carolina April 3-5.

The Property Claim Services division of the American Insurance Services Group Inc. estimated the most extensive damage, \$40 million, occurred in Georgia.

Damage in Alabama was estimated at \$25 million and storm losses in Arkansas were estimated at \$10 million.

The early April storms were classified Catastrophe No. 84 by Property Claim Services, which classifies events producing more than \$5 million in insured property damages. ■

## Comings & goings: buyers

to that he was manager of benefits with Beatrice Co. in Chicago. Mr. Soden received a bachelor of arts degree from the University of Northern Iowa in Cedar Falls. In addition he holds the Fellow, Life Management Institute and Associate, Life & Health Claims designations.

\*\*\*  
**Geraldine K. Marquart**, 40, named assistant vp-risk management for Whitman Corp. in Chicago.

In this position she is responsible for property/casualty insurance, loss control, fleet safety and other risk management functions for Whitman and its subsidiary companies. Ms. Marquart replaces **Wayne Gano**, who left the company, and reports to Ralph J. Switzer, senior vp-financial operations. Prior to joining Whitman, which is a strategic management company with operations in consumer goods and services, Ms. Mar-

quart had been group manager of corporate insurance with Avon Products Inc. of New York, where she was employed for 11 years. Prior to that, Ms. Marquart was assistant risk manager of Budget Rent-A-Car Corp. in Chicago. Ms. Marquart received bachelor of arts and master of arts degrees from Beloit College in Be-

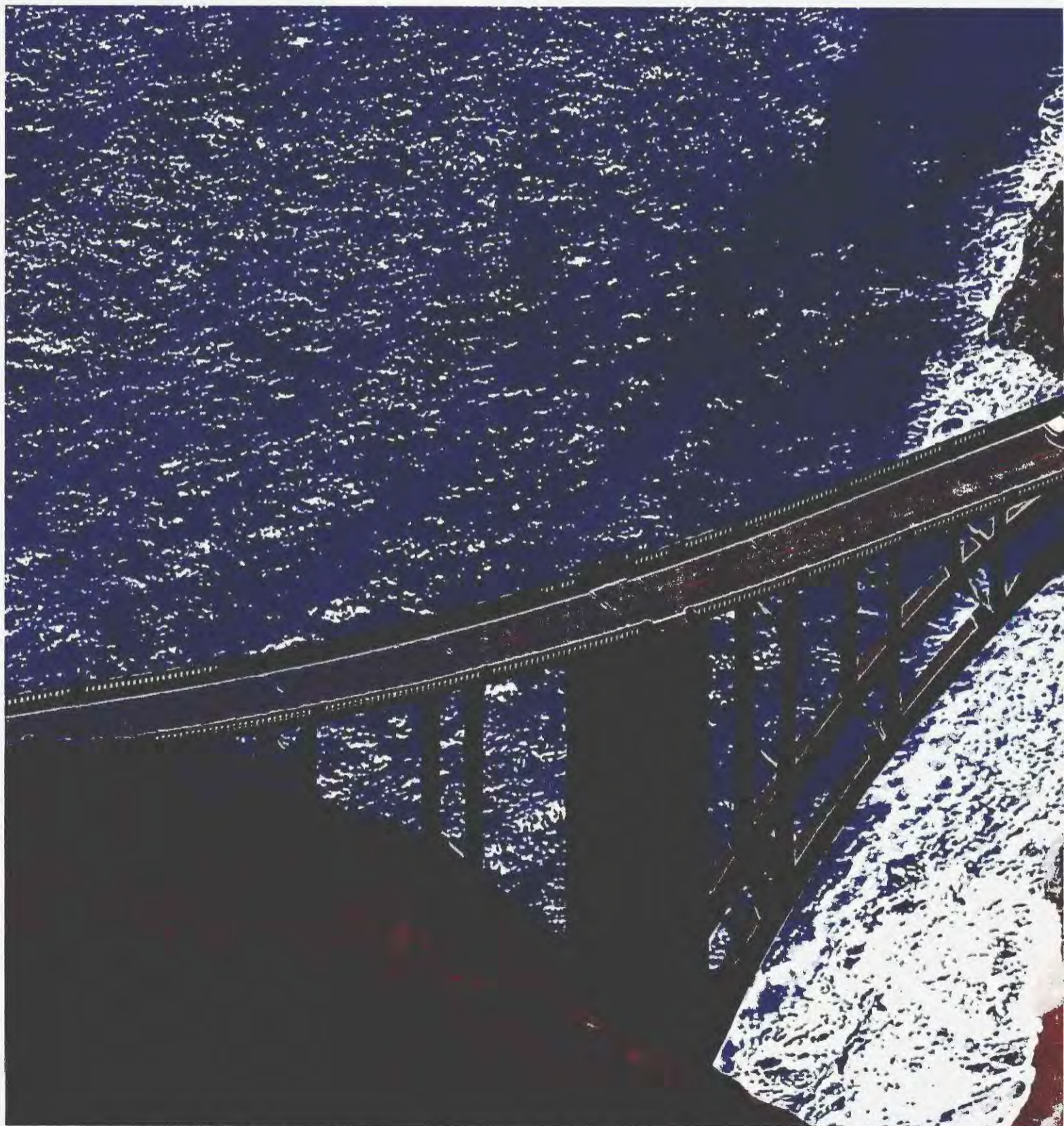


**Ms. Marquart**

loit, Wis. In addition, she holds the Associate in Risk Management designation. Ms. Marquart is a member of the Allied Product Institute's Risk Management Council and a deputy member of the Risk & Insurance Management Society.

•  
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# Outhwaite reports '86 syndicate profit

By CAROLYN ALDRED

LONDON—Lloyd's of London underwriter Richard Outhwaite is paying hefty profits to members of syndicate 317/661 for the marine syndicate's 1986 underwriting year.

RHM Outhwaite (Underwriting Agencies) Ltd. announced this month that members of the syndicate's general fund would receive aftertax profits of 16.7% of their 1986 written premium volume.

U.S. members of the syndicate—which under Lloyd's regulations

## London

must maintain a separate U.S. dollar fund—will receive aftertax profits equaling 15.5% of written premium volume for the 1986 underwriting year.

However, Outhwaite simultaneously announced that "application has been made to Lloyd's for late submission" of the syndicate's accounts for its 1982 underwriting year, which so far has not been closed.

Members of the 1982 under-

writing year face huge losses, mainly due to liabilities stemming from dozens of runoff reinsurance policies Mr. Outhwaite wrote to cover liabilities stemming from other syndicates and insurance companies' past underwriting years.

The results for the 1982 underwriting year as of Dec. 31, 1988, will be released later this month, according to an Outhwaite spokesman.

## Contingency fees

Government proposals to increase access to the British legal system, particularly plans to introduce contingency fees for plaintiff's attorneys, will lead to an "explosion" of litigation, warns The Adam Smith Institute.

"Encouraging the expansion of the legal profession by the introduction of contingency fees and other measures would undoubtedly lead to an explosion of new legal action," according to a report published by the London-based economic institute this month.

"As lawyers devised new ways of gaining even higher settlements, our legal system would take on many of the characteristics of that in America. It is a prospect worth resisting," says author Peter Young, a director of Moncrieff Strategy Ltd., a consulting firm, and a policy adviser to The Adam Smith Institute.

The report is a response to government "Green Paper" proposals to reform legal services in Britain (*BI*, Nov. 14, 1988). The proposals are intended to increase competition among lawyers and reduce legal costs for consumers.

Among the proposals are four alternative suggestions for removing the current prohibition against contingency fees in England and Wales:

- The introduction of "speculative funding," which currently is allowed in Scotland, whereby a lawyer receives his normal fee only if he wins the case.

- Another form of speculative funding whereby a lawyer's fees are increased above the normal rate if he wins but he receives no fee if unsuccessful.

- Restricted contingency fees under which a lawyer retains a proportion of the amount recovered in litigation, but the maximum amount retained by an attorney is regulated by legislation or professional rules.

- Unrestricted contingency fees.

The government's proposals point out that significant differences between the U.S. and British legal systems—like the British rule that the losing party pays the winner's legal costs and the awarding of damages in Britain by judges rather than juries—"would restrain the introduction in Britain of some of the worst excesses of the U.S. system," the ASI report notes.

However, "contingency fees will provide lawyers with the incentive to try and remove these barriers," the ASI's report warns.

"The disadvantages of a U.S.-style legal system have not been fully appreciated by the government nor by independent commentators. Aspects of the government's proposals which are likely to take us in an American direction, such as the introduction of contingency fees, need to be reconsidered in the light of the considerable evidence of the damage caused by the American legal system," says the institute's report.

The ASI concludes in the report that the "proposal to introduce contingency fees should be rejected outright."

In addition, the Law Society, which represents non-trial lawyers in England and Wales, opposes plans to introduce contingency fees in its own response to the government's proposed legal reforms.

In a 57-page response document published this month, the Law Society notes that the British system's practice of the losing party paying the winning party's legal costs creates a problem in introducing any form of speculative funding or contingency fee system.

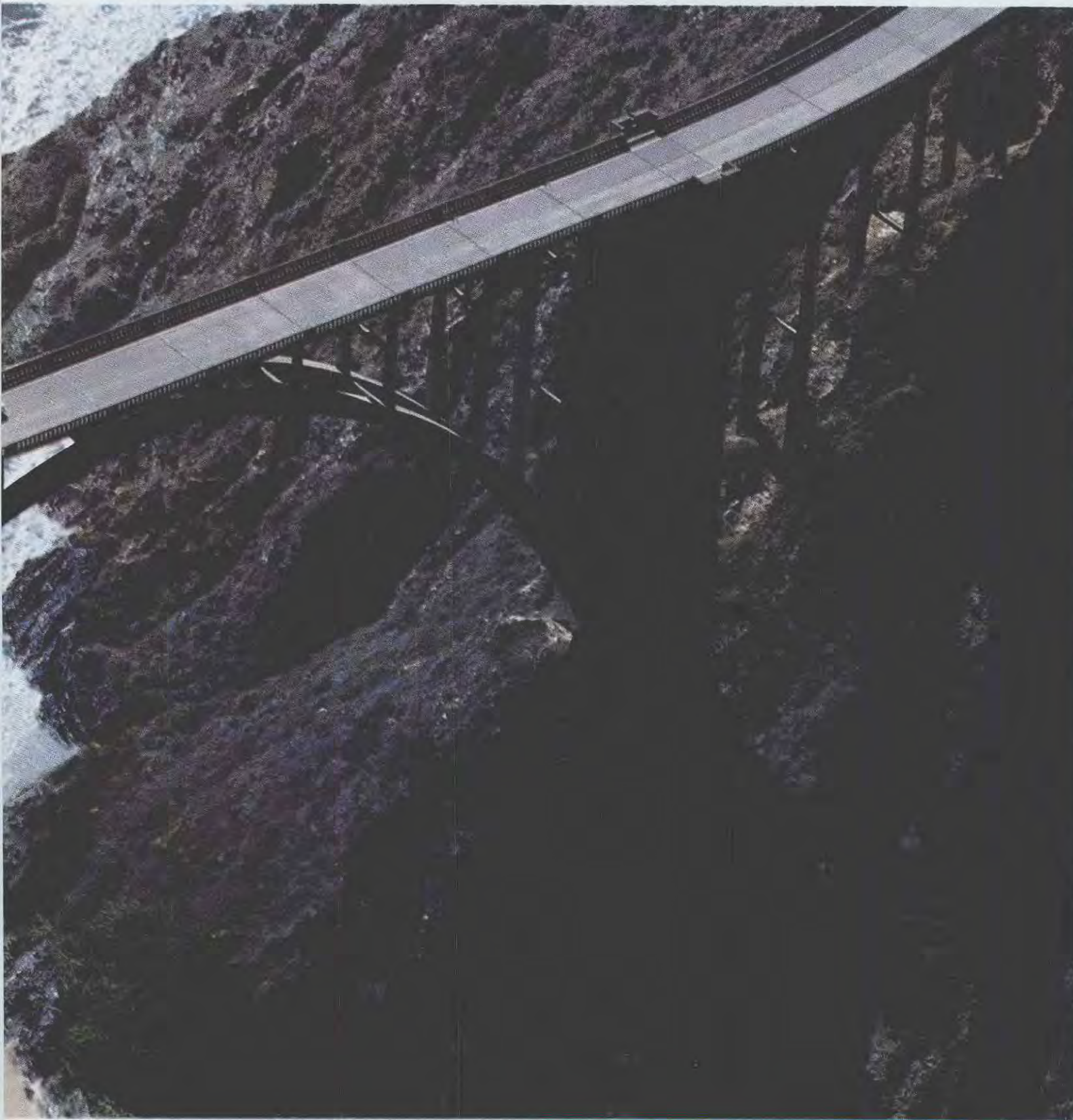
In addition, "there is a serious risk that permitting contingency fees would put severe strain on the integrity of a small minority of practitioners and it would take only a few instances of malpractice to taint the system of justice itself," the Law Society contends.

The most sensible way to enable prospective litigants to bring legal action is to enhance government-sponsored legal aid funding, the Law Society says.

The government should "make the upper income limit for legal aid flexible... so that those facing particularly expensive litigation are enabled to obtain legal aid if their

Continued on next page

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## London

Continued from previous page  
income exceeds the normal upper limit. The cost of that would be comparatively small, and it would have none of the dangers for the integrity of our system of justice which contingency fees would involve," the Law Society suggests.

Meanwhile, "it is essential that the theoretical availability of speculative funding should not be used as an excuse for the government to withdraw legal aid from the categories of case for which such funding is practical," said the Law Society.

For example, "federally funded legal services organizations in the U.S. are prohibited from undertaking work which could be done for a contingency fee," it notes.

### Damage limits

The British government is considering raising the amount of damages survivors can claim for bereavement following the death of a relative.

Sir Nicholas Lyell, the government's solicitor general, announced this month that the gov-

ernment plans to discuss with the insurance industry and other parties a plan to increase the level of non-economic bereavement damages a plaintiff can seek.

Currently, Britain caps the amount a survivor can claim for bereavement at 3,500 pounds (\$5,824 at current exchange rates).

An increase in bereavement damages to 10,000 pounds per claimant (\$16,400) is being sought among a series of compensation measures by Lawrence Cunliffe, a Labor Party member of Parliament.

However, an increase in maximum bereavement compensation does not require an act of Parliament as the Lord Chancellor can

increase the level of damages by a statutory order, said Sir Nicholas.

Meanwhile, the government plans to oppose Mr. Cunliffe's bill because of objections to other proposals included in the bill, said Sir Nicholas.

The proposal would establish a compensation advisory board that would recommend to defendants and courts the level of compensation to be awarded to accident victims.

### Ferry compensation

A group of passengers who survived when a ferry capsized in the English Channel in March 1987 has been awarded more than \$1 million

in damages to cover nervous shock stemming from the tragedy.

The group of 10 people were awarded damages totaling 645,000 pounds (\$1.1 million) in a test arbitration case to determine the level of compensation suitable for other surviving passengers of the ferry, which capsized off the Belgian port of Zeebrugge killing nearly 200 people (BI, March 16, 1987).

Individual damages awarded varied from 9,000 pounds (\$15,000) to more than 150,000 pounds (\$249,000) per person depending on the extent of the shock and psychiatric damage suffered by the victims.

The 10 cases went to arbitration by agreement between the ferry's London-based owner, Peninsular & Oriental Steam Navigation Co., and Manchester-based plaintiffs' law firm Pannone Napier, which is coordinating claims of the ferry victims.

Damages for other claims, such as loss of property and physical injuries, were not included in the arbitration, which concentrated on damages for nervous shock, post-traumatic stress disorder and pathological grief, which is described as "grief in excess of normal grief."

Meanwhile, "there are approximately 100 cases where a claim for nervous shock has been indicated," said a P&O spokesman.

So far, P&O and its liability insurer, Standard Steamship Protection & Indemnity Assn. (Bermuda) Ltd., have settled 121 of the claims filed by the 299 passengers who survived the disaster, said a P&O spokesman.

In addition, claims relating to 86 of the 155 passengers who died in the incident have been settled, he added.

### Capital injection

Mercantile & General Reinsurance Co. P.L.C. plans to almost double the capital and surplus of its U.S. subsidiary by injecting another \$50 million in capital.

The capital and surplus of The Mercantile & General Reinsurance Co. of America, based in Morristown, N.J., currently totals \$55 million.

With the additional injection, the U.S. company "will become one of the top 25 companies in that market which have in excess of \$100 million of surplus," according to M&G's annual report published this month.

London-based M&G, the reinsurance underwriting subsidiary of London-based Prudential Corp. P.L.C., announced total 1988 pretax profits of 85.8 million pounds (\$155.3 million at year-end 1988 exchange rates), up 27.1% from 67.5 million pounds (\$127.4 million at year-end 1987 exchange rates) in 1987.

Pretax property/casualty profits increased 60% to 33.6 million pounds (\$60.8 million) in 1988 from 21 million pounds (\$39.5 million) in 1987, although total net property/casualty premium revenues for the company fell 5.4% to 237.7 million pounds (\$430.2 million) in 1988, from 251.4 million pounds (\$472.6 million) in 1987.

"In many markets, primary rates have continued to fall and there has been no slowdown in the moves toward further concentration of the insurance industry through mergers and acquisitions. In addition many primary companies, with the help of their own improved results, have been increasing their retentions substantially and, in consequence, purchasing less reinsurance," noted John Austin, M&G's general business operations manager, in explaining the decrease in premium revenues.

"At the same time, in many cases, reinsurance on the traditional proportional basis is in-

Continued on next page



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Continued from previous page  
creasingly being replaced by non-proportional cover. Finally, in the reinsurance market, the improvement in results in recent years has inevitably led to increased capacity and stronger competition for most lines of business," he added.

Meanwhile, the company had to increase reserves by 6.5 million pounds (\$12.2 million) in 1988 (compared with an additional 9.2 million pounds (\$17.3 million) in 1987) for asbestos-related claims arising from business written in earlier years.

The company also set up a special provision of 5 million pounds (\$9.1 million) last year for claims related to the loss of the Piper Alpha oil platform last July.

M&G also further increased its reserves for future claims relating to acquired immune deficiency syndrome.

"By the end of 1987 we had established an AIDS provision of 63 million pounds (\$118.4 million) for our life account. At the end of 1988 that provision had been increased to 102 million pounds (\$184.6 million). This year we have also recognized the possible impact which the disease may have on our continuous disability account and have provided seven million pounds (\$12.7 million) for that purpose," said Roger Sansom, general manager responsible for life operations.

## Royal Re results

London-based Royal Reinsurance Co. Ltd. increased pretax profits slightly to 11.9 million pounds in 1988 (\$21.4 million at year-end 1988 exchange rate), compared with 11.7 million pounds the previous year (\$22 million at year-end 1987 exchange rate).

Gross premium revenues increased 17.7% to 129.1 million pounds in 1988 (\$219.2 million), from 109.6 million pounds in 1987 (\$206 million).

The company decided to concentrate more resources on the development of non-proportional reinsurance business and likely will continue to do so as conditions in the proportional treaty reinsurance market do not improve, the company noted in its annual report.

"In the most recent renewal season Royal Re stood aside from the scramble for proportional business generated by market overcapacity; the company will continue to take a restrained approach to this class until trading conditions offer realistic prospects of a reasonable return," noted Sir John Cuckney, chairman of Royal Re, in the annual report.

## Heath selling office

Lloyd's of London broker C.E. Heath P.L.C. is selling its London headquarters office but will occupy it on a lease-back basis.

And, Heath is selling certain stock investments to repay loans.

The broker plans to sell its main office in London's financial district for 23.5 million pounds (40.3 million) and lease it back.

The building, which comprises some 50,000 square feet of office space, "is no longer large enough to accommodate all of Heath's City-based operations and a move to alternative accommodation will be required in the medium term," the company said.

The company is entering a five-year lease at a rent of 1.98 million pounds (\$3.4 million) per year. The lease allows termination at C.E. Heath's option at any time after the first two years.

In addition, Heath has sold major shareholdings in two other companies for a total of 11.2 million pounds (\$19.2 million).

## Comings & goings

Zurich Insurance Co. has ap-

pointed **Dennis White** as chief executive for the United Kingdom and Ireland.

Mr. White, currently managing director of the reinsurance marine division of London & Edinburgh Insurance Group, will succeed Frank Hall, who is retiring on Aug. 1.

**Michael Newman** has been appointed regional director of the international division of London-based Prudential Corp. P.L.C. He will be responsible for the development of Prudential's business in southeast Asia.

Mr. Newman had been chief executive and financial director of Britannia Arrow Holdings P.L.C. and has been a consultant to Prudential in southeast Asia since mid-1988.

**Lan Burrows** has been appointed London branch casualty underwriting manager for Guardian Royal Exchange P.L.C. Mr. Burrows previously was organization and methods manager.

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## Comings &amp; goings: industry

## Eigsti, Maines named to new SAFECO posts

**Roger H. Eigsti** has been named president and chief operating officer of SAFECO Corp. in Seattle.

In addition, **Bruce Maines**, who had been president of SAFECO, has been named chairman of the company. Mr. Maines also continues as SAFECO's chief executive officer.

Mr. Eigsti, 47, has been executive vp and chief financial officer of SAFECO since 1985. He previously headed SAFECO's life insurance and commercial credit operations.

Mr. Maines, 62, joined SAFECO in 1950 and has held a variety of

legal and general management positions. He was named president in 1981 and appointed chief executive officer in 1986.

Mr. Maines succeeds as chairman **R.M. Trafton**, who will remain on the company's board.

Also at SAFECO, **Boh A. Dickey** promoted to senior vp and chief financial officer. He joined the company in 1982 as controller.

**In other insurer changes:**

**Robert G. Schwartz**, chairman of Metropolitan Life Insurance Co. of New York, will assume the additional positions of president and chief executive officer, effective Sept. 1. Mr. Schwartz succeeds President and CEO **John J. Creedon**, who is retiring.

**Walter R. Bateman** named vp of Harleysville Group Inc. of Harleysville, Pa. In addition, **Robert J. Lockwood** named vp-claims of Harleysville Mutual Insurance Co. of Harleysville, Pa., a unit of Harleysville Group.

**John W. Wright** joined The New England as vp-employee benefits/marketing and sales. Most recently, Mr. Wright was regional vp-group marketing in the Midwest for Great-West Life Assurance Co.

**Charles R. Rudd** named vp-finance, reinsurance and administration of International Technology Underwriters Inc. of Bethesda, Md.

## Agents/brokers

**Alden Ames III** promoted to president of American Business Insurance Brokers of San Francisco, formerly San Francisco Agencies and a subsidiary of ABI Management Inc.

Also at ABI Brokers, **Gary Goddard** promoted to executive vp.

**Russell T. Sheehan** rejoined Johnson & Higgins of New York as vp and senior international benefits consultant.

**Robert W. Butler** appointed vp-risk management services of Corroon & Black of Michigan Inc. in Livonia.

**Carla Vel** named vp of Amalgamated Programs Corp. in New York.

**John P. Casey** named senior vp and director of the newly opened New York metropolitan office of A.W. Lawrence & Co. Inc., a subsidiary of Lawrence Group Inc.

**Jeannie LaChapelle** appointed regional vp of the Northern California division of James Mitchell & Co. of Sacramento.

**Sharlie Deese** named vp-third party administration at Berwanger Overmyer Associates of Columbus, Ohio.

## Reinsurance

**Richard J. Matinale** promoted to executive vp of The Reinsurance

Continued on page 24



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## Comings & goings: industry

Continued from page 22

Corp. of New York in New York City.

**Robert J. Repke** promoted to vp of Employers Reinsurance Corp. of Overland Park, Kan. Mr. Repke is based in Employers Re's San Francisco office.

General Reinsurance Corp. of Stamford, Conn., announced the following promotions to vp: **Louis Bartenstein**, **Kevin C. Lehman** and **Jonathan F. Murphy** in Stamford; and **Barbara T. Hudson** in Los Angeles.

**John W. Smithson** named chairman, president and chief executive officer of PMA Reinsurance Corp. of Philadelphia.

**Alistair D. Johnston** appointed president and director of Herbert Clough Inc. of Stamford, Conn., a reinsurance intermediary.

**David L. Beebe** joined multi-line reinsurer American Re-Insurance Co. of Princeton, N.J., as vp-contracts service. Most recently, Mr. Beebe was vp-contracts of Willcox Inc.

**John W. Reagan** appointed viced president of Continental Reinsurance Corp. of New York.

At IRM Services Inc. of Charlotte, N.C.: **Richard S. Thomson** named resident vp and regional manager in the Southwestern regional office in Dallas and

**Thomas H. Lemke** named resident vp and regional manager in the Southern regional office in Atlanta.

**David Gilligan** promoted to president of J.L. Kelley Inc. reinsurance brokers in Franklin Lakes, N.J. Additionally, **Bernard J. Bowden** appointed executive vp and **Raymond T. Kerwin** named vp.

**S. Lennart Barkinge** joined reinsurance intermediary Sullivan Payne Co. as senior vp and manager of a new branch office in Chicago. In his most recent position, Mr. Barkinge was senior vp of Thomas A. Greene & Co.

**Lawrence C. Magnant Jr.** joined TPF&C Reinsurance in Stamford, Conn., a division of Towers, Perrin, Forster & Crosby Inc., as vp.

In his previous position, Mr. Magnant was president of his own firm, Magnant Reinsurance Intermediaries.

### HMOs/PPOs

**David K. Ellwanger** promoted to executive director for the New Orleans, Southern region, operations division of PARTNERS National Health Plans of New Orleans.

### Excess/surplus

**Daniel W. Monnin** joined surplus lines broker AVRECO Inc. of Chicago as vp and property manager. Mr. Monnin previously served as vp and property manager for Neal, Lloyd & Co. Inc.

**Martin G. Horwitz** named vp and manager-professional and financial services division for McAlear of Illinois Inc. in Chicago, a unit of Willis Faber Holdings Inc. Mr. Horwitz was formerly vp-national accounts department of Alexander & Alexander Inc. in Detroit.

### Other suppliers

**Martin A. Clark** appointed vp and manager-West Coast operations for claims administrator Richard & Associates of Metairie, La.

He is based in Huntington Beach, Calif.

**Gary N. Lapidis** appointed executive vp and chief executive officer of HealthPro Inc. of Worcester, Mass., a managed care and utilization review vendor.

At New York-based Anistics Inc., an Alexander & Alexander Services Inc. subsidiary, **Harry L. Shuford** named director-financial consulting and **Wayne E. Seel** named director-information services.

**Anthony Manley** joined North American Benefits Network Inc. of Cleveland as vp-operations. In his most recent position, Mr. Manley served as vp-claims at Variable Protection Administrators Inc.

**Judson L. Hobby** joined Co-

pers & Lybrand's Risk Management Consulting Services in Atlanta as senior consultant. He previously was a consultant with the Tillinghast division of Towers, Perrin, Forster & Crosby Inc.

**Barry Smith** joined PCS Inc. of Scottsdale, Ariz., as vp-claims. In his previous position, Mr. Smith served as vp-sales and marketing of Baxter Healthcare Corp.

**John Denler** joined employee benefit consultant Godwins Inc. of Briarcliff Manor, N.Y., as a senior consultant. Mr. Denler, who is based in Godwins' Detroit office, most recently served as assistant treasurer for Flint Ink Corp.

**Joseph F. Warfel** promoted to vp-group operations for the St. Louis and Denver offices of J.W. Terrill Inc. of St. Louis. Mr. Warfel will be based in Terrill's St. Louis office.

**Thomas R. Burke** joined A. Foster Higgins & Co. Inc. in Princeton, N.J., as a principal in its national health care practice. Pre-



Mr. Burke



Mr. Reuter

viously, Mr. Burke served as chief of staff at the Department of Health and Human Services during the Reagan administration.

**Charles D. Reuter** joined the New York office of Buck Consultants Inc. as a benefit consultant. In his previous position, Mr. Reuter was a managing consultant with A. Foster Higgins & Co. Inc.

**Douglas A. Gibby**, **Stephen A. Korducki**, **Joseph L. Lineberry Jr.**, **Hugh J. McFarland** and **Michael D. Schachet** promoted to senior vps of Booke & Co. of Winston-Salem, N.C. ■

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# Met Life unit forms health care data center

Corporate Health Strategies Inc., a health care consulting firm, has created the Health Care Data Center to provide employers with health care cost information.

Westport, Conn.-based Corporate Health Strategies, a subsidiary of Metropolitan Life Insurance Co. of New York, will use its data base of more than 100 million health care claims to provide employers with health care cost trends based on actual experience.

The Health Care Data Center will analyze specific health care claims according to industry groups, providing employers with information about what kinds of claims to expect and how to reduce them.

"We will look at how the shape of the health care industry has changed in the 1980s and the cost

## Markets

implications that employers face as a result," said David W. Rinaldo, director of the center.

Although the Health Care Data Center will only trend health care claims initially, it will eventually add workers compensation claim trending to the data base, he explained.

"We want to solidify our foundation before we expand," he added.

Prior to the center's creation, Mr. Rinaldo was the director of information services at Corporate Health Strategies.

For information, contact Mr. Rinaldo at Corporate Health Strategies Inc., 276 Post Road, Westport, Conn. 06880; 203-454-6116.

## Massachusetts PPO

Blue Cross & Blue Shield of Massachusetts will begin offering its preferred provider organization, Master Health Preferred, in Massachusetts effective July 1.

The Massachusetts Blues last month received approval from the state's Division of Insurance to market Master Health Preferred, making it the first state-approved PPO in Massachusetts.

"This decision means that Master Health Preferred is the only PPO in Massachusetts that the Division of Insurance has certified as meeting or exceeding all standards required by law," said Joseph R.

Driscoll, senior vp-marketing at Blue Cross & Blue Shield of Massachusetts.

Employers currently offering a traditional indemnity plan can expect to save at least 10% of their health care costs by switching to Master Health Preferred, estimates Mr. Driscoll.

Master Health Preferred will be immediately offered to BC/BS group accounts in the state as either an option or replacement for existing coverage, he added.

Approved services provided within the preferred network will be covered at a 100% rate, and participants will be charged a fee of between \$5 and \$25 each time they use a service. Reimbursement for services provided outside the network will be at 80%.

Potential physicians are still

being interviewed, but 4,000 to 5,000 doctors are expected to join the new PPO network, said a Massachusetts Blues spokeswoman.

Currently, Master Health Preferred has contracted with 46 hospitals throughout Massachusetts, the spokeswoman said.

For more information, contact Joan Kelley, Director of PPO Product Management, Blue Cross & Blue Shield of Massachusetts, 10 Summer St., Boston, Mass. 02110; 617-956-3016.

## New AIG unit

New York-based American International Group Inc. is expanding its services abroad in Hong Kong and Italy.

AIG has established a new investment bank in Hong Kong and has been licensed to write life insurance in Italy.

The new Hong Kong-based bank, AIA Capital Corp. Ltd., is a subsidiary of AIA Capital Corp. (Holdings) Ltd. in Bermuda.

Edward E. Matthews, AIG's executive vp-finance, has been named chairman of AIA Capital Corp. Ltd.

The development of merchant banking activities comes in response to the increasingly specialized nature of the financial markets of the Asia-Pacific region and is intended to provide AIG with a major competitive edge, according to a company statement.

Cesar Zalamea, a managing director of AIG Investment Corp. (ASIA) Ltd., and Ronald Arculli, a partner in the Hong Kong law firm of Woo, Kwan, Lee & Lo, are vice chairmen of the bank.

Most business conducted by AIA Capital Corp. Ltd. will be project and corporate finance, including mergers and acquisitions, corporate restructuring, privatizations and project co-financing.

In addition, American Life Insurance Co.'s European life insurer, Compagnie Europeenne d'Assurances sur la Vie (Euravie) of France, has been authorized to write life insurance policies in Italy.

ALICO is a Wilmington, Del.-based subsidiary of AIG.

Products Euravie will offer include term insurance, group life and disability, annuities, whole life, personal accident and pensions coverage.

## Mergers/acquisitions

ML Settlement Services Inc. in Los Angeles has acquired Detroit-based Leslie Johnson Co.

Portland, Maine-based UNUM Corp. has reached an agreement in principle to acquire Thomas L. Jacobs & Associates Inc. of Chicago.

Hilb, Rogal & Hamilton Co. of Richmond, Va., has merged with Gainesville, Ga.-based Turner, Wood & Smith Insurance Agency Inc.

## New offices

A.W. Lawrence & Co. Inc. of Schenectady, N.Y., a subsidiary of Lawrence Agency Corp., has opened a new office at 770 Broadway, New York, N.Y. 10003; 212-674-8753.

Southfield, Mich.-based Burns & Wilcox Ltd., a subsidiary of H.W. Kaufman Financial Group Inc., has relocated its corporate headquarters and also opened a new office in New Orleans.

The new headquarters are at 29355 Northwestern Highway, Suite 200, Southfield, Mich. 48034; 313-354-0400. The New Orleans branch office address is 3636 S. I-10 Service Road, Suite 303, Metairie, La. 70001; 504-838-9941. ■



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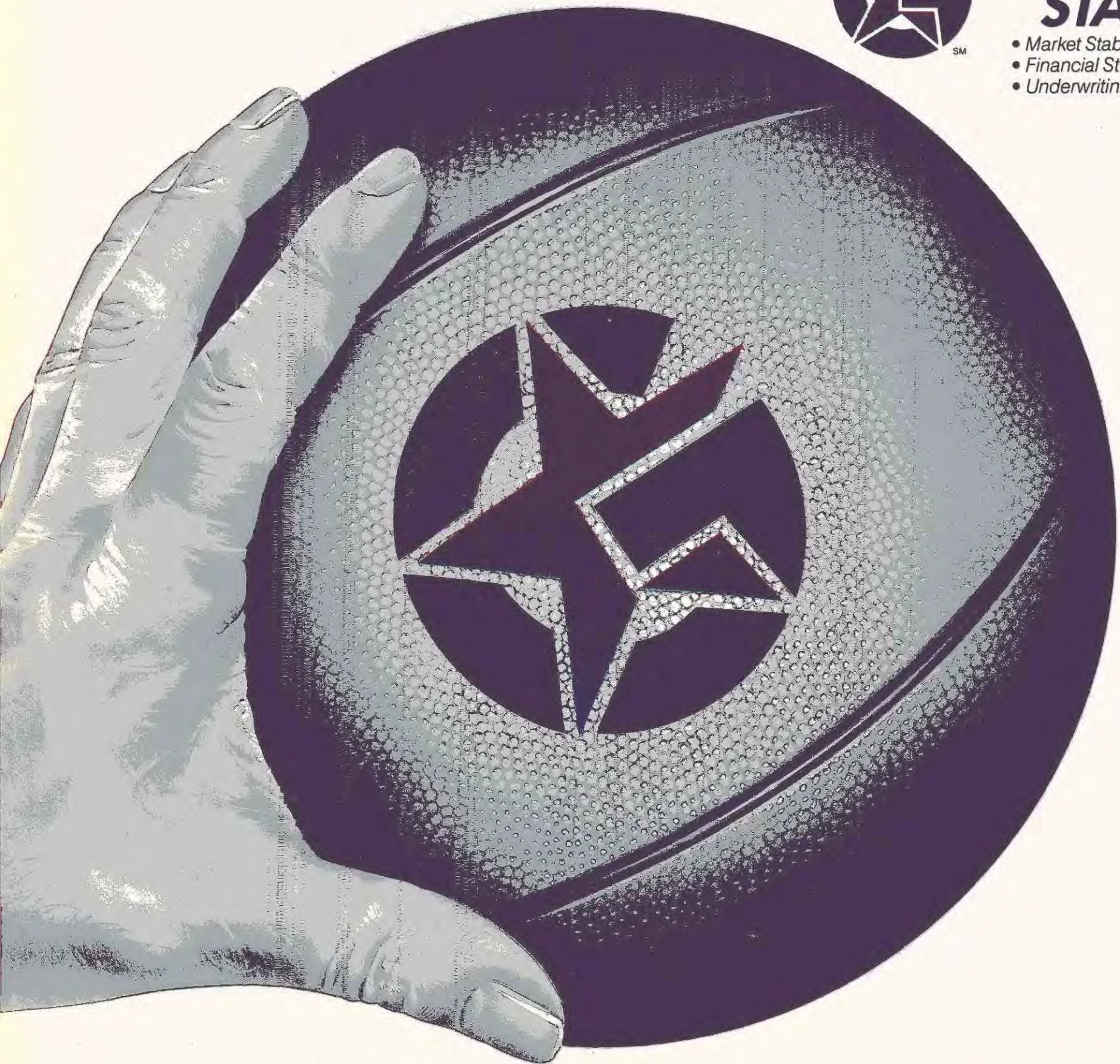
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# Taxing consequences

## Multinationals must weigh risks, benefits of local coverage

By Thomas J. Drag

**T**HE MANAGEMENT of a U.S.-based multinational corporation must address the question of how best to insure the risks of its subsidiaries operating in a number of foreign countries. Since insurance available locally in the foreign countries may not be adequate, the company may consider establishing a completely non-admitted program. This may not be the best solution.

The most common non-admitted policy is one that is written in the United States by an underwriter not authorized to do business, for example, in Country X. On the other hand, a non-admitted policy may be one written in the United States by an underwriter with subsidiaries and affiliates around the world. Although it is possible to purchase local, in-country coverage in Country X from the worldwide insurer, it is only considered local coverage if it is purchased and issued in Country X. Purchasing a policy here in the United States from such an underwriter does not constitute local coverage.

A major drawback of a totally non-admitted program is the tax treatment of premiums and losses. This is often overlooked until a loss occurs. Under a non-admitted policy, the U.S.-based parent corporation typically pays the premiums and is entitled to receive the proceeds in the event of a covered loss. Tax problems arise because the U.S. parent company, which pays the premiums and receives the proceeds from the insurance company, is separate and distinct from the foreign subsidiary, which suffers the loss and needs the proceeds to rebuild or pay damages to a third party. In addition, these companies are located in different tax jurisdictions with distinct tax rates and rules.

To understand the impact of taxation, let us start with a basic scenario. A company in the United States obtains insurance for its U.S. factory. The premiums for the insurance are tax-deductible. If there is a loss, a tax deduction may be taken for the

### Speaking out

loss, which must be offset by the amount of insurance proceeds received. If the insurance proceeds exceed the book value of the loss (typically, the adjusted basis of the property), the tax on the excess may be deferred by reinvesting the proceeds within a prescribed time limit (tax-free rollover). Thus, for most U.S. businesses, there will be no immediate tax payable as a result of the receipt of an insurance payment, provided the proceeds are reinvested.

The tax treatment of insurance premiums and proceeds is similar in many other countries. Typically they permit a local company to deduct insurance premiums paid to a local insurer and to deduct losses sustained but not compensated by insurance. Some countries provide tax relief for the receipt of insurance proceeds, for example, by way of a tax-free rollover.

The tax situation becomes more complex, however, when the U.S. parent company carries the insurance and the foreign subsidiary sustains the loss. First and foremost is the possibility that the U.S. parent company may not be able to deduct the premium and will be taxed on the insurance proceeds in the event of a loss. If the parent company carries the policy to protect its business investment, pays the premiums and is solely entitled to the proceeds, it would seem logical to permit the parent company to take a deduction for the premiums.

The Internal Revenue Service, however, might take a different view. Assuming the worst case (non-deductibility of premium), the cost of such coverage would be approximately 1.67 times the cost of coverage if the premiums were deductible. (This assumes a combined federal and state effective corporate tax rate of 40%, a typical rate for many foreign countries.) The higher aftertax cost of the U.S. premiums could be justified, however, if a tax-deductible premium paid for comparable

foreign-based insurance were more than 1.67 times as expensive as the premium paid by the parent company in the United States.

After considering the possible additional tax cost of a non-deductible premium, management must look to the additional tax cost associated with the receipt of proceeds by the U.S. parent company. It appears that, under U.S. tax rules, the full amount of the proceeds would be included in the parent company's taxable income without offset and without the opportunity for tax-free rollover. However, to get a complete picture, we need to look at several other variables.

First, the subsidiary may be entitled to a tax deduction for the loss in calculating its local country income tax. Let us now assume that the subsidiary is highly profitable in a country that has a corporate income tax rate comparable to that of the United States and that the U.S. parent company can transmit the proceeds to the subsidiary as a non-taxable contribution to capital. In this case, the combined economic effect for the parent company and the subsidiary, upon receipt of the proceeds, would be the same as if the subsidiary had received the proceeds directly from local insurance. If, on the other hand, the subsidiary were subject to little or no local tax (because of low rates, loss, etc.), then the U.S. parent company would be subject to taxes that could have been avoided by insuring locally.

To take a different example, assume the U.S. parent company enjoys a low effective U.S. tax rate and that its subsidiary is in a high tax country that

*Continued on next page*



Thomas J. Drag is senior vp and national director of the international division of Alexander & Alexander Inc. in New York. Deloitte Haskins + Sells assisted with the preparation of this article.

# Product liability cover is vendor's business

By Henry Salfeld

## Speaking out

“WE DO NOT NEED product liability insurance. We insist that each one of our suppliers include our firm as an additional insured-vendor under its commercial general liability policy and furnish us with a certificate of insurance.”

With this categorical statement, the treasurer who also handles the insurance of a large retail corporation rejected the recommendation of its broker to buy product liability insurance for the company.

Yet besides the amount of clerical work involved in following up the receipt of certificates of insurance, watching the expiration dates and reviewing the coverages and limits of each supplier, there are many instances in which the vendor is not or is inadequately covered under the supplier's policy and vendor endorsement.

Since the previous broad and limited form vendors endorsements were replaced in 1985 and 1988 by a single additional insured-vendors endorsement (CG 20151185), a new analysis is required.

Whether the 1988 version supersedes the one of 1985 or only repeats,

amends and explains its conditions is a moot question. It appears that the Insurance Services Office Inc., its author, believes the substitution theory.

Regardless of how the question is answered, the endorsement applies to “your products,” i.e. products of the named policyholder—the supplier—that are sold to and distributed or sold by the retailer in the “regular course” of its business. There is no coverage for occasional transactions.

The vendor is subject to all conditions, limitations and exclusions of the supplier's policy and the certificate of insurance usually does not give all the necessary information.

Although the endorsement requires the vendor's name to be stated, the vendor does not become a “named insured” with all its rights and obligations. The following are two conditions of the policy that mention and are applicable to the named insured and not to an unnamed one:

Under the caption “Who is an insured,” the policy lists executive officers and directors as policyholders

if the named policyholder is a corporation and this, therefore, does not extend to a vendor corporation.

Only the first named policyholder can cancel or change the policy or is entitled to receive a notice of cancellation or non-renewal from the insurer. A clause in a certificate that the insurer should notify the certificate holder in advance of the cancellation, non-renewal or material change of the policy may not be legally binding on the insurers.

Most important, but frequently disregarded, is the fact that the policy limits of liability apply jointly to the named and all additional policyholders. This is particularly serious because the commercial general liability policy, just as its predecessor, includes an aggregate limit for product liability so that the insurer is only obligated to pay up to the aggregate limit regardless of how many claims are made against the named policyholder and all additional policyholders.

The endorsement also contains an exclusion for unauthorized express warranties. In the 1985 version the

exclusion applied to warranties not authorized by the named insured—the supplier—which was changed in 1988 to simply the insured. As the vendor is the insured, it would have to authorize itself, which does not accomplish the stated purposes of the insurer.

Another exclusion applies to the substitution of parts, unless under instructions of the manufacturer. The same exclusion was in the old broad form vendors endorsement, but this does not answer what happens if the instructions are given by the distributor or wholesaler from which the vendor acquired the goods?

All this leads to the conclusion that the apocryphal retailer mentioned above, i.e. the vendor, does not obtain adequate coverage by relying on a vendor's endorsement.

ISO's statement in its 1988 version that “attachment of the endorsement may eliminate the vendors' need to purchase separate products liability coverage for themselves” is much too broad.

Only through its own product liability insurance can a vendor obtain the broadest coverage available.

*Henry Salfeld is a consultant with Frenkel & Co. Inc. in New York.*

## Taxing consequences

*Continued from previous page*

does not allow tax-free rollover of insurance proceeds. The asset sustaining the loss is fully depreciated so that insurance proceeds, if received by the subsidiary, would be fully taxable in the foreign country. In this example, the receipt of proceeds by the U.S. parent company would actually produce a lower combined tax burden.

In making the above analysis, there are several issues that must be considered in detail in the foreign jurisdiction. Most countries permit a deduction for losses sustained to the extent not indemnified by insurance. Insurance proceeds received in excess of the tax-deductible amount are generally subject to income tax. Some countries, such as Japan, permit a tax-free rollover similar to U.S. rules. France permits a deferral of the recognition of gain. Other countries, such as Brazil and Chile, neither permit tax-free rollovers nor a deferral of the recognition of gain.

Payment of insurance premiums for locally admitted insurance is generally deductible as a business expense; however, payments for non-admitted foreign insurance are often not tax deductible. Exchange control rules may prohibit the non-admitted premium payment itself, and there may be civil and criminal penalties for violations of local insurance regulations.

If the U.S. parent company decides to seek reimbursement from the foreign subsidiary for insurance costs, management must examine whether such payment is deductible by the subsidiary and whether there may be restrictions on the ability of the subsidiary to make payments to the U.S. parent company. Such restrictions are common in Latin American countries. Also, the impact of local withholding taxes on premiums and other payments, such as management fees, must be considered.

If the U.S. parent company receives the insurance proceeds and remits them to the subsidiary as a capital contribution, the chances are very good in many countries that this remittance of funds will be treated as a capital contribution and not subjected to local income tax in the hands of the subsidiary. At the same time, the loss should remain tax deductible on the foreign subsidiary's local income tax return. Such a tax deduction should not be affected by the capital contribution, which should

be considered to be an unrelated transaction.

Some countries impose a capital tax on additional capital investment. These taxes are generally nominal in amount. Typically, the exchange control authorities will not require disclosure of the source of the funds being invested in the subsidiary. However, if the foreign revenue authorities decide to treat the remittance of the funds by the U.S. parent company as taxable insurance proceeds, rather than accepting the funds as a tax-free contribution to the capital of the subsidiary, double taxation could result. If the United States has an income tax treaty with the country in question providing procedures for resolving double taxation, the problem might be alleviated.

Although a detailed discussion of local tax considerations is beyond the scope of this article, the following illustrates how some countries with strict local insurance regulations treat a number of these tax issues:

- **Brazil.** Losses are tax deductible but the rollover of insurance proceeds is not tax-free. Brazil's corporate tax rate is approximately 44%.
- **Chile.** Losses are tax deductible in Chile but tax-free rollover of insurance proceeds is not allowed. The corporate tax rate in Chile is approximately 31.8% to 45% on distributed profits.
- **France.** Losses are tax deductible but the rollover of insurance proceeds is taxable. France's corporate tax rate is approximately 39%.
- **Italy.** Losses are tax deductible but tax-free rollover of insurance proceeds is not permitted. The corporate tax rate in Italy is approximately 46.37%.
- **Japan.** Losses are tax deductible and Japan permits the tax-free rollover of insurance proceeds. Japan's corporate tax rate is approximately 55%.

The above discussion should have made it clear that centralizing all your insurance to cover your operations worldwide with a non-admitted program is not a simple solution when taxation has been considered. In many cases, it is more cost-effective to pay the premium and receive loss payments in the local country.

The management of a multinational company should first investigate the possibility of insuring all exposures locally. Then, management must compare the alternatives, with an understanding of how taxation affects the premiums and how both

taxation and exchange controls may affect the final recovery in the event of a claim. In some cases, local insurance is the most cost-effective decision because of deductibility of the premiums and losses against proceeds; in other cases, non-admitted insurance achieves a lower final cost.

Overall, a combination of local insurance and non-admitted insurance under a controlled master program may work best. Local coverage is purchased for all local exposures, while the difference-in-conditions master policy, sometimes referred to as a “gap” policy, is the overriding policy. It functions as a wrap-around policy, picking up all exposures that cannot be covered or are inadequately covered at other locations.

Under a controlled master program, it is possible to insure the U.S. tax liability to some degree. While this may seem to violate the principle of indemnity, actually the opposite is true: not to have the tax liability insurance violates the principle of indemnity. In order for the policyholder to be indemnified, the tax liability must be insured, since that liability is part of the loss. Underwriters providing coverage for the U.S. tax liability assume local coverage wherever possible, preferably with the same underwriter. Local tax deductions are considered in determining the tax liability amount for a loss paid under the DIC policy.

Taxation of international insurance programs is a complicated subject with implications that can significantly affect the cost of a program. While losing or reducing tax deductibility of premiums is unfortunate, it cannot compare to the surprise that management may experience when the company's loss recovery is taxed as ordinary income.

Every company has its own tax objectives and its own risk management objectives. These must be coordinated and management must consider the tax ramifications of insurance coverage on a country-by-country basis. There is no “simple” solution. The decision to purchase non-admitted insurance should not be made for reasons of expediency but only after a thorough consideration of the alternatives.

Please note that the discussion of tax considerations in this article is illustrative, it is not intended as tax advice. Readers should rely on their own tax advisers in all cases.

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# RMIS fall from spotlight at RIMS

**T**HE DIVERSITY, complexity and increasing size of the Risk & Insurance Management Society conference amazes me every year, as does RIMS' ability to pull off the event with relatively few problems.

The national RIMS conference is the mecca for risk management information system vendors, as well as other service providers in the risk and insurance industry. Prospects, clients and competitors alike—as well as an occasional consultant—have the opportunity to witness new innovations from existing vendors as well as to see new entrants in the market. It can be a confusing spectacle, even to veteran attendees—especially as the exhibition area continues its dramatic growth.

Like the 1988 conference in Washington, D.C., this year's conference did not have the RMIS emphasis that was evident at earlier conferences in Toronto and New Orleans. This year, the emphasis was on employee benefit and workers compensation crises.

The terms I would use to describe RMIS interest at the conference are stable and sophisticated. Interest is still there, despite the reduced emphasis as a major topic; but there is a decided lack of "hoopla" or "gee whiz" comments by attendees to both sessions and vendor booths.

The several sessions offered at the RIMS conference this year were reasonably well attended. Furthermore, the attendees exhibited a good knowledge of their needs as evidenced by questions from the audience.

When tallied from the podium, more than 80% of the attendees at the two RMIS sessions I spoke at had an automated system. Most were looking for specific expansions, how to add to their system. Often, though, the system they had in place was too myopic and needed substantial redesign.

Although most vendors reported a drop in traffic from previous conferences, the quality of "prospects" visiting their booths was better. Visitors asked more specific, detailed questions and their level of understanding was much higher. Cost consciousness, both in terms of system upgrades and purchases, as well as the

savings that would be generated from the changes, were predominant in the minds of the visitors.

As a result, vendors could be much more detailed in their explanations, rather than just answering basic questions that they were used to receiving since the early years of RMIS interest.

Among the vendors themselves there were few changes. No drastically new and innovative system features were unveiled this year. Mostly, there were modifications to existing products. Risk Sciences Group, Corporate Systems, Tillinghast, Helmsman, Travelers, CIC and Gallagher Risk Data, et al, had modifications and new

be enough diversity to satisfy a wide range of needs. It is assumed that most of these core members would be large enough to warrant a sophisticated RMIS, as well as be able to seed enough cash for the necessary design and implementation work.

Because they would be starting at ground zero, the designers would seek to take advantage of the most recent technology in terms of software and hardware, especially focusing on the portability of the system. That means that the system would be easily compatible with mainframe, mini and micro hardware applications, as well as major software (i.e., operating systems).

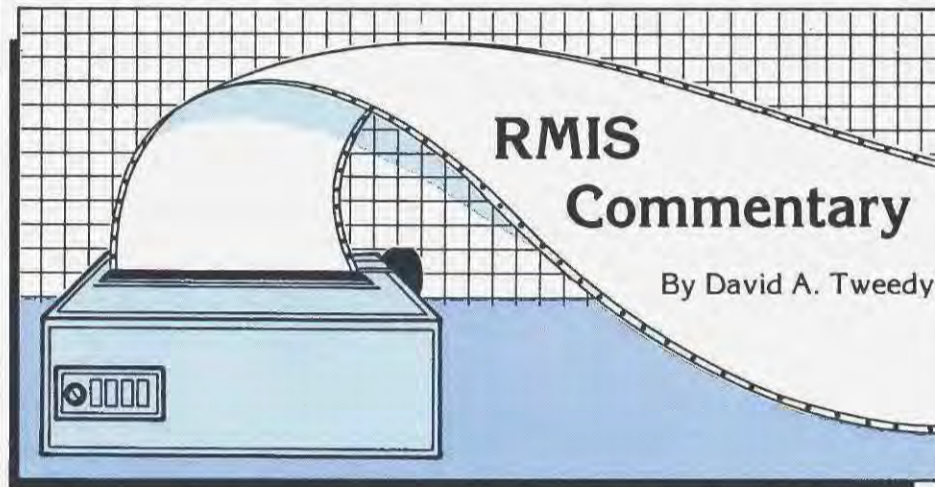
come true as we have seen a major retreat of the many large brokers away from their timeshare mainframe systems. In 1988 and 1989, I believe, we have seen RMIS enter the mature stage where marketing exceeded research and development as a focus. There are relatively few new players, causing the total number of vendors to remain static.

What is coming for the future? Systems, whether they be micro, mini or mainframe, will be faster, more powerful, easier to use and more compatible with each other. Micro-based systems are, for all intents and purposes, as competitive from a functional standpoint as the larger computers. The basic question still remains, however, do you want your system run by yourself or by someone else (stand-alone vs. support)? That won't change, no matter how inexpensive a micro is.

Expert systems applications are probably not yet ready for RMIS, but that certainly is around the corner. The oft-rumored merging with the employee benefits system—especially in the similarities between workers compensation and health claims—continue, although few vendors exhibited capabilities in both areas.

Despite the fact that the spotlight no longer seems to be on RMIS at RIMS, there is no question but that the systems will continue to be a vital risk management tool. Quality systems of all sizes and types are available and, although no drastic innovations have been made, RMIS are much more comprehensive, flexible, compatible and less expensive than in the past.

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



twists this year but nothing significantly different.

Also, while there were new vendors on the scene, there certainly was not the tremendous influx of new participants as was seen in recent years. The real growth in system vendors was on the employee benefits side.

One interesting item during the conference concerned the potential design of a mid-range computer system (minicomputer) as part of a collaborative effort of several potential users. What I found fascinating was the innovative approach to system design. Rather than spend a lot of money pursuing standard marketing research, this consortium would be made up of 10 ultimate users of the system.

The system would be designed exactly to their own specific needs. Among the 10 members, there would

I will be closely following this consortium's development with interest since it is one of the few new non-microcomputer marketing efforts that the RMIS industry has seen in the last few years. Because of heavy research and development start-up costs, this may be one of the few successful ways of entering a mature market such as the RMIS industry.

Probably the most important impression I had from the Atlanta conference regarding RMIS was a confirmation that market maturity had definitely established itself. As in most mature markets, the primary focus of vendors is marketing.

In 1984, RMIS was definitely in the growth stage with a heavy emphasis on research and development. The last two years were the "shakeout" stage, where we saw many vendors leave the market.

These predictions have apparently

## Compensation for Samaritan's death reversed

### Legal briefs

Injuries that an employee sustained while returning home from a business trip, when he stopped to assist an injured pedestrian, were not injuries "arising out of employment," for the purposes of workers compensation, the Supreme Court of North Carolina ruled. The court reversed a 1987 decision of the Court of Appeals of North Carolina (*BI*, Nov. 14, 1988).

Timothy Roberts, while returning home from a business trip, was struck and killed by a car as he assisted an injured pedestrian who had no connection to Mr. Roberts' duties nor his employer's business. Mr. Roberts has been on a business trip and was returning from the airport when he encountered a pedestrian who had been injured while walking on an interstate ramp.

Mr. Roberts stopped and offered to assist another person who had stopped to help. Mr. Roberts positioned himself near the pedestrian's body to

direct cars away. While standing near the pedestrian's body, he was struck by a car and killed. Mr. Roberts' benevolent act received some attention from the media and mention was made of his employer, Burlington Industries Inc. His widow and daughter sought compensation. The state industrial commission denied benefits but was reversed by the Court of Appeals of North Carolina.

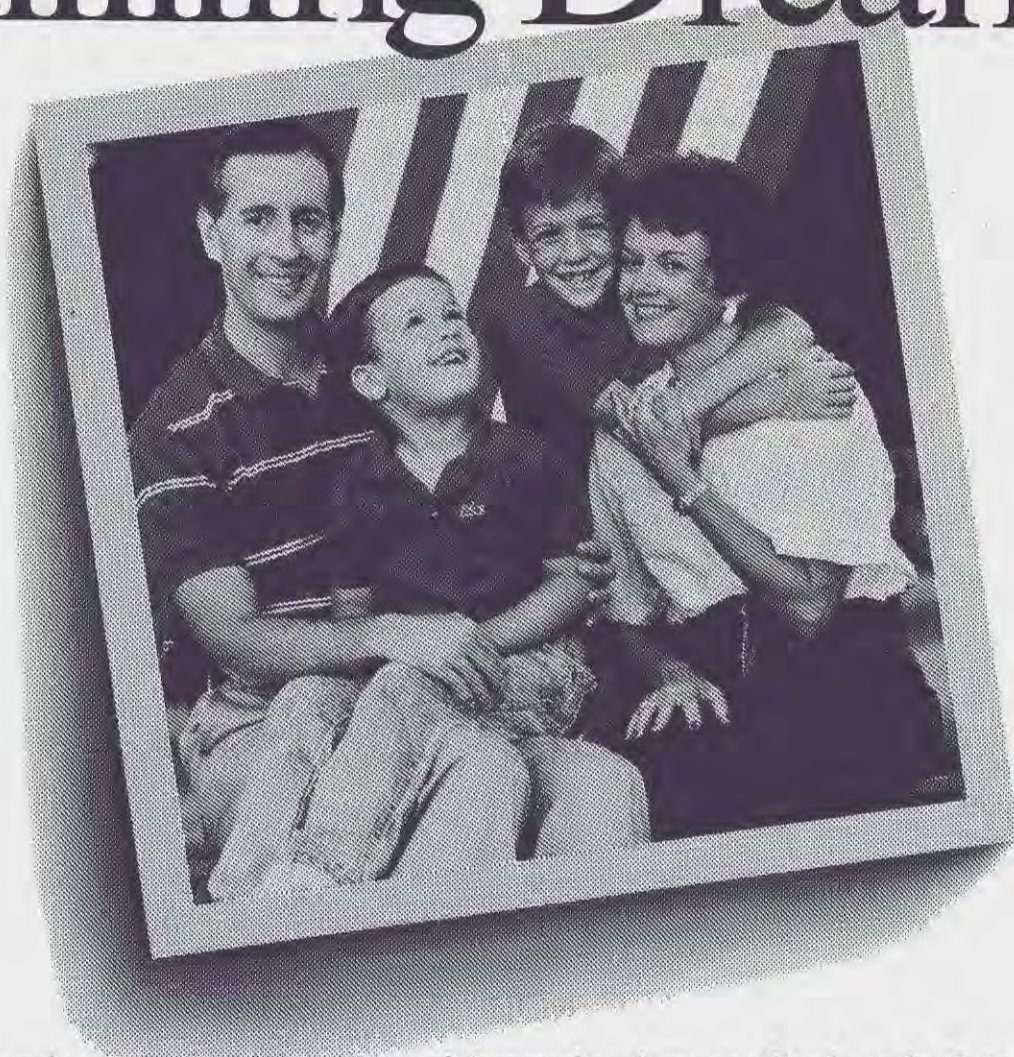
The state Supreme Court said that an injury to an employee while he is performing acts for the benefit of third persons does not arise out of the employment unless the acts benefit the employer to an appreciable extent. Here, the court said that no one—but Mr. Roberts—who was involved in the events surrounding his accidental death had any connection with Burlington.

Thus, the court concluded that his death did not arise out of his employment. Any goodwill that might have benefitted Burlington arising out of the news stories were purely speculative and could not serve as a basis for holding that the appreciable benefit to the employer test was met, the court observed. In denying benefits, the court emphasized that the workers compensation law was not intended to establish general insurance benefits.

*Roberts vs. Burlington Industries Inc.*, Supreme Court of North Carolina, Feb. 3, 1988 (*BI*/01/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.*

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# Fewer underfunded plans terminated: PBGC

By JERRY GEISEL

## Washington

WASHINGTON—The number of claims incurred by the Pension Benefit Guaranty Corp. is declining sharply.

During its most recent fiscal year, which ended Sept. 30, 1988, the Washington, D.C.-based PBGC incurred 25 claims from the terminations of underfunded defined benefit pension plans, according to the agency's newly released annual report.

That is down significantly from the 60 claims the agency incurred in fiscal 1987 and is the smallest number of claims incurred by the PBGC since the agency was established by Congress in 1974 to protect workers' and retirees' basic pension benefits.

The number of fiscal 1988

claims, however, could later increase depending on the termination dates given to several pending claims.

Based on current information, the PBGC estimates that incurred claims in 1988 will cost the agency \$229 million, up from \$149 million in claims incurred in fiscal 1987. However, the fiscal 1987 figures do not include more than \$2 billion in potential claims from several severely underfunded pension plans sponsored by Dallas-based LTV Corp.

The termination of LTV's plans is being contested by the PBGC in a federal appellate court.

During the last year, the PBGC's

single-employer fund deficit—the difference between assets and benefits guaranteed to participants in terminated plans the PBGC has taken over—remained virtually even at about \$1.5 billion.

However, premium income for the agency's single-employer fund increased to \$464.4 million in fiscal 1988, up from \$267.6 million in fiscal 1987.

That increase in premium income is the result of a new law that took effect in January 1988 that boosted premiums.

The annual premium for individual employers with defined benefit plans now ranges from \$16 per participant to \$50 per participant

based on how well an employer's pension plan is funded.

Until 1988, the annual premium was \$8.50 per plan participant, regardless of a plan's funding levels.

Other highlights in the report include:

- The PBGC paid \$324.7 million in benefits in fiscal 1988 to 112,800 participants in single and multiemployer pension plans the agency has taken over. That compares to \$303.6 million in payments to 112,500 participants in fiscal 1987.

The agency also says it is obligated to pay benefits to another 104,000 participants when they become eligible for benefit payments in the future.

- The PBGC received about 11,000 notices from employers of standard plan terminations in the

fiscal year, about the same as the year before. A standard termination is one in which there are sufficient assets to pay promised benefits.

- During the 1988 calendar year, some 166 overfunded pension plans were terminated with the sponsoring employers recovering \$1.8 billion in surplus assets. In calendar year 1987, some 270 overfunded plans were terminated with employers recouping \$1.9 billion in surplus assets.

Free single copies of the annual report are available from the Communications and Public Affairs Department (CC38000), Pension Benefit Guaranty Corp., 2020 K St. N.W., Washington, D.C. 20006.

## Section 89 testing

The Internal Revenue Service is making clear that the effective date of complying with Section 89 is being pushed back to Oct. 1 from July 1.

Earlier this month Treasury Secretary Nicholas Brady announced that non-discrimination testing required under Section 89 would be delayed until Oct. 1 (BI, May 8).

However, Mr. Brady did not make clear whether the delay also applied to Section 89(k), the portion of the law that explains how employers must notify employees of available benefits.

The IRS, though, in Notice 89-65, says the delay also applies to the benefit notification requirements laid down by Section 89(k).

## Parental leaves

The Senate Labor and Human Resources Committee has approved legislation, S. 345, that would require employers with more than 20 employees to give workers up to 10 weeks of unpaid leave to care for a newborn, newly adopted or seriously ill child as well as 10 weeks of unpaid leave to care for a seriously ill parent.

The legislation also would require employers to give employees up to 13 weeks unpaid leave in the event an employee was seriously ill.

A similar measure, H.R. 770, already has cleared the House Education and Labor Committee.

The Bush administration, though, has threatened to veto parental leave legislation. Labor Secretary Elizabeth Dole says leave policies should be decided by employers without interference from the federal government.

"The administration supports and encourages parental and medical leave policies designed to meet the specific needs of individual companies and their employees. We strongly believe this can be best achieved voluntarily," she said.

## Retiree benefits rule

The Supreme Court has declined to review and thus let stand an appeals court decision that said employers can reduce or modify retiree health care benefits without violating federal law if they reserve the right to do so in plan documents.

Under that decision, the 6th U.S. Circuit Court of Appeals said American General Corp., a Houston-based insurance holding company, could alter retiree health care benefits because plan documents state that the company has the right to make plan changes.

The right to cut retirees' health care benefits—if spelled out in plan documents such as a group insurance plan—pre-empts "oral statements" participants may have received about their benefits, the appeals court said (BI, Jan. 2). ■

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**MAY 18. Insurance Claims Problems** seminar in Nyack, N.Y., co-sponsored by the Westchester, North Jersey and Hudson Valley chapters of the Society of Chartered Property & Casualty Underwriters; \$25; \$28 at the door. George Goodman, Dayton, Corey & Dubben, 335 Manville Road, Pleasantville, N.Y. 10570; 914-769-0013.

**MAY 18-19. Retiree Health Benefits & the New FASB Ruling-Defusing the Time Bomb** conference in New York City, sponsored by the HealthWays Foundation; \$725. The HealthWays Foundation, c/o The Center to Promote Health Care Studies Inc., 14 Colvin Road, Scarsdale, N.Y. 10583; 201-636-6200.

**MAY 18-19. Solving the Workers Compensation Puzzle** workshop in Oxnard, Calif., sponsored by the University of Southern California-Santa Barbara; \$145 for one day; \$250 for both days. Department of Marketing, UCSB Extension, Santa Barbara, Calif. 93106; 805-961-3351.

**MAY 18-19. National Assn. of Employers on Health Care Action's 13th Annual Conference: Purchasing Quality Managed Health Care Service** in Minneapolis; \$445 for NAEHCA members; \$545 for non-members. NAEHCA, 104 Crandon Blvd., Suite 304, Key Biscayne, Fla. 33149; 305-361-2810.

**MAY 21-23. Managing the Utilization of Mental Health and Chemical Dependency Services and Benefits** seminar in Denver, sponsored by the American Medical Care & Review Assn.; \$375 for AMCR members; \$500 for non-members. Sandy Drury, AMCR, 5410 Grosvenor Lane, Suite 210, Bethesda, Md. 20814; 301-493-9552.

**MAY 21-24. Risk Management and Captive Insurance Conference 1989: The Asia Pacific Challenge** in Singapore, co-sponsored by Alexander Risk Management Pte. Ltd., Sedgwick Risk Management Services and the Singapore Insurance Training Centre; \$1,200 Singapore (\$615.36); \$200 Singapore for guests (\$102.56). Singapore Insurance Training Centre, 10 Shelton Way, Suite 14-06, MAS Building, Singapore 0207; phone: 221-2336; fax: 220-6684.

**MAY 21-24. Risk Management Climbs the Charts** conference in Nashville, Tenn., sponsored by the Public Risk Management Assn.; \$375 for PRIMA members; \$445 for non-members. PRIMA, 1120 G St. N.W., Suite 400, Washington, D.C. 20005; 202-626-4650.

**MAY 21-31. Fifth International Fire Protection Engineering Institute** in Ontario, Canada, sponsored by the Society of Fire Protection Engineers; \$485. Institute Secretariat, Society of Fire Protection Engineers, 60 Batterymarch St., Boston, Mass. 02110; 617-480-0686.

**MAY 22-23. FAS 87 and 88: Practical Problems and Solutions** seminar in Bermuda, co-sponsored by the Society of Actuaries and the American Academy of Actuaries; \$355 for U.S. Society of Actuaries members; \$390 for non-members. Society of Actuaries, P.O. Box 71293, Chicago, Ill. 60694; 312-706-3545.

**MAY 22-23. Introduction to Hull and P&I Insurance** seminar in New York City, sponsored by The World Trade Institute; \$695; \$630 for each additional registrant from the same organization. Registrar, The World Trade Institute, 1 World Trade Center, 55 West, New York, N.Y. 10048; 212-466-4044.

**MAY 22-23. Understanding Reinsurance Contract Language** conference in New York City, sponsored by Executive Enterprises Inc.; \$990. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-831-8333; 212-645-7880.

**MAY 22-24. NAI's 1989 Executive Underwriting Clinic** in Rosemont, Ill., sponsored by the National Assn. of Independent Insurers; \$185. NAI, 2600 River Road, Des Plaines, Ill. 60018-3286; 312-297-7800.

**MAY 23-24. Killer Diseases—Technical & Insurance Aspects** conference in London, sponsored by the Insurance & Reinsurance Research Group Ltd.; 380 pounds (\$633.84). Insurance & Reinsurance Research Group Ltd., Bridge House, 181 Queen Victoria St., London, England EC4V 4DD; phone: 01-236-2175; fax: 01-489-1487.

**MAY 23-25. Can We Afford the Future?—Benefits in the 21st Century** conference in Washington, D.C., sponsored by the Assn. of Private Pension & Welfare Plans; \$525 for APPWP members; \$595 for non-members. APPWP, 1331 Pennsylvania Ave. N.W., Suite 719, Washington, D.C. 20004; 202-737-6666.

**MAY 24. Employer Compliance with Section 89** conference in Springfield, Ill., sponsored by The Illinois State Chamber of Commerce Center for Business Management; \$120 for ISCC members; \$180 for non-members. Also May 26 in Chicago. ISCC Center For Business Management, 20 N. Wacker Drive, Chicago, Ill. 60606; 312-372-7373.

**MAY 24. Financial Institutions—Special Risks and Insurance** conference in London, sponsored by the Insurance & Reinsurance Research Group Ltd.; 210 pounds (\$350.28). Insurance & Reinsurance Research Group Ltd., Bridge House, 181 Queen Victoria St., London, England EC4V 4DD; phone: 01-236-2175; fax:

01-489-1487.

**MAY 24. The Ohio Manufacturers Assn.'s and the Coalition for Cost Effective Health Services' Seventh Annual Health Care Management Conference** in Columbus, Ohio; \$105 for OMA or CCEHS members; \$140 for non-members. Ohio Manufacturers Assn. 33 N. High St., Columbus, Ohio 43215-3005 614-224-1722.

**MAY 24-25. On-Site Groundwater and Soil Remediation** seminar in Los Angeles, sponsored by Groundwater Technology Inc.; \$425 for corporations; \$325 for government. Discounts for three or more registrants from the same organization. Brian Jaffarian, Groundwater Technology Inc. 220 Norwood Park S., Norwood, Mass. 02062; 617-769-7600.

**MAY 24-26. Captive Insurance** conference in Grand Cayman, Cayman Islands, co-sponsored by the Cayman Insurance Managers' Assn. and the Tillinghast division of Towers, Perrin, Forster & Crosby Inc.; \$685. Conference Director, Tillinghast/TPF&C, Financial Center, 695 E. Main St., Suite 600, Stamford, Conn. 06901-213E; 809-949-8228.

**MAY 25. Employee Benefits in the Courts**  
*Continued on next page*

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## Datebook

Continued from previous page

breakfast seminar in Lisle, Ill., sponsored by the West Suburban Chicago chapter of WEB; \$10 for WEB members; \$20 for non-members. L. Zoeller, 200 W. Adams, Suite 2015, Chicago, Ill. 60606; 312-558-4585.

**MAY 25. Second Annual Claims Seminar** in Atlanta, co-sponsored by Drew, Eckl & Farnham and Forcon International-Georgia Ltd.; no charge. Forcon International-Georgia Ltd., P.O. Box 49721, Atlanta, Ga. 30359; 404-321-4969.

**MAY 25-26. Brief Reinsurance** course in New York City, sponsored by The College of Insurance; \$195 for College sponsors; \$245 for non-sponsors. College of Insurance, 101 Murray St., New York, N.Y. 10007-2132; 212-962-4111.

**MAY 30-JUNE 2. Reinsurance Accounting & Finance for Ceders & Assurers** seminar in Tarrytown, N.Y., sponsored by Robert W. Strain Seminars Inc.; \$1,445. Robert W. Strain Seminars Inc., Box 1000, Wingdale, N.Y. 12594; 914-832-8384 or 212-677-5974.

**MAY 31. Insuring Long Term Care** seminar in Chicago, co-sponsored by the Society of Actuaries and the American Academy of Actuaries; \$355 for society members; \$390 for non-members. Society of Actuaries, P.O. Box 71293, Chi-

cago, Ill. 60694; 312-706-3545.

**JUNE 1-2. Risk and Insurance Management in Banking** seminar in Washington, D.C., sponsored by the American Banking Assn.; \$495 for ABA members; \$620 for non-members. Tom Aubrey, American Banking Assn., 1120 Connecticut Ave. N.W., Washington, D.C. 20036; 202-663-5293.

**JUNE 1-2. Legal Aspects of Occupational Safety and Health** course in Los Angeles, sponsored by the University of Southern California's Institute of Safety and Systems Management; \$385. University of Southern California, Institute of Safety and Systems Management, Office of Extension and In-Service Programs, 3500 S. Figueroa St., Suite 202, Los Angeles, Calif. 90007; 213-743-6383.

**JUNE 1-2. Current Issues in Insurance Letters of Credit** conference in New York, sponsored by Executive Enterprises Inc.; \$990. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-831-8333; 212-645-7880.

**JUNE 5-6. The Environmental Insurance Law Institute** in New York City, sponsored by Executive Enterprises Inc.; \$990. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-831-8333; 212-645-7880.

**JUNE 5-9. Practical Risk Management** course in London, sponsored by the Insurance & Reinsurance Research Group Ltd.; 775 pounds (\$1,292.70). Insurance & Reinsurance Research Group Ltd., Bridge House, 181 Queen Victoria St., London, England EC4V 4DD; phone: 01-236-2175; fax: 01-489-1487.

**JUNE 5-9. Management and Administrative Skills for the Occupational Safety and Health Professional** course in Los Angeles, sponsored by the University of Southern California's Institute of Safety and Systems Management; \$735. University of Southern California, Institute of Safety and Systems Management, Office of Extension and In-Service Programs, 3500 S. Figueroa St., Suite 202, Los Angeles, Calif. 90007; 213-743-6383.

**JUNE 7-8. Product Development Boot Camp** seminar in Oak Brook, Ill., co-sponsored by the Society of Actuaries and Individual Life Insurance and Annuity Product Development Section; \$460 for Society of Actuaries members; \$495 for non-members. Society of Actuaries Seminar Department, P.O. Box 71293, Chicago, Ill. 60694; 312-706-3545.

**JUNE 7-9. Fundamentals of Insurance** course in San Francisco, sponsored by the Risk & Insurance Management Society Inc.; \$540 for RIMS members; \$640 for non-members. Fran Jordan, RIMS, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

**JUNE 8. Reinsurance Law Update** conference

in London, sponsored by the Insurance & Reinsurance Research Group Ltd.; 220 pounds (\$366.96). Insurance & Reinsurance Research Group Ltd., Bridge House, 181 Queen Victoria St., London, England EC4V 4DD; phone: 01-236-2175; fax: 01-489-1487.

**JUNE 8-9. Financial Analysis for Risk Management** course in Washington, D.C., sponsored by The College of Insurance; \$595 for College sponsors; \$695 for non-sponsors. The College of Insurance, 101 Murray St., New York, N.Y. 10007-2132; 212-964-3381.

**JUNE 8-9. Health Care Risk and Insurance Management: Constructing the Comprehensive Program** seminar in Chicago, sponsored by the American Society for Healthcare Risk Management; \$345 for ASHRM members; \$465 for non-members. Trudy Goldman, American Society for Healthcare Risk Management, 840 N. Lake Shore Drive, Chicago, Ill. 60600; 312-289-6425.

**JUNE 8-9. Linking Data and Long Term Care Services** conference in Washington, D.C., sponsored by the National Assn. of Health Data Organizations; \$225 for NAHDO regular and associate members; \$300 for NAHDO individual members and non-members. Julie Greene, NAHDO, 316 Pennsylvania Ave. S.E., Suite 202, Washington, D.C. 20003.

**JUNE 8-9. ERISA Basics: A Primer on ERISA Issues** conference in San Francisco, co-sponsored by the American Bar Assn. sections

on Business Law, Labor and Employment Law, Real Property, Probate and Trust Law, Taxation, and Tort and Insurance Practice, and the ABA Division for Professional Education; \$400 for ABA members; \$375 for members of sponsoring ABA sections; \$425 for others. Division for Professional Education, American Bar Assn., 750 N. Lake Shore Drive, Chicago, Ill. 60611; 312-988-6200.

**JUNE 11-13. Annual American Insurance Assn. General Counsel's Symposium** in Washington, D.C., sponsored by AIA; \$150 for members; \$225 for non-members. Ronald S. Gass, AIA, 1130 Connecticut Ave., Washington, D.C. 20036; 202-828-7100.

**JUNE 11-14. Setting the Stage—HMOs and the American Health System in the Next Decade** institute in Atlanta, sponsored by the Group Health Assn. of America Inc.; \$555 for GHAA members; \$655 for non-members; \$230 for students/retirees. Registrar, Group Health Assn. of America Inc., 1129 20th St. N.W., Suite 600, Washington, D.C. 20036.

**JUNE 12. The Basics of Benefits Administration** seminar in Peoria, Ill., sponsored by Key Productivity Center; \$145. **Also June 13** in Chicago; **June 14** in Neenah, Wis.; **June 15** in Milwaukee; and **June 16** in Minneapolis. Key Productivity Center, P.O. Box 27-480, Kansas City, Mo. 64180; 800-821-3919; 913-345-2140.

**JUNE 12-13. Transportation of Hazardous Materials/Waste** course in Sacramento, Calif., sponsored by the University of Southern California's Institute of Safety and Systems Management; \$100. **Also July 10** in Los Angeles. University of Southern California, Institute of Safety and Systems Management, Office of Extension and In-Service Programs, 3500 S. Figueroa St., Suite 202, Los Angeles, Calif. 90007; 213-743-6383.

**JUNE 12-13. Claims Reserving in Non-Life Insurance** conference in London, sponsored by the Insurance & Reinsurance Research Group Ltd.; 410 pounds (\$683.88). Insurance & Reinsurance Research Group Ltd., Bridge House, 181 Queen Victoria St., London, England EC4V 4DD; phone: 01-236-2175; fax: 01-489-1487.

**JUNE 12-13. Fundamentals of Statutory Insurance Accounting** conference in New York City, sponsored by Executive Enterprises Inc.; \$990. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-831-8333; 212-645-7880.

**JUNE 12-14. Techniques of Risk Management** course in Orlando, Fla., sponsored by the Risk & Insurance Management Society Inc.; \$540 for RIMS members; \$640 for non-members. RIMS, 205 E. 42nd St., Suite 1504, New York, N.Y. 10017; 212-286-9292.

**JUNE 13. Flexible Benefits: Are They Right for Your Company?** conference/trade show in Boston, sponsored by the New England Benefits Council; \$110 for NEBC members; \$150 for non-members. NEBC, 675 Massachusetts Ave., Cambridge, Mass. 02139; 617-547-6484.

**JUNE 13-14. Reinsurance Systems** course in Boston, sponsored by The College of Insurance; \$595 for College sponsors; \$695 for non-sponsors. **Also Oct. 24-25** in Chicago. Professional Programs, The College of Insurance, 101 Murray St., New York, N.Y. 10007-2132; 212-962-4111.

**JUNE 13-15. Hazard Communication for the Industrial Hygienist** seminar in Boston, co-sponsored by the National Center for Hazard Communication, the University of Maryland's Center for Professional Development and the American Industrial Hygiene Assn.; \$595. **Also June 27-29** in Los Angeles. Registration Clerk, University of Maryland Center for Professional Development, University Boulevard at Adelphi Road, College Park, Md. 20742.

**JUNE 13-15. Seventh Annual Hazardous Materials Management** conference and exhibition in Atlantic City, N.J., sponsored by Hazmat World; \$80 for June 13; \$135 for June 14 and 15; \$325 for all three days; \$395 for all three days plus copy of 1989 proceedings. Tower Conference Management Co., 800 Roosevelt Road, Building E, Suite 408, Glen Ellyn, Ill. 60137-5835; 312-469-3373.

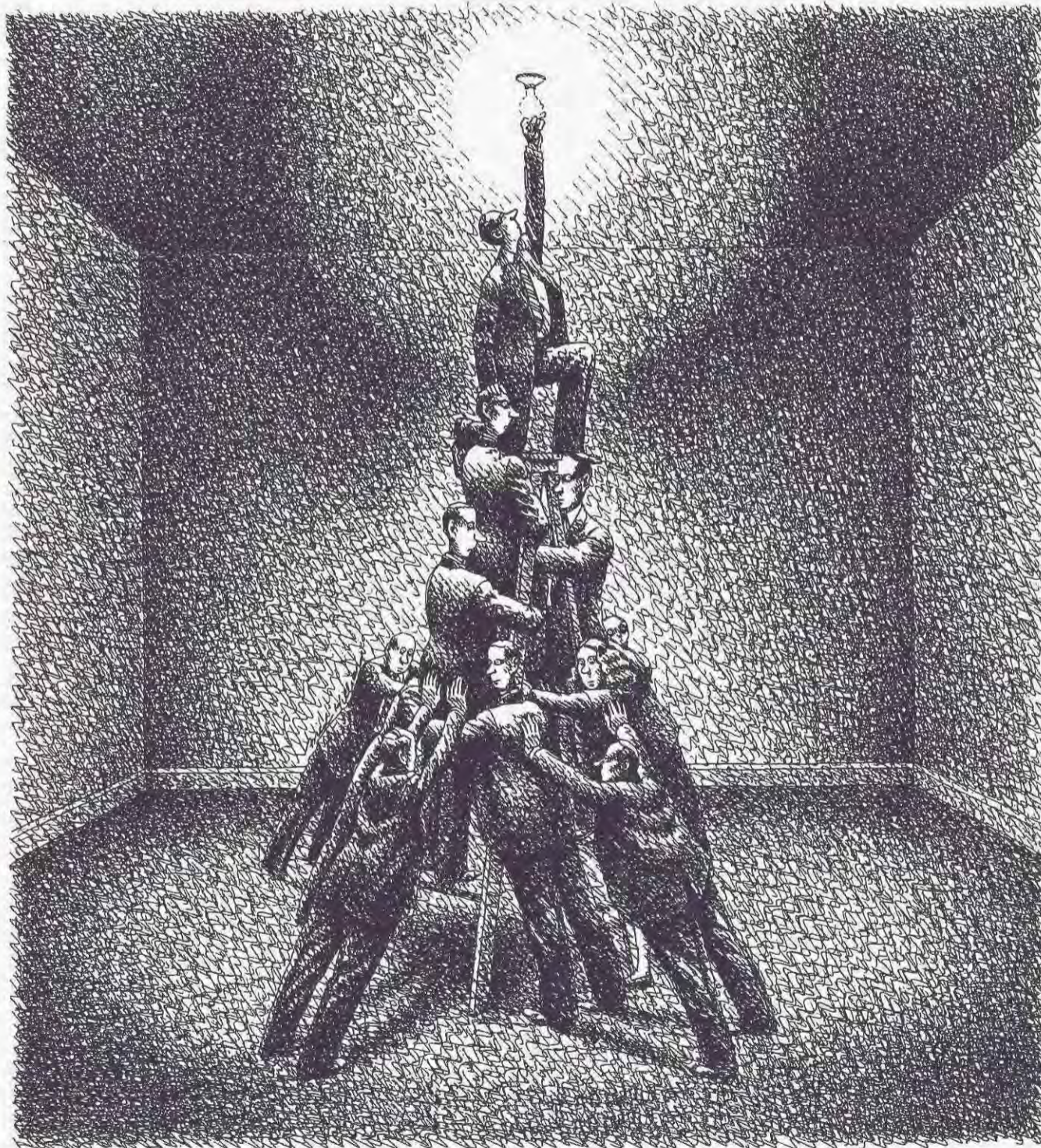
**JUNE 14. The 5500 Series Forms: Recent Actuarial Changes** workshop in Commerce, Calif., sponsored by The National Institute of Pension Administrators; \$85 for regular and associate NIPA members; \$110 for non-members. NIPA, 145 W. First St., Suite A, Tustin, Calif. 92680; 714-731-3524.

**JUNE 14-16. Understanding Property/Casualty Statutory Financial Statements** seminar in New York City, sponsored by Executive Enterprises Inc.; \$990. **Also July 17-19** in San Francisco. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-831-8333; 212-645-7880.

**JUNE 15. Assn. of Professional Insurance Women's 1989 Insurance Woman of the Year Awards** in New York City; \$50. APIW, Catherine Ancone, 212-785-2500.

**JUNE 15-16. The 1989 Insurance & Reinsurance Research Bureau's Lloyd's Conference: Developing Lloyd's Business** in London; 410 pounds (\$683.88). Insurance & Reinsurance Research Group Ltd., Bridge House, 181 Queen Victoria St., London, England EC4V 4DD; phone: 01-236-2175; fax: 01-489-1487.

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# Texas reform package passes Senate

AUSTIN, Texas—A package of legislative reforms aimed at shortening up the way Texas insurance companies operate and increasing regulation passed the Texas Senate and is being considered by the House.

The reforms, packaged in S.B. 255, originally sponsored by Sen. John Montford, D-Lubbock, include measures that would clarify Texas antitrust laws to eliminate exemptions that currently apply to insurers, boost capital and surplus requirements, remove some confidentiality restrictions related to information about companies under state supervision and force insurers to provide more financial information to the state.

Sen. Montford has been an outspoken critic of the management practices of the Texas State Board of Insurance since the collapse of National County Mutual Fire Insurance Co. of Dallas last October.

If the proposed legislation is enacted in its current form, it would change the Texas Business & Commerce Code to include "the business of insurance and reinsurance" among industries that can be held in violation of state antitrust statutes. Insurers and reinsurers in the state currently enjoy limited immunity from such laws.

Despite that limited immunity, the Texas attorney general's sued insurance industry defendant last year, charging them with violations of state antitrust law. That litigation is pending in Travis County District Court in Austin (BI, March 27).

The insurance reform legislation also addresses Sen. Montford's concern that Texas insurers are undercapitalized by calling for new insurers to maintain capital and surplus of at least \$700,000. Companies already operating may continue to meet the current \$400,000 minimum unless there is "a change of control" of the insurer after Aug. 31.

Under the legislation, insurers in Texas would be required to file additional data on losses and supply information such as anticipated underwriting profits to the Texas State Board of Insurance, which would use the data when considering rate filings.

The state's insurance commissioner would not be able to keep confidential information related to insurers under supervision unless it could be shown that confidentiality was necessary in order to supervise the company, the legislation states.

If information is kept confidential, the confidentiality could not last more than 90 days.

—By Michael Bradford

## Around the states

commissioner to be unavailable or unaffordable in the state: owners, landlords and tenants; manufacturers and contractors; products and completed operations; governmental subdivisions; public schools; day-care centers; liquor retailers; recreational; professional; medical malpractice; commercial and private passenger auto; and general liability, as well as workers compensation coverage.

The report will also include information on the financial condition of individual insurers operating in the state, and authorizes the commissioner to require property/casualty insurers to submit any additional information he believes

is necessary to compile the report.

- H.B. 206, which prohibits insurance companies from requiring prior hospitalization before a long-term care insurance policy's coverage begins, unless the insurer offers a policyholder the option of selecting another policy that does not have the requirement.

The bill also allows insurers to offer long-term care benefits either through a rider to or as a provision under a life insurance policy.

- H.B. 205, which authorizes the insurance commissioner to conduct insurer financial examinations at least once every three years, rather than the former practice of once every five years.

- H.B. 207, which requires insurers to include a 31-day grace period for late payments under group health insurance contracts, a requirement already made under group life and individual life and health insurance policies.

- H.B. 566, which allows insurers domiciled in another state to move to Georgia and become domiciled there.

In addition, five of six bills previously awaiting the governor's signature (BI, April 3) have now been signed. They are:

- H.B. 203, requires insurers to give 60 days' notice prior to cancellation or non-renewal of individual or group accident and sickness insurance policies, except for non-payment of premium.

- H.B. 216, which requires insurers to provide the names of pol-

icyholders and policy coverage information within 60 days of a written request from claimants. It also requires policyholders to disclose, within 30 days of written request, the names of all known insurers that might be liable for coverage upon a claim.

- H.B. 472, which allows corporations to purchase corporate-owned life insurance for directors, officers, employees and certain shareholders and obligors.

- H.B. 525, which repeals the July 1, 1989, sunset provision in Georgia law relating to the assessment of litigation costs and attorneys' fees for frivolous actions and defenses.

- S.B. 239, which establishes tort action for frivolous or abusive lawsuits: it is found that the

Continued on next page



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## Georgia reforms

ATLANTA—Six insurance related bills passed by the Georgia Legislature during the final days of its 1989 legislative session last month have been signed into law by Gov. Joe Frank Harris.

The six bills are:

- H.B. 176, which legalizes multiple employer trusts in Georgia.

The bill allows groups of small employers to band together under a multiple employer agreement to buy life, accident and sickness insurance as one large group for rating purposes.

- H.B. 178, which authorizes the commissioner of insurance to compile and distribute an annual report on the property/casualty insurance industry, both on a state level and nationwide, to General Assembly members beginning in July 1990.

The report will include an evaluation of any of the following lines of liability coverage deemed by the

## CED study

Continued from page 3  
insurance and workers compensation—and social insurance—including the Social Security Disability Income program—where the purpose is to compensate victims and not to deter future injuries.

- Limits on punitive damages.
- Elimination of joint and several liability.
- A uniform product liability statute.
- A bar against product liability lawsuits pertaining to those aspects of a product that comply with regulations in existence at the time the product was manufactured.
- Greater use of alternative dispute resolution.

Looking at how the tort liability system interacts with social and private insurance, the CED is recommending greater reliance on private insurance and social insurance than the tort system.

"Existing private and public insurance programs should be relied upon to cover injuries and diseases where occupational exposure is not the predominant cause," the report said.

And, workers compensation should be the sole source of remedy where occupation exposure is the predominant cause of injury, the group also maintains.

Superimposing tort liability for product-related workplace injuries is "costly and inefficient," according to the CED.

In addition, the CED has suggested that punitive damages be awarded only in cases of willful misconduct and should be limited to a "modest multiple" of the compensatory damages.

"Punitive awards are a significant component in the unpredictability of size and awarding of damages in tort liability cases," says the CED. "The potential for huge punitive awards encourages suits and distorts the settlement process."

Limiting punitive damage awards also will limit businesses' "exposure to unpredictable and potentially bankrupting punitive awards," the CED concluded.

The CED also advocates eliminating joint and several liability since "it tends to encourage the frivolous naming of deep-pocket defendants because they can be liable for the entire award even if only minimally responsible."

Under joint and several liability courts can assign costs arbitrarily, systematically imposing excessive cost on parties with assets or insurance and inadequately penalizing others, the CED says.

The CED says joint and several liability "encourages the unprincipled use of the liability system for the purpose of compensation."

The CED also wants Congress to enact a uniform product liability statute.

"The diversity of state standards causes costly and inefficient uncertainty" in the tort liability system, said the CED.

In addition, "the diversity of

**The CED hopes its recommendations will 'jump-start the debate over tort liability.'**

state standards encourages forum shopping by plaintiffs," the group argued.

Congress has considered several federal product liability reform bills, but none has been approved, the CED noted.

The United States already has federal standards for antitrust and other commercial laws and the "same logic argues for a federal product liability law," according to the organization.

The CED says that manufacturers should be able to shield themselves from retroactive product liability by arguing that their products adhered to all social, technological and regulatory standards at the time the product was produced.

"Liability imparted retroactively for unknowable risks cannot be a useful deterrent," the CED cautioned.

In the same vein, the CED argues that there should be more stringent limits on the amount of time that can lapse between an accident and the filing of a product liability lawsuit.

And, the CED argues that the courts should return to a fault-based system of assessing liability. This would include disallowing or modifying liability if a product was misused, altered or used in a way that the manufacturer explicitly warned against.

"These measures would provide all parties with incentives to take cost-justified care," according to the CED.

Finally, the CED advocates greater use of alternative dispute resolution mechanisms such as arbitration, mediation and mini-trials.

Arbitration is the submission of a dispute to one or more neutral persons for a final and binding decision.

Mediation is the submission of a

dispute to a third party for assistance in reaching a mutually acceptable solution.

A mini-trial is a voluntary, non-binding method of settling disputes whereby the parties conduct an abbreviated trial before a neutral third party, often a retired judge. By learning about their opposition's position, both parties are encouraged to make settlement offers.

"There is a need to better educate law students, judges, corporate management and general counsel on the benefits of ADR," the CED says.

The CED says it hopes its recommendations will "jump-start the debate over tort liability."

"If well-designed, our courts, regulatory agencies and social insurance programs can mesh well with each other and with market forces and can jointly control risk and compensate injury," says the CED.

"But if they remain poorly designed and uncoordinated, the potentially useful forces can generate wasteful distortions from which we all lose in the long run." ■

## Around the states

Continued from previous page  
plaintiff acted with malice and without substantial justification.

A sixth bill, S.B. 267, that would set up a Georgia High Risk Health Insurance Plan, still awaited the governor's signature.

—By Linda J. Collins

## Montana comp fund

HELENA, Mont.—A bill that would create a new mechanism to provide workers compensation insurance to Montana employers has been signed by Gov. Stan Stevens.

S.B. 428, sponsored by Sen. Gene Thayer, R-Great Falls, would create a new mechanism—the State Mutual Compensation Fund—to replace the State Compensation Fund, which is operating at a deficit.

The governor had expressed concern about the regulation of the State Compensation Fund because the Department of Labor managed the fund and regulated private workers comp insurers. He said this dual responsibility represented a conflict of interest.

In response, the bill calls for the new state work comp fund to be managed by a five-member board of directors, with each serving four-year terms. An executive director would be appointed by the governor.

Under the legislation, the new fund would assume the \$157.3 million deficit incurred by the former fund. However, a payroll tax aimed at eliminating the workers comp fund deficit was enacted in 1987 and the shortfall is expected to be erased by 1991. Since 1987, when Montana significantly reformed its workers comp system, the fund has been self-supporting.

The new insurance mechanism would attempt to avoid a deficit partly by encouraging employers to implement safety programs to reduce losses. The new fund would offer those employers that "have safer working environments more competitive rates," said a Montana Chamber of Commerce spokesman.

The new fund will begin writing coverage Jan. 1, 1990 and will be the "insurer of last resort," as was

the old fund, the spokesman said. Thus, it would be required to write all workers compensation risks rejected by the commercial market.

However, the bill contains a provision that allows the Montana commissioner of labor to form a workers comp assigned risk pool no later than six months after the fund begins writing coverage, the spokesman said. If a pool is formed, the state fund would have the authority to reject risks that would then be automatically accepted by the assigned risk pool.

—By Michael Bradford

## Insolvent HMO

TRENTON, N.J.—A 32,000-member health maintenance organization has been placed in receivership by a New Jersey judge.

Short Hills, N.J.-based Foundation Health Plan had \$11.1 million in liabilities and only about \$5.3 million in total assets as of Dec. 31, 1988, making it statutorily insolvent by \$5.6 million, the New Jersey Insurance Department said.

Superior Court Judge Harry A. Margolis named New Jersey Insurance Commissioner Kenneth D. Merin receiver. Mr. Merin has appointed Newton, Mass.-based Schuer Management Group Inc. as deputy receiver for the HMO's rehabilitation.

Foundation Health Plan—which operates in Essex, Hudson, Union, Bergen, Passaic, Morris, Middlesex and Somerset counties—is owned by Foundation Health Corp. of Sacramento, Calif.

The HMO's "current financial difficulties stem in part from either the inability or unwillingness of its parent to provide additional capital," said the statement.

However, a spokeswoman for the company said that "Foundation Health Corp.'s current strategy is to focus its resources on its California plan and its contract with CHAMPUS, which provides health care to military retirees and beneficiaries in California and Hawaii." Consequently, Foundation "will no longer be providing cash to out-of-state affiliates," she said.

—By Collin Nash

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# Insurer Topics

A special editorial section sent exclusively to insurers and reinsurers

## Brain power

### Expert systems combine human judgment, computer accuracy

By MARK A. HOFMANN

Cyborgs—hybrids of man and machine—have long been a staple of science fiction.

However, expert systems—real-life variations of this fantasy—rapidly are becoming denizens of insurance company underwriting departments.

Expert systems are computer programs that apply knowledge gleaned from human experts. These systems now can perform numerous underwriting functions—such as application approval and policy issuance. And, in many cases, expert systems perform more quickly and accurately than their flesh-and-blood counterparts, insurance automation authorities point out.

However, expert systems will never completely replace the human touch in underwriting, these observers note.

Expert systems are not the only example of how automation is changing underwriting (see story, page 36F). New data bases and improved communications networks have placed increasingly accurate and complete information at underwriters' fingertips.

Nevertheless, expert systems are getting the lion's share of the attention from insurers.

"Expert systems are here, they're real, they work," observed Tom Roberts, director of expert systems for Indianapolis-based Gateway Information Systems Inc., a unit of Swiss Reinsurance Co.

Mr. Roberts explained that expert systems blend human expertise and automated dependability to improve the underwriting process by maintaining consistent performance standards. "Expert systems don't have hangovers or bad days," he said.

In addition, expert systems can dramatically increase the speed with which policies can be underwritten.

For instance, Mutual Life Insurance Co. of New York's expert system has cut the time it takes to process some individual life insurance policies to three hours from three days.

In addition, Jim Carroll, an area director with Philadelphia-based CIGNA Bond Services says that expert systems provide an underwriting consistency because they examine all policy applications "without prejudice," unlike human underwriters.

The applications of expert systems to underwriting vary considerably between the life insurance and property/casualty insurance industries. However, expert systems technology seems to lend itself more readily to life insurance underwriting because of the number of variables involved in each property/casualty policy (see story, page 36D).

"Expert systems are still a speculative technology in property/casualty insurance," said James Stallard, vp-personal insurance administration for Woodland Hills, Calif.-based Transamerica Insurance Co.

"I think life is a lot simpler than property/casualty" insurance to use an expert system, said Mr. Stallard.

Property/casualty insurance can involve an enormously complex set of variables, he pointed out. For example, thousands of models of automobiles are currently being insured, with countless different classifications of drivers based on age, accident record and other variables, he said.

Even if an expert system meshes with an insurer's particular operations, designing an expert system is much different—and more difficult—than installing other types of automation systems.

Putting the "expert" into an expert system is a laborious process involving countless hours of interviews with seasoned underwriters, Gateway's Mr. Roberts said (see story, page 36E). Every hour spent interviewing an expert requires about 15 hours of additional work including transcription and review, he pointed out.

Lynn Edwards, product marketing manager-insurance at Syntelligence Inc., a Sunnyvale, Calif.-based vendor of expert systems, noted that her company had spent 200 man-years developing its expert system programming language and then the systems themselves for insurers and commercial banks. In addition, adding a client insurer's customized information—which accounts for 15% to 20% of the expert system—may take another six to 12 months to program, Ms. Edwards said.

Not all insurers agree with the approach of creating an expert system from a vendor-provided "shell" that is customized to meet the customer's needs.

Henry Rodrigues, vp of information systems for Continental Canada in Toronto, a unit of Continental Corp., said his company built its personal-lines expert system from scratch

because the insurer felt that a shell provided complexity that wasn't needed.

Mr. Rodrigues said that the system was designed to meet two goals: efficiency and quality control.

Brokers—the Canadian equivalent of independent agents—enter information through terminals in their office, which is transmitted to Continental Canada in Toronto. The expert system then examines policy information as well as the broker's business history to see, for example, how many times the broker has submitted exceptions to underwriting rules.

Mr. Rodrigues said that because brokers know that their submissions are being reviewed, they tend to adhere to Continental Canada's guidelines more readily, thus improving the quality of business being considered.

Mr. Rodrigues said that Continental Canada was able to create the system it wanted by doing its own work and using its own experts' expertise rather than adding that knowledge to a vendor's basic package. Using this approach, "you end up with economy and simplicity," he said.

No matter what approach is taken to creating the system—whether buying a "shell" system or developing the entire system on one's own—expert systems cannot totally replace human underwriters, for even the most sophisticated expert system remains incapable of carrying out all of an underwriter's functions, noted Gateway's Mr. Roberts.

Instead, expert systems serve "to take the mundane away from the underwriters," Mr. Roberts said. The systems speed up routine processing while freeing human underwriters to deal with the more challenging and difficult submissions, he added.

For the foreseeable future, which Mr. Roberts defined as the next 15 to 20 years, expert systems are extremely unlikely to achieve the flexibility of the human mind. Expert systems will be able to perform only relatively simple tasks and not solve complicated problems, he said.

Tackling problem applications will remain a task reserved for human underwriters because machines simply will not be able to bring in-depth knowledge to the process, Mr. Roberts said.

Stressing how expert systems improve the underwriter's lot by taking over repetitive chores is particularly important in winning underwriters' acceptance of the new technology, emphasize expert systems authorities.

David E. Hoffman, a partner with Chicago-based Andersen Consulting, a unit of Arthur Andersen & Co., said that underwriters may feel threatened by the introduction of an expert system (see story, page 36D).

One of the better ways to convince underwriters to accept the trend toward expert systems is to stress that in addition to freeing underwriters from boring tasks, expert systems will allow them to spend more time on the more intriguing aspects of their work, Mr. Hoffman said.

As an example, he explained that the time underwriters

spend on clerical work can be spent talking to agents because expert systems perform the clerical function. Such discussions can promote the development of new products. Mr. Hoffman said.

Gateway's Mr. Roberts noted that insurers attempting to introduce an expert system can appeal to the underwriter's ego by stressing that the underwriter is indeed an expert whose knowledge will achieve a kind of immortality when it is programmed into the system, he said.

Russell D. Suever, vp of Lincoln National Risk Management Inc., a Fort Wayne, Ind.-based unit of Lincoln National Corp. that markets an expert system for life insurance underwriting, explained that insurers might have to redefine the underwriter's job to make the most of expert systems.

Expert systems may eventually eliminate more than 50% of the cases life underwriters handle, he said. But insurers will not want to lose the investment they have made in training their underwriting staff, he said.

As a result, in addition to concentrating their efforts on challenging cases, underwriters will assume some marketing functions as well, Mr. Suever predicted. They will talk more with agents than they currently do and spend more of their time turning the information they've gathered into possible

*Continued on next page*



## Insurer topics

# Systems improve life insurers' productivity

By MARK A. HOFMANN

While some property/casualty insurers are using expert systems primarily as a quality assurance device, life insurers say the systems can be a key to greater underwriting productivity (see story, page 36E).

Both Mutual Life Insurance Co. of New York and Transamerica Occidental Life Insurance Co. are reporting faster turnaround in approving life insurance applications with the help of expert systems.



Mr. Howman

An expert underwriting system in use at the Syracuse, N.Y.-office of MONY has cut the underwriting process—during which an application is submitted, reviewed, approved and mailed—to as little as three hours from about three days previously, said Paul M. Howman, director of underwriting research at the New York-based

Mutual of New York Financial Services unit.

Increasing underwriting capacity without increasing the workforce was one of MONY's goals when it began looking for ways to improve its underwriting process in 1985.

Underwriters, field people and systems personnel met in a "joint application development session," which Mr. Howman said involved "basically locking the doors" until the participants identified what they wanted in the system.

Session participants decided they needed a new type of automated underwriting system because existing systems simply couldn't handle the demands that eventually would be made of them, he said.

Some life insurers had used automated, non-expert systems technology underwriting

**'Our people who do input should be able to input exactly what they saw on the application,' says Paul Howman of MONY, even if the information was misspelled or ungrammatical. In addition, a system should be able to issue policies without human intervention, he says.**

systems since the early 1980s, Mr. Howman said. But the systems, which depended on traditional computer languages such as COBOL, rather than natural language applications, could handle applications that were absolutely "clean"—with no questions left unanswered.

Since such policy applications accounted for only about 3% of MONY's business, creating that type of system would not have been worthwhile, he explained.

After further discussion and experimentation with a pilot system, MONY systems experts laid out the specifications for the expert system to vendors. The system would be a life underwriting system that could be fully integrated with the company's existing data bases, said Mr. Howman. It also had to be able to use natural language.

"Our people who do input should be able to input exactly what they saw on the application," he said, even if the information was misspelled or ungrammatical. In addition, the system would have to be able to issue policies without human intervention, Mr. Howman said.

MONY started to deploy the system, called "Comprehensive Life Underwriting Expert System," in August 1987 according to "a stringent but cautious timetable," Mr. Howman said. "It has been in full production since April 1988."

The system is now able to approve and issue, without involving individual underwriters, about 52% of the eligible applications submitted to MONY. Eligible applications are those that present no problems with the amount of coverage sought in relation to the age of the applicant, Mr. Howman said.

The system cost "several million dollars," he said, though he could not provide specific costs. Mr. Howman also could not put a specific figure on how much money the system has saved the insurer, particularly in regard to turnaround time.

"I can't put a dollar figure on this one as much as I'd love to," he said.

However, Mr. Howman did say that the system has had a great impact on its field force. Agents are motivated to sell more insurance, he said, because the system can handle more applications. The system also attracts agents who represent other insurers to MONY, he said.

At the same time, the size of the underwriting staff has remained stable, Mr. Howman said. During the changeover, underwriters were under great strain, he said, because MONY did not want to hire underwriters who would have to be laid off once the system was up. Overtime and the use of contract underwriters became necessary to handle the workload, he said.

Mr. Howman makes no attempt to hide the difficulty of putting such a system together.

The most difficult part of creating CLUES was "getting the systems to talk to each other and to use natural language," he said. These techniques are among "some of the highest proprietary information we have," he said.

Meanwhile, an expert system will save Los Angeles-based Transamerica Occidental Life Insurance Co. at least \$500,000 over the next five years due to improved processing and the system's ability to handle more business without adding more people, according to Bill Scott, vp of individual new business.

The goal established for the Transamerica Occidental Expert System was same-day turnaround for life insurance policies, said Mr. Scott.

Despite the doubts of some, who believed that the number of variables involved in underwriting life insurance would make the use of expert systems impractical, the insurer forged ahead with work on the expert system because "we thought there'd be cost benefits" in that area, Mr. Scott said.

"We did everything in-house," said Jerry Edelman, expert systems lead analyst. A critical step was building an initial working prototype, which took about a month, as well as constantly adding to the initial knowledge data base, he said.

Underwriters who were not involved in the development of TOES were initially leery of it. But, demonstrations of the system "pretty much diffused all concerns," Mr. Scott said.

The system was introduced as a pilot program last July and currently approves about 25% of the insurer's new business non-medical applications, he said. An additional 40% to 50% of those not approved by TOES can be approved "easily" by an underwriter, he added.

## Many factors comprise system success

By MARK A. HOFMANN

ORLANDO, Fla.—Implementing a life insurance underwriting expert system requires thorough planning and a firm commitment from management to see the project to completion, says a consultant.

At least a half-dozen key factors are involved in the successful im-

plementation of an expert system, says David E. Hoffman, a partner with Andersen Consulting in Chicago.

Mr. Hoffman described the critical factors during a panel discussion concerning expert systems at the recent Life Office Management Assn.'s triennial systems forum in Orlando, Fla.

An insurer wanting to introduce

a life underwriting expert system must begin with management commitment to the program. "This sounds like motherhood and apple pie," Mr. Hoffman said, adding that across-the-board commitment to an expert system is often difficult to achieve.

A key to achieving the necessary commitment is creating an executive steering committee of six to eight people who represent all of the disciplines that will be affected by the expert system. In addition to the underwriting and policyholder service departments, marketing and data processing officials should be represented, he said.

The mere creation of such a committee "raises the visibility of the project," he said. Even though the committee might need to gather for only three or four formal meetings during the installation of the expert system, the committee's support for the system is critical "so they can neutralize from the top any problems that might affect lower levels," said Mr. Hoffman.

A second necessary factor is to clearly define the goals the system is expected to meet, according to Mr. Hoffman. How much the system will do and how much it can realistically deliver must be determined.

Another factor in successful implementation is cost-benefit analysis, Mr. Hoffman said.

In addition, once officials determine that the expert system's benefits justify the costs of creating it, they must institute a method for tracking the system's results, he said.

The third, and sometimes least understood, factor is managing management's expectations of the system, Mr. Hoffman said.

Expert system supporters must make sure that upper management doesn't expect the new device to do

**Sometimes, managers have visions of saving money by slashing underwriting staffs because they don't realize that the expert system is a tool for underwriters, not a replacement for them, David Hoffman says.**

things it can't, Mr. Hoffman cautioned.

Sometimes, managers have visions of saving money by slashing underwriting staffs because they don't realize that the expert system is a tool for underwriters, not a replacement for them, he said.

One way to keep management expectations realistic is to set up a "model office," Mr. Hoffman said. This small-scale replica of the expert system might be programmed with 10 sample policies that could be altered to demonstrate different scenarios, he said.

This preview would allow managers to see what the system could do before the system was functioning and integrated into the insurer's other automated systems, he said.

Mr. Hoffman stressed that putting together a model is worth the effort because more abstract forms of demonstrating what the system does simply aren't as effective. "It's very difficult to try to explain this on paper," he said.

Managing changes in the organization that an expert system will invariably produce is another factor. Installing an expert system may mean that some portions of the company might have to be restructured, said Mr. Hoffman. This could mean changes in job responsibilities or staffing changes in particular departments, he pointed out.

He noted that there is a tendency for the rumor mill to begin churn-

ing out misinformation about the system's impact on jobs. Employees may wrongly believe that the expert system will replace their positions rather than enhance them. Supporters of the system "need to be up-front and open about what they're doing," he said.

One of the key facets of managing change is to make sure that underwriters accept rather than resist the installation of the expert system, Mr. Hoffman said. He suggested that a respected senior underwriter be involved in the implementation process as early as possible. This underwriter would function as a "champion" of the system who would explain to other underwriters how the system will make their lives easier, he said.

Other people who could promote acceptance of the expert system include marketing and policyholder service managers. "It's in their best interest to expedite the underwriting process," Mr. Hoffman said.

Mr. Hoffman also advocated an incremental approach to installing the system as a key factor in promoting its success.

"You need to show management some victories along the way," he said.

Managers who have committed large sums of money to the system need to see that progress is being made, he said. If they do not see periodic victories, they may be tempted to discontinue the program, he said.

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# Knowledge fuels expert systems

By MARK A. HOFMANN

FORT WAYNE, Ind.—Putting the expert into an expert system is no easy task; not only is the process painstaking, but the experts may feel their job security is threatened by the process.

The very term "knowledge engineering" means different things to different people, says Dr. Arthur W. DeTore, a physician who serves as vp and knowledge engineer for Fort Wayne, Ind.-based Lincoln National Risk Management Inc.

Lincoln National, an affiliate of Lincoln National Corp., markets the Lincoln National Life Underwriting System, an expert system marketed to life insurance companies.

To some people, "knowledge engineering" refers to any task connected with the creation of an expert system, be it interviewing experts, programming the system or designing the questions posed to the experts, Dr. DeTore said.

But to Dr. DeTore, knowledge engineering involves structuring the experts' knowledge into a form to be programmed.

Putting together an expert system requires three steps: acquiring knowledge from the expert, modeling it so it can be programmed and programming it, according to Dr. DeTore.

"To be 'knowledge-engineered' is an intense process," Dr. DeTore said of obtaining the knowledge from the experts.

To extract the most information from the experts, knowledge engineers have developed several approaches, he said. Some use methods that involve having the expert interact with a computer through a question-and-answer format.

Dr. DeTore, however, prefers using a two-step process that combines unstructured interviews and a technique known as protocol analysis, during which the expert thinks out loud as he or she describes how a problem is solved.

During the unstructured interview, the knowledge engineer sits down with the expert and chats about problem solving, Dr. DeTore explained.

In the second step—protocol analysis—the expert orally describes his or her problem-solving process for a certain task, Dr. DeTore said. Protocol analysis is sometimes recorded on audiocassettes, he said.

Despite the technical aspects of the process, the key to creating expert systems remains extracting the knowledge from the expert.

"In expert systems, which some people call knowledge-based systems, the knowledge is more important than the

system," said Dr. DeTore.

For example, the knowledge required for a life insurance underwriting expert system is extremely detailed. The concepts involved may be very difficult for the medical professional, underwriter or actuary being interviewed to explain to a layman, Dr. DeTore pointed out.

Thus, it is important to have a qualified interviewer that understands the expert's area of expertise, he said.

Lincoln National Risk Management uses physicians to carry out the interviews for its life underwriting expert systems, Dr. DeTore explained. Doing so helps quality control, he said: A medical expert would have a much better chance of catching another medical expert in an obvious mistake than would a computer expert.

But professional expertise alone cannot guarantee successful interviews. Knowledge engineers must win the trust of their subjects as well. "If you don't have the cooperation of the expert, you might as well forget it," said Dr. DeTore.

Underwriters and other experts often feel that they may be threatening their own job security by revealing how they make decisions.

To overcome such fears, Dr. DeTore emphasizes to the underwriting experts that the system is intended to help them carry out their jobs, not to throw them out into the street, he said. "The underwriter has the final say" in whether to accept or reject a risk, he said.

In addition, Dr. DeTore said his company always relies on several experts in order to cull a range of knowledge.

Even with the psychological safeguards, gathering the knowledge needed in an expert system is a grueling process for the person being interviewed. Dr. DeTore suggests limiting interviewing to one hour per day, depending on what type of information is being sought.

For example, Dr. DeTore might need to interview an individual for only a couple of hours to get that person's knowledge needed to create an expert system on scuba diving, while extracting knowledge from an expert underwriter could require weeks of interviews, he said.

The amount of time the expert must spend being interviewed mandates a firm management commitment to the project as well as the cooperation of the individual whose knowledge is being sought, Dr. DeTore said. "You have to get management to buy in to give you this person's time," he said.

# Surety bond underwriters receive help

By MARK A. HOFMANN

PHILADELPHIA—The desire to improve underwriting quality led Philadelphia-based CIGNA Bond Services to create an expert system called "Surety Aide" to help surety bond underwriters make decisions.

"It's not the decision-maker. It's an adjunct to the human underwriter," stressed Jim Carroll, an area director with the bond services unit of CIGNA Corp.

"The value of the system is that it provides a consistency in the underwriting process," he added.

Mr. Carroll said that the creation of Surety Aide was part of a broader strategy emphasizing surety underwriting discipline rather than an attempt to speed up the underwriting process.

When the system was finished in early 1988, it first was used to examine the insurer's entire book of surety bond business to assure that corporate underwriting guidelines were being met, he explained.

Building the expert system came in response to the big losses suffered by surety companies in the 1980s.

Mr. Carroll said that gathering the expertise for Surety Aide took about a year. Analysts from CIGNA's Systems Division interviewed and watched surety underwriters at work.

"I think some people felt like they were being interrogated in court," Mr. Carroll said. "It's a very taxing process."

It's also an ongoing process, Mr. Carroll said. "The system is an evolving system," he said. Because of this, systems experts are assigned to constantly update information contained in Surety Aide's data base.

All of the programming for the system was completed in-house. CIGNA declined to reveal the cost of the system.

Continued on page 36F

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BI

## Insurer topics

### Surety bond system

Continued from previous page

Mr. Carroll said that he was surprised to watch how knowledgeable engineers broke down what appeared to be basically intuitive processes into a form of knowledge that could be programmed into the expert system. The system itself attempts to follow those intuitive processes, he noted.

Like a human, it can "jump" from factor to factor without following a set path, he said.

What Surety Aide cannot do is make judgments about non-financial factors involved in underwriting surety bonds, Mr. Carroll said. "All non-financial parts of the equation are beyond the scope of the system," he said.

The system uses the contractor's financial statements for the three most recent years and a schedule of jobs

currently under way to generate a financial analysis of four factors: a contractor's net worth, working capital, profit history and forecast of future profitability.

Non-financial considerations like a contractor's geographic location and its technical qualifications are left for the human underwriter to weigh in making the decision to accept or reject the business.

"It takes into consideration each element as it fits into the whole picture" just as an experienced underwriter would, Mr. Carroll said.

If the system finds something in its analysis questionable, it flashes the question onto a computer terminal for the human underwriter to pursue.

The underwriter and Surety Aide examine a risk si-

multaneously, Mr. Carroll said. "It's a very interactive system," almost like a discussion between humans, he said.

At the end of its examination of a risk, Surety Aide prints out an underwriting summary, Mr. Carroll said. However, it does not decide which accounts should be underwritten, he stressed.

"The system looks at all cases equally, without prejudice," said Mr. Carroll. This consistency is particularly important when first reviewing what might seem to be among the best pieces of business submitted to the bond underwriters, he said. Underwriters sometimes don't give an application sufficient scrutiny if it has the earmarks of a good risk, he noted.

By subjecting all submissions to the same type of examination, Surety Aide can catch potential problems that might otherwise have gone unnoticed, he said.

Some underwriters initially

were skeptical about claims that Surety Aide could improve how they dealt with surety submissions, he said.

"There are some people who never believe a machine can do anything as well as a person," Mr. Carroll said. But over time, most underwriters have concluded that the system is a valuable tool, he said.

CIGNA probably will expand the system, which currently is operating only in the bond service's main Philadelphia office, to the division's 12 branch offices during the next few years, he said.

Mr. Carroll said that he has no way to quantify how much money Surety Aide has saved his division. "We are convinced that, over time, the system becomes very valuable in terms of loss avoidance," he said. ■

**What Surety Aide cannot do is make judgments about non-financial factors involved in underwriting surety bonds, says Jim Carroll of CIGNA Corp. 'All non-financial parts of the equation are beyond the scope of the system.'**

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**INSURER TOPICS**

## Some companies favor PC systems over mainframes

By MARK A. HOFMANN

One of the most common pieces of electronic data processing equipment—the humble and ubiquitous personal computer—is helping to streamline the insurance underwriting process.

For example, New York-based American International Group Inc.'s recent switch to a nationwide PC-based system for its workers compensation policy processing has improved both efficiency and communications.

Meanwhile, a small California insurance company has found that a PC-based system can provide not only underwriting information, but also can track policies throughout the underwriting process and perform other office functions for only a fraction of the cost of a mainframe computer.

The impetus for AIG's switchover came during the rewriting of the software for the workers comp system, said Paul Rauen, management information systems officer from AIG's domestic general brokerage group in New York.

The company had found that its mainframe system was difficult for underwriters to use and operated too slowly, he said.

AIG data processing officials chose the PC route after considering two other options: modifications to the mainframe system and establishing regional microcomputer systems.

"We felt the (PC) system would be a lot easier to use and a lot more accessible to non-technicians," Mr. Rauen said.

Mr. Rauen also noted that because much of the workers comp policy processing did not require constant access to the insurer's mainframe computers, AIG could realize "a lot of efficiencies" by transferring the work in progress to PCs. In fact, the mainframe might be needed only three or four times during the several weeks it takes to process a workers compensation policy, he said.

The PC network's electronic mail system also has improved communications by eliminating "some of the telephone tag," Mr. Rauen pointed out.

Much of the business conducted by phone really didn't require oral contact and could be done just as effectively through the system, he said. Now, messages can be left in electronic mailboxes overnight for underwriters' attention first thing in the morning, he said.

"We're finding our communication is enhanced; it's allowing us to manage communications much better," Mr. Rauen said.

While AIG has not yet calculated how much savings the system has produced, Mr. Rauen said "it's enabling us to process our business faster," which cannot help but improve cash flow.

Overall, "We feel it will improve the quality of information in the area of workers compensation policies," said Mr. Rauen, adding that AIG already has received some "nibbles" from other insurers about licensing the work comp system as a means of enhancing their operations.

AIG's workers compensation network PCs operate on software developed for the insurer by East Malvern, Pa.-based Rabbit Software Corp.

On the other side of the country, a start-up operation chose a personal computer-based system developed by Microrim of Redmond, Wash., over a mainframe system for economic reasons.

For Superior National Insurance Co., a Woodland Hills, Calif.-based regional property/casualty insurer that began operations under its current management in 1985, a personal computer-based network could be put together for a fraction of the cost of its mainframe-based counterpart, said Linda Nelson, a consultant for Microrim who has been working with the insurer for about a year.

The insurance industry in general presents a "situation where you have a growing, growing amount of data," Ms. Nelson explained.

Most large insurers rely on a system of mainframe computers to sort through the billions of bits of electronic information they need to survive.

But for a start-up company like Superior National, a network of personal computers seemed to make more economic sense, she said.

The R:BASE system, which was installed about four years ago with five work stations and an initial investment of about \$100,000, has since expanded to about 200 PCs at several locations.

Although she could not quantify Superior National's savings by operating a PC-based system rather than a mainframe system, Ms. Nelson did say: "We've literally been able to save millions."

One of the beauties of the PC approach is the timeliness of the information it provides, she said.

Data—including historic claims, current claims, regulatory changes, billing status, general policy information and legal information—"is constantly being updated," Ms. Nelson said.

In addition, the system enhances Superior National's policy management efforts because it is easy to track the status of a policy in the system, she said.

Another virtue of the personal computer approach, which Ms. Nelson claims is "unique," is the ease with which people can be trained to use it. More people are familiar with PCs than mainframes, she explained.

She added that she thinks the PC system has fewer technical problems than a comparable mainframe system would develop.

For example, the personal computer system doesn't require the same temperature-controlled and dust-free environment to function as a mainframe system does, she said.

# Auto claim data base offers insurers clues

Enhanced data bases are improving the quality of information available to some insurers.

One example is the Comprehensive Loss Underwriting Exchange—or C.L.U.E.—an information service introduced by Atlanta-based Equifax Inc. in late 1987.

C.L.U.E. allows insurer subscribers to access a prospective automobile insurance policyholder's claims history from a pool of information culled from other insurers.

More than 200 property/casualty insurance companies generating about 42% of the nation's personal automobile direct written premiums currently feed claims information into the system, explained Joe Cash, Equifax's vp for the property/casualty industry.

Equifax hopes that percentage will climb to 60% by year-end, he added.

Creation of C.L.U.E. was "driven by big demand" revealed in a 1985 survey of insurance company executives conducted by Equifax that found most insurers considered state motor vehicle records inadequate for automobile insurance underwriting decisions, Mr. Cash explained.

And, in many cases, the accuracy of claims information on an application for automobile insurance records was "dependent on the honesty of the applicant and agent," he added.

Jack Sullivan, vp-personal lines underwriting for the Holmdel, N.J.-based property/casualty subsidiaries of Prudential Life Insurance Co. of America, agreed that the data available from state motor vehicle departments is often incomplete. Prudential is a participating insurer in C.L.U.E.

For example, not all accidents are reported to state authorities by local police, Mr. Sullivan said.

At the same time, consumers have demanded a more personalized approach to automobile insurance, Mr. Sullivan said. They feel their insurance rates should reflect their own driving record rather than traditional determinants such as whether they live in an urban or rural area, he said.

This was one of the arguments put forth in California's controversial Proposition 103 (BI, Nov. 14, 1988).

In addition, consumer groups in other states are seeking similar emphasis on individual driving records, rather than geographic rating, in determining personal automobile insurance rates (see related story, page 1).

In response, Equifax put together an advisory group consisting of some of its customers' senior underwriting executives to discuss starting a system that would fill the gaps in automobile claims information, Mr. Cash said.

"This is the first time the insurance industry has banded together to design a data base for all to share," Mr. Cash said. Although he declined to say how much the system cost to develop, Mr. Cash did say that he thought the expense of creating C.L.U.E. would probably deter would-be competitors.

He added that the system's first full year of operation—1988—was "disappointing" because companies had a difficult time adapting to C.L.U.E.

Although he would not disclose how many inquiries the system currently handles per day, he said that use of C.L.U.E. has been growing "steadily" during the past few months.

Companies that subscribe to the system provide at least three years'

worth of historical automobile claims data, Mr. Cash said. Each month, another computer tape containing new and open claims is added to C.L.U.E., increasing its data base. Insurers pay about \$2 per search, Mr. Cash noted.

Prudential's Mr. Sullivan said that his company has found access to the data base to be a money saver. In terms of risks avoided as well as the additional charges that have been levied for some drivers as a result of C.L.U.E.'s information, Prudential has saved between \$3 and \$4 for every \$1 paid for the service, he said.

—By Mark A. Hofmann

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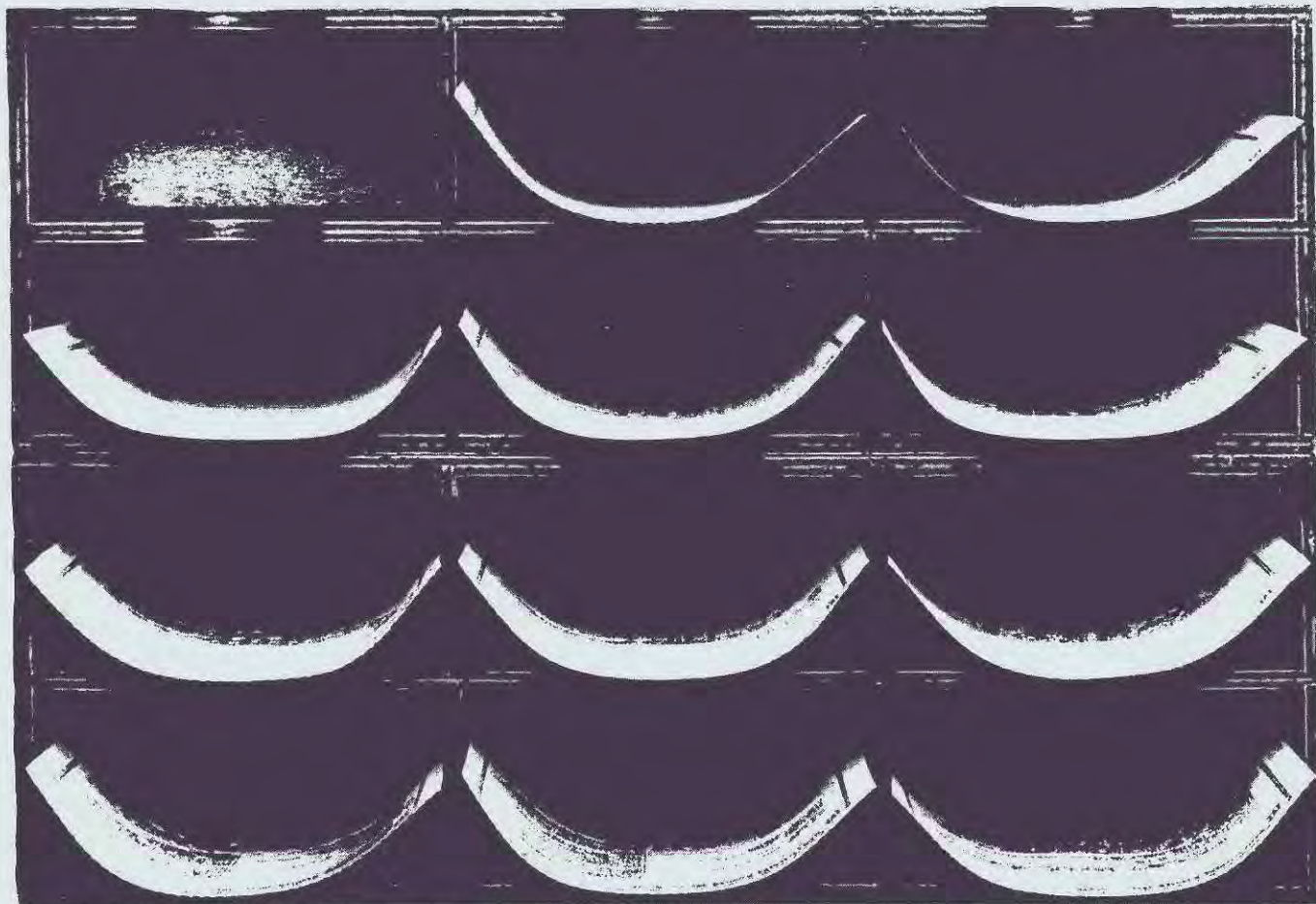
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## Insurer topics

# Regulation hikes auto premiums: S. Carolina study

Too much regulation rather than too little is one of the reasons for the relatively high cost of automobile insurance in South Carolina, according to a recent study.

South Carolina's recent six-month freeze on automobile insurance rates is "reminiscent of (if not inspired by) the approval of a large rate rollback approved by California voters last November," say the study's authors, Scott E. Harrington and S. Travis Pritchett, both insurance professors at the University of South Carolina in Columbia.

However, the authors report, the type of rate regulation that was imposed by California's Proposition 103, "while novel in California, typifies the approach used by South Carolina policy makers to deal with the auto insurance affordability problem during the past two decades."

The result has been that "the current regulatory system forces low-risk drivers to pay higher premiums so that high-risk drivers can pay lower premiums," say the authors in "Automobile Insurance Reform in South Carolina," a 22-page study released by the South Carolina Policy Council. The council is a Columbia-based, non-profit, non-partisan research and education organization.

Although South Carolina's 1987 average total premium per policyholder vehicle of \$506 was slightly below the 1987 national average of \$520, "the affordability problem in South Carolina is much worse than is implied by its ranking," according to the authors.

For example, the state's per capita income is among the 10 lowest in the nation and the average auto premium grew by 50% during the 1982-86 period, the sixth highest rate of increase in the country, they note.

Rather than focusing on rate regulation, legislators should seek to implement policies that will reduce the magnitude and rate of growth in claims costs, write Messrs. Harrington and Pritchett.

"In particular, it is doubtful that the current tort liability and insurance system for auto accidents provides benefits to consumers that are worth the premiums necessary to finance the system.

"An elective no-fault system, or a mandatory no-fault system with modest personal injury protection

benefits and a strong threshold for recovering non-economic damages, should be adopted to provide a more efficient payment system for injuries at a significantly lower cost than the present system of unlimited tort liability," the authors say.

Messrs. Harrington and Pritchett also praise Gov. Carroll Campbell's recent call for limiting tort recovery for non-economic damages. They also support the governor's proposal to increase the number of rating classes for automobile coverage.

Copies of "Automobile Insurance Reform in South Carolina" cost \$5 and are available by writing the South Carolina Policy Council, 1518 Washington St., Columbia, S.C. 29201.

**The 'system forces low-risk drivers to pay higher premiums so that high-risk drivers can pay lower premiums,' say the authors.**

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**Business  
Insurance**

## Howden trial

Continued from page 7

The cover note "shows the way documents appear to be reinsurance contracts (while) Mr. Grob and the others were creating a confetti trail of what was really going on," he said.

The prosecutor also told the jury that documents maintained at Howden concerning these reinsurance contracts were not always reliable.

"Records of the group were not very good," he said. "There were gaps in them. . . and a number of documents of which the Crown says would be doubtful as to the authenticity of their dates. Some documents are backdated. . . (and) there is reason to believe that the documents may not have been made" at the time they were said to have been made, Mr. Hill said.

Meanwhile, Alexander & Alexander Services Inc.—which acquired Howden in January 1982—was told about the Sphere Drake shortfall in February 1982, said Mr. Hill. As a result, A&A ordered its auditors, Deloitte Haskins & Sells, led by Tony Shearer, to examine Howden's underwriting subsidiaries, the prosecutor told the jury.

"Solving Sphere Drake's problems leads to the reinsurance placed with SIR," said Mr. Hill. When Mr. Shearer asked Mr. Grob about the SIR cover note from the Sphere Drake treaty, Mr. Grob said he knew nothing about it, said Mr. Hill.

During his three-day opening statement, Mr. Hill also detailed the alleged flow of reinsurance premiums from Sphere Drake, Howden subsidiary Capital Marine Insurance Co. Ltd. of Bermuda, and Mr. Posgate's syndicates into the defendants' own holdings.

For example, Mr. Hill said in 1978 and 1979 premiums totaling nearly 2 million pounds (\$3.3 million at current exchange rate), \$5.1 million and \$31,975 Canadian were brokered by Alexander Howden Insurance Brokers Ltd. for Sphere Drake, Capital Marine and Posgate syndicates. From that amount, he said, the four Howden executives—Messrs. Grob, Carpenter, Comery and Page—moved:

- About \$2.5 million into Panamanian companies controlled by the four, although Mr. Hill did not say which ones. This money eventually was used to help finance the acquisition of the Banque du Rhone.

- \$1 million to Panamanian trusts owned by the four, namely Gambit Holdings S.A. for Mr. Grob; Holagio Holdings S.A. for Mr. Comery; Armida Holdings S.A. for Mr. Carpenter; and Pirana Holdings S.A. for Mr. Page. This money was used to help capitalize SIR, Mr. Hill said.

- More than 1.3 million pounds (\$2.2 million at current exchange rate) to Liechtenstein corporation Southern Reinsurance A.G., which was owned equally by the four former executives. These funds eventually were transferred to SIR.

Also, other premiums that were supposed to be transferred to the Banque du Rhone account of SNA Re (Bermuda) Ltd.—an insurer that was 20% owned by Mr. Grob—were in fact transferred to the bank account of SNA Re Captive, which was controlled by the executives, or their Panamanian companies to either purchase the Banque du Rhone or help capitalize SIR, he alleged.

"The Crown's case is that the four engaged themselves in considered plans to misappropriate the moneys from the Howden group and Posgate syndicates," said Mr. Hill. These actions were "not paying Peter to pay Paul, but paying Peter to pay Peter," he said. "It was misappropriation and misuse being done for their use and their purposes."

Much of the reinsurance premiums that eventually landed in the secret companies came from Mr. Posgate's syndicates either as direct reinsurance or as retrocessions from Sphere Drake and Capital Marine, according to Mr. Hill, who added that Mr. Posgate has claimed that he knew nothing about the transfer of money to the secret companies.

But, Mr. Hill says that as a member of Howden's board of directors, Mr. Posgate "would have direct access to information of these companies if he'd asked." Also, if the secret operations were so dependent on Mr. Posgate's reinsurance, then the four former Howden executives would have been worried about what an "uninformed" Mr. Posgate might have done to hurt the scheme, said Mr. Hill.

Besides, Mr. Posgate was given a 10% share in a secret syndicate that bought the 51% stake in the Banque du Rhone and that was scheduled to buy the remaining

49%, said Mr. Hill, describing this arrangement as the "golden handcuff" to keep Mr. Posgate a part of the conspiracy.

During the proceedings last week, Mr. Hill said that when A&A raided Howden's offices on Billiter Street in 1982, it found in Mr. Page's office commission schedules from an SIR bank account and other documents that show some of the "black box payments."

The term "black box" came from Mr. Grob when he was asked by A&A to explain the payments, Mr. Hill explained. Mr. Grob said Howden used SIR and its predecessor, Southern Reinsurance A.G. in Liechtenstein, as a way of making "black box payments" to Howden executives at a time when Britain's Inland Revenue charged phenomenally high taxes on salaries, said Mr. Hill.

The payments uncovered by A&A included:

- 40,000 pounds (\$66,400 at current exchange rate) paid in 1980 on

a stop-loss policy to Mr. Grob and others.

- 12,000 pounds (\$19,920) paid to Mr. Page's assistant, Sydney Todd, as an "insurance claim."

- 5,000 pounds (\$8,300) paid to Mr. Grob's son and daughter-in-law.

- 30,105 pounds (\$49,974) paid in cash in 1981 to Mr. Posgate in Geneva.

According to the prosecutor, among other things found at the Billiter Street offices was evidence that \$2,000 was paid to help buy a house in London for Mr. Posgate and a woman named Laura Davies, and evidence of payments for works of art acquired by Messrs. Grob, Comery, Carpenter and Posgate, Mr. Hill said.

In addition, a series of payments were made from the SNA Re Captive accounts or SIR, including money to fund the creation of U.K. insurer Western Financial Services and its subsidiary Western Financial Resources. Of those funds,

about 165,000 pounds (\$273,900) were transferred from Western into the four Panamanian trusts to help purchase the Banque du Rhone.

Western also paid 73,500 pounds (\$122,010) to purchase a house for Mr. Carpenter's son, said Mr. Hill, and other money went to buy shares in a company called L. Texas Petroleum.

Among the witnesses called by the prosecution last week was Allan Veale, Howden's company secretary since 1986, who confirmed titles of the defendants and other Howden executives, and Charles Gordon Seymour, former general manager of Alexander Howden Group (Bermuda) Ltd.

Among the witnesses expected to be called during the next few weeks are former Lloyd's member Mario Benbassat, chairman of the Banque du Rhone; Lloyd's underwriter Stephen Merrett, as an expert witness; Mr. Dean of Sphere Drake; and Mr. Shearer of Deloitte Haskins.

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## Centaur

Continued from page 3

If the liquidation is approved, policyholders can turn to the guaranty funds in any of the 42 states in which Centaur was licensed. Centaur also wrote on a non-admitted basis in Arizona, Kansas and Vermont.

Under the proposed liquidation plan, Centaur policyholders will have two years to file claims against the insurer's estate with the guaranty fund.

Only after direct policyholder claims are fully satisfied will any remaining assets of Centaur be used to pay reinsurance claims.

Centaur assumed reinsurance from some 22 insurers, including the insolvent Mission Insurance Co. Mission is Centaur's largest creditor of Centaur and is owed some \$89 million, according to the Illinois Insurance Department spokesman.

As a result, California Insurance

**The department plans to investigate if Borg-Warner should play a role in the liquidation, says a department spokesman. 'To the extent Borg-Warner—or any other entity—injured Centaur, (the liquidator) will seek remedy.'**

Commissioner Roxani Gillespie, in her role as Mission's liquidator, is suing Borg-Warner to recover losses owed by Centaur to Mission. (BI, July 17, 1988). In her suit, Ms. Gillespie alleges that Borg-Warner "dominated and controlled" Centaur and therefore should be held liable for its debts.

The suit, which attempts to pierce the corporate veil separating Borg-Warner from Centaur, claims Centaur is \$14.2 million behind on its payments to Mission for known losses and could owe Mission an additional \$66 million.

Ms. Gillespie's lawsuit is pro-

ceeding in state court in Los Angeles.

Similarly, two suits were filed in U.S. District Court in Chicago against Borg Warner by six other insurers that ceded business to Centaur in an attempt to recoup losses owed by Centaur (BI, March 14, 1988). However, both of those suits were dismissed on the grounds that they were premature.

In addition, the federal court said it would not rule on one of the suits in deference to the state court rehabilitation proceedings.

That suit had been filed by four Hartford Insurance Group units—

Hartford Casualty Insurance Co., Twin City Fire Insurance Co., Nutmeg Insurance Co. and Pacific Insurance Co. Ltd. of Hawaii—which alleged they were owed at least \$4.5 million in known losses and at least \$15 million in unreported losses from Centaur.

The Hartford units ceded business to Centaur from 1981 to 1984 through reinsurance broker G.L. Hodscr. & Son Inc., a unit of Corroon & Black Corp.

Separately, Central National Insurance Co. of Omaha, Neb., and subsidiary Protective National Insurance Co.—both units of Professional Underwriters Investment Inc.—had sued Borg-Warner in February 1988 in the same federal court in Chicago. That suit also was dismissed.

Central National alleged Centaur owed it more than \$640,000 in paid losses and an estimated \$4 million in unreported future losses, while Protective National alleged it was owed more than \$7 million in paid

losses and an additional \$5 million in future losses.

Central National ceded property, casualty, ocean marine and other risks to Centaur between 1983 and 1984 under a quota-share reinsurance agreement managed by Cravens Re Treaty Facilities Inc. of San Francisco.

Protective National ceded property, casualty and workers compensation risks to Centaur under three quota-share reinsurance agreements between 1982 and 1984.

The business was produced for Protective National by Global Surplus Lines Insurance Services Inc., a managing general agency subsidiary of Frank B. Hall & Co. Inc.

Protective National's inability to collect on reinsurance covering the Global Surplus programs forced it to place itself under the supervision of the Nebraska Insurance Department in 1986 (BI, June 2, 1986; May 26, 1986).

Earlier this month, Hartford filed a motion with the federal court for reconsideration of its suit, citing the petition for liquidation as evidence that there is not enough money to pay ceding companies.

Furthermore, Hartford has an affidavit from the Illinois Insurance Department acknowledging that after offsets Centaur would still owe Hartford "substantial sums of money," according to Hartford attorney James I. Rubin of Butler, Rubin, Newcomer, Saltarelli & Boyd in Chicago.

Central National and Protective National were expected to file a motion for reconsideration late last week, according to their attorney, Hugh McCombs of Mayer, Brown & Platt in Chicago.

The Illinois Insurance Department also plans to investigate what role, if any, Borg-Warner should play in the liquidation of Centaur, according to the department spokesman.

"To the extent Borg-Warner—or any other entity—injured Centaur, (the liquidator) will seek remedy," said the spokesman.

According to the spokesman, for Borg-Warner to be held liable for Centaur's debts the company must have not only dominated and controlled Centaur to such an extent that they were virtually the same company, but Borg-Warner also must have injured Centaur.

"Just because Borg-Warner owned Centaur doesn't make it liable," the spokesman explained.

In addition, the Insurance Department will look to other sources of funds for Centaur.

For example, the Illinois Insurance Department currently is negotiating with several alien reinsurers to which Centaur ceded business to recover paid losses that had been thought to be unrecoverable.

Separately, Centaur has sued three liability insurers to recover part of the roughly \$20 million it lost as a result of alleged embezzlement by former employees of Atlantic & Gulf Insurance Agency Inc., a managing general agency wholly owned by Centaur (BI, May 6, 1985).

The Insurance Department is attempting to determine the definitive amount that Centaur is owed so that it can negotiate a settlement with those insurers: Hartford Insurance Co. of Illinois, Hartford Accident & Indemnity Co. and Continental Insurance Co.

Hartford Insurance Co. wrote a comprehensive dishonesty, disappearance and destruction policy with a \$10 million aggregate limit covering Borg-Warner and its subsidiaries, while Hartford Accident & Indemnity wrote a separate blanket bond covering Centaur.

Continental also wrote a comprehensive dishonesty, disappearance and destruction policy with a \$250,000 limit covering Atlantic & Gulf.

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## Broker results

Continued from page 3

(rate) declines on renewals, and this is the third series of price decreases," noted Frank R. Wiczynski, corporate secretary of Alexander & Alexander Services Inc. in Baltimore.

"We don't see any signs, unfortunately, of any bottoming or abatement, which leaves us in the difficult position of trying to produce more business to replace non-renewals. It's very, very tough out there," Mr. Wiczynski stressed.

"This is going to be a real tough year for brokers," predicted Ira H. Malis, securities analyst with Alex. Brown & Sons Inc. in Baltimore.

"Just to stay even in a rating environment that is down by 15% to 20%. . . is pretty good," agreed Michael J. Cloherty, vp of finance for Arthur J. Gallagher & Co. in Rolling Meadows, Ill.

Any revenue gains "were due to flat to slightly higher contingency commissions and dramatically higher short-term interest rates, which were 250 to 300 basis points higher in the first quarter than they were a year ago," Mr. Rosencrants said.

"But, on the negative side, intense price competition continued to take a heavy toll and expenses were up in the quarter; therefore, there was continued erosion of profit margins," he added.

In fact, while most brokers reported slight revenue gains, only Richmond, Va.-based Hilb, Rogal & Hamilton Co. reported a net income gain in the quarter.

And revenues from 18 companies acquired by HRH in 1988 and two in the first quarter of 1989—all but three of which were purchases—distort any year-to-year comparison of that broker's earnings.

Gross revenues of M&M, the world's largest insurance broker, grew 4.6% in the quarter to \$622.7 million from \$595.3 million in the first quarter of 1988. However, first-quarter revenues from M&M's brokerage operations fell 1.8% to \$378.5 million from \$385.3 million in 1988.

M&M's first-quarter net income dropped 6.2% to \$88.3 million from \$94.1 million in 1988.

Property/casualty rate reductions "essentially chewed up our new business (revenues), which was running at 13% to 15%" of total revenues, Mr. Bischoff explained. However, M&M was able to curb its non-renewals to a "historic" low of 4% to 5% from the 6% to 10% levels it had been averaging throughout 1988, he added.

As in 1988, M&M's consulting operations continued to bolster its revenues. It reported 22.4% growth in consulting revenues to \$178 million in the first quarter of 1989 from \$145.4 million in 1988. In the first quarter of 1988, M&M's consulting revenues grew 44.4% from \$100.7 million in the first quarter of 1987, though more than half of the 1988 revenue growth was due to acquisitions.

Mr. Bischoff explained that about 85% of M&M's consulting revenues are generated by William M. Mercer Meidinger Hansen Inc., the world's largest employee benefits consultant, which "has been in a very strong growth mode."

The broker's "consulting business is chugging along just as rapidly as it ever has been and will continue to do so" as long as Congress continues to pass benefits legislation, Shearson's Mr. Smith predicted.

M&M also was pleased with the growth of its Putnam Inc. investment management subsidiary, which reported a 2.5% increase in revenues to \$66.2 million from \$64.6 million in the first quarter of 1988, Mr. Bischoff noted.

M&M's "benefits operations are doing well, and while Putnam's business is not growing that much,

**'We don't see any signs, unfortunately, of any bottoming or abatement, which leaves us in the difficult position of trying to produce more business to replace non-renewals. It's very, very tough out there,' Mr. Wiczynski of A&A stresses.**

it is not dropping either. The only difference was their insurance brokerage business," noted Drexel Burnham Lambert's Mr. Keefe.

Mr. Bischoff said that M&M's "cost containment efforts are still very strong." In fact, most of its expense growth is attributable to the strong growth of the broker's consulting operations, which are more labor-intensive.

"Within those areas where we can control expenses and still give quality service to our clients, I think we have done everything we should be doing," Mr. Bischoff added.

But because of the property/casualty rating environment, Alex. Brown's Mr. Malis expects 1989 "to be a down year for (M&M) earnings-wise."

Revenues of New York-based Alexander & Alexander grew only 0.8% in the first quarter of 1989 to \$302.5 million from \$300 million in the first quarter of 1988.

And the broker's net income dropped 27.3% to \$12 million from \$16.5 million in the first quarter of 1988.

Both Mr. Rosencrants and Mr. Malis characterized A&A's first quarter results as "disappointing."

In fact, Mr. Malis said that without contingency commissions A&A's revenues "would have been flat."

But A&A's Mr. Wiczynski attributed the slight revenue gain to investment income earned on fiduciary funds, "which was helped by higher interest rates."

And Shearson's Mr. Smith noted that A&A's decision to purchase annuities to fund its pension obligations for certain U.S. retirees "saved them some money in the first quarter."

Mr. Wiczynski explained that since A&A has purchased annuities to fund these retirees' benefits, A&A no longer owes a pension obligation to those retirees, which reduced its expenses by \$7.9 million in the first quarter. "Without that, you would have seen a 4% increase in our expenses instead of a 2% increase," he said.

Corroon & Black's first-quarter gross revenues grew 12.8% to \$119.7 million from \$106.1 million in the first quarter of 1988.

But Corroon & Black's net income plunged 86.1% to \$12.1 million in the quarter from \$87.1 million in the first quarter of 1988 because of a non-recurring after-tax gain of \$73.9 million in the first quarter of 1988 from Corroon & Black's sale of its 29.9% equity interest in Lloyd's of London broker Minet Holdings P.L.C. (BI, Feb. 1, 1988; Dec. 14, 1987).

The broker's operating income—before taxes and the non-recurring gain—dropped only 7.2% to \$19.7 million from \$21.2 million.

Shearson's Mr. Smith attributed Corroon & Black's strong revenue growth in the first quarter to 10 acquisitions it has completed in the past 12 months.

However, Mr. Smith noted that Corroon & Black's small life, accident and health insurer subsidiary, Consumer Benefit Life Insurance Co. in Nashville, Tenn., generated losses in the first quarter and will likely do so in the second quarter.

Continued on next page



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# Prop. 103 ruling to trigger other campaigns

By MARK A. HOFMANN

The California Supreme Court's decision upholding most of Proposition 103 is giving a green light to similar efforts in other states, consumer activists and insurance industry representatives agree.

Insurance reform drives are most likely in New Jersey, Pennsylvania, Illinois, Ohio and Texas, observers say. Wisconsin and Maryland also were labeled as states where reform efforts are likely to sprout.

"We're going to be seeing more of this across the country. What Proposition 103 has done is provide a national focus for this issue," said John Hildreth, executive director of Consumers Union's southwest regional office in Austin, Texas.

"I think the fact that the court upheld the main features of Proposition 103 has given consumer groups a lot of support," agreed David Brummond, assistant vp and assistant general counsel-legislative department, for the Des Plaines, Ill.-based National Assn. of Independent Insurers.

"But I don't see it as generating anything new; it's given more to movements already in place."

"Many consumers throughout the U.S. may believe the decision supports contentions that industry greed and inefficiency are the underlying causes of high auto rates," added David L. Ream, president of the National Assn. of Professional Insurance Agents in Alexandria, Va.

"The decision will thus embolden consumers and consumer leaders to seek punitive proposals such as (rate) rollback movements in other states," he said.

Indeed, Proposition 103 will give consumer advocates an incentive to introduce legislation rolling back property/casualty insurance rates in other states, predicted Howard Greene, associate legislative director-governmental affairs of the Risk & Insurance Management Society Inc. in New York. Earlier this year RIMS issued a statement opposing Proposition 103 and similar legislation in other states (BI, March 6).

The California Supreme Court decision also "may help drive the debate over the McCarran-Ferguson Act. This definitely impacts risk managers, and I hope they realize it," Mr. Greene said.

A Colorado risk manager advised other risk managers to become involved in the debate of insurance industry reforms, even if the reforms solely pertain to personal automobile insurance.

The public's anger over "personal lines auto is the lightning rod of the whole thing," said Samuel Y. Fisher, insurance manager for Hamilton Brothers Oil Co. in Denver and chairman of RIMS' government affairs committee.

"As professional buyers of insurance, we have to get involved and try to mitigate the problems. We have to get involved in personal lines issues in every state to help derail other Proposition 103-type issues," Mr. Fisher said.

Insurance industry analysts also predict a spread of Proposition 103 sentiment to other states.

For example, Michael J. Morrissey, chairman of Firemark Consultants Inc. in Morristown, N.J., said that Proposition 103 is an example of a political pendulum swinging back to anti-insurance industry sentiment. He predicted similar measures in other states would gain steam as a result of the court's decision.

Michael A. Lewis, first vp for Dean Witter

Reynolds in New York, agreed: "We feel that this, in conjunction with a poor underwriting environment, makes for a difficult investment climate for the insurance industry."

"It represents an unfavorable precedent for legislation in other states," he added.

"The insurance industry always said each state was a crucible for testing things," noted J. Robert Hunter, president of the Alexandria, Va.-based National Insurance Consumer Organization, in reference to property/casualty insurance companies' longtime contention that state regulation is preferable to federal regulation.

"Now we're going to find out. We have 50 labs," said Mr. Hunter, one of the insurance industry's most vocal critics.

NICO joined other consumer groups last week in unveiling a list of proposed changes in federal and state laws. The package includes elimination of insurers' limited antitrust exemptions, including the exemption granted in the McCarran-Ferguson Act; an end to prohibitions on agent rebates; establishment of independent consumer advocates who would represent consumers in rate hearings; tougher drunk driving laws; and lower speed limits.

David F. Snyder, counsel for the American Insurance Assn. in California, noted that some portions of the package already had been advocated by insurers. "We will support and work with consumer groups on everything that reduces losses," he said, pointing specifically to tougher drunk driving laws and more stringent enforcement of speed limits.

But, he added, "There is no proof at all that consumer advocates or any increased regulation guarantees lower insurance rates—witness Massachusetts and New Jersey."

Auto insurance in those two states is largely written through assigned risk pools, and the Massachusetts personal auto market deteriorated so badly that several major insurers have chosen to cease doing any business in the state rather than pay the assigned risk pool assessment during the past two years.

Eric Hall, director of industry affairs for the PIA, noted that his group also favors some of the measures proposed by the consumer advocates. "We support—and have supported for years—measures that encompass automobile safety," he said.

But the PIA does not support repeal of McCarran-Ferguson, he said. "We believe industrywide collection of data, promulgation of insurance rates and companies' ability to deviate off of bureau rates is the most efficient measure of producing a rate. I fail to see how focusing on how data is collected ultimately lowers the cost of insurance," he said.

Franklin W. Nutter, president of the Schaumburg, Ill.-based Alliance of American Insurers, issued a statement praising the safety features contained in the consumer groups' proposal. He noted that a 14-point plan to lower automobile insurance costs issued by the Alliance a few weeks ago contained many of the same suggestions.

But he disagreed strongly with the activists' call for antitrust exemption repeal and greater government regulation in the marketplace. Such intervention, he said, "is anticompetitive."

Many consumer groups, flush with a feeling of triumph in the wake of the California court's decision, are spurning an offer to work with the insurance industry in an attempt to lower auto insurance rates.

"This shows you can win against this giant of an industry," said Lorraine Driscoll, legislative liaison for Citizen Action in Washington, D.C.

Citizen Action, an umbrella group of more than 20 state consumer federations that promote a wide range of issues, announced in January a list of 14 states in which its affiliates would push for changes in insurance laws.

"Certainly, states that were not on the list before this will consider campaigns," Ms. Driscoll said.

"The dam that insurers erected to hold back the will of the people has busted," said Pete MacDowell, legislative director for Ohio Citizen Action in Columbus, Ohio, one of the 14 states on Citizen Action's original list.

The enactment of Proposition 103 and the subsequent Supreme Court ruling upholding most of its provisions "has shown people they can do something about auto rates," he added.

One of the most visible attempts to "do something about auto rates" by replicating at least part of Proposition 103's technique and success is being made by Hackensack-based New Jersey Citizen Action.

The group is attempting to put a non-binding referendum on the November ballot in each of the state's 21 counties. In addition, the group has joined with the New Brunswick-based New Jersey Public Interest Research Group to form Citizens Auto Revolt, which is promoting the referendum.

Phyllis Sallowe-Kaye, New Jersey Citizen Action's executive director, said that the boards of freeholders of four counties—Atlantic, Camden, Gloucester and Morris—already have approved placing the referendum on ballots in their counties, and that 10 more boards were expected to act within the very near future.

The referendum calls for:

- A 20% rollback in automobile insurance rates with the effective date to be determined by the Legislature.
- Abolition of the state's deficit-ridden joint underwriting association for personal auto insurance.
- An end to all surcharges added to auto insurance policies to fund the JUA.
- The payment of the JUA's debt by insurance companies.
- Repeal of the state's antitrust exemption for insurers.
- The establishment of a computerized automobile insurance price information system that would be operated by the state government.

Support for the referendum is "moving rapidly" she said. If the referendum is approved, Ms. Sallowe-Kaye said that she hopes its provisions are introduced as bills in the state Assembly.

However, she stressed that one critical difference between New Jersey and California is that referenda are non-binding in the Garden State. For example, in 1980, six counties in the southern part of New Jersey approved a referendum calling for a new state of South Jersey, but the Legislature never acted on the measure.

"Auto insurance is the top consumer issue" in neighboring Pennsylvania, said Tom Gluck, associate director at Pennsylvania Citizen Action's Harrisburg office. But the tactics in Pennsylvania differ somewhat from those in New Jersey in part because there is no initiative process in Pennsylvania, he said.

Instead of focusing on repeal of antitrust

exemptions—which are not contained in Pennsylvania's antitrust law—or seeking specific rate rollbacks, Pennsylvania Citizen Action is emphasizing the creation of a consumer advocate's office through legislation, Mr. Gluck said. He said such an office is needed to counterbalance the influence of the insurance industry.

"The insurance lobby is very powerful," he said, while adding that the California "court decision potentially changes some of the dynamics here."

Pennsylvania House Majority Leader Robert O'Donnell, D-Philadelphia, is expected to introduce legislation that would, among other things, establish an insurance consumer advocate's office to represent policyholders in rate hearings.

NICO's Mr. Hunter also pointed to the impact the Proposition 103 ruling is having on state legislators as one of the decision's most wide-ranging effects. "It's spreading to a lot of states without consumer groups. I think we're finding a lot of born-again consumerists in the legislatures," he said.

Mr. Hunter added that reform efforts appear to be gathering bipartisan political support, particularly in regard to state antitrust exemptions. "I think repealing the antitrust exemption is very Republican," he said.

Repealing insurers' antitrust exemption may be the most widespread objective of consumer groups.

For example, the Chicago-based Illinois Public Action Committee is supporting a bill that was approved earlier this month by the House Judiciary Committee that would abolish the exemption. H.B. 2147 will soon go to the House floor for debate, said IPAC Associate Director John Cameron.

Two other bills supported by the group also have received committee approval during the past three weeks. The House Executive Committee approved H.B. 2144, which would roll back property/casualty insurance rates 15% from January 1989 levels and make the insurance commissioner's job an elected post. And, the House Consumer Protection Committee gave its approval to H.B. 2148, which would establish a flex-rating system for property/casualty insurance.

Mr. Cameron said the timing of committees' actions couldn't be better. "Coming at the same time as the Supreme Court's decision in California gives us tremendous momentum," he said.

To persuade the full Legislature to take action on its proposals, IPAC last week called for a statewide campaign in which consumers would mail to their state legislators copies of their most recent auto insurance premium notices bearing the message "I'm fed up," Mr. Cameron said.

However, a spokeswoman for the Alliance of American Insurers commented, "The fact of the matter is IPAC would like to draw an analogy between Illinois and California and that's simply not true. There is no analogy."

More companies write personal auto insurance in Illinois than in California, and the average personal automobile insurance premium cost in Illinois only ranks 25th in the nation, she said.

IPAC "should be asking people to write to their auto insurance companies and say 'Thank God we've got this system we do in this state,'" the spokeswoman said, adding that "there is no great groundswell of people around the state who are unhappy with their auto insurance."

One state where consumer activists are not

Continued on next page

## Michigan House OKs antitrust changes

LANSING, Mich.—A package of 10 bills that would repeal insurers' exemption from Michigan antitrust laws is pending in the state Senate following House approval.

The bills, introduced by Reps. Pat Gagliardi, D-Drummond Island, and Thomas Power, R-Traverse City, would, among other things, prohibit insurance trade associations from setting uniform rates for insurers in Michigan.

Under the proposals, insurers that violate Michigan antitrust statutes could face civil and criminal penalties of up to \$1 million per offense for corporations or partnerships, said Peter Strauss, assistant vp and regional manager for the Alliance of American Insurers, based in Schaumburg, Ill.

The package is now before the state Senate Commerce Committee.

Although the bills were opposed by insurance trade associations, the outcome in the House was not a surprise, given the consumerist atmosphere in the state and the Democratic majority in the House, observers said.

"This is exactly what we expected," said Nancy Nowak, president of the Michigan Insurance Federation, which represents 27 Michigan-based insurance companies, including several small regional insurers.

The industry's odds may improve in the Senate, however, which is predominantly Republican, remarked a spokesman for the Professional Insurance Agents of Michigan.

Rep. Gagliardi maintains that the legislation, designed to protect the consumer, will not harm the insurance industry in the process.

"The need for insurance has never been larger, and the

competition is good," he said. "Our insurance industry has done a pretty fair job in Michigan, and it shouldn't object to the loss of special status."

However, industry spokespersons are concerned that such consumer-driven legislation, which is drafted to increase competition in the marketplace, will instead reduce competition and increase rates because smaller insurers will be unable to compete without sufficient data.

In addition to the antitrust reform bills, state Sen. Richard Posthumus, R-Kent County, currently is drafting a proposal that will mandate reductions in automobile insurance premiums and auto insurance rate subsidization in the Detroit metropolitan area, said a spokeswoman from the senator's office.

—By Laura Mazzuca

## Proposition 103

Continued from page 1

makes the state insurance commissioner's office an elective post; allows agents to rebate portions of their commissions; allows banks to sell insurance; removes insurers' exemptions from state antitrust laws; and limits insurers' ability to cancel or not renew auto insurance policies.

While the California Supreme Court ruling upheld most of Proposition 103, it struck down as unconstitutional a provision that would have required insurers to be "substantially threatened with insolvency" before they could receive relief from the rate rollback (BI, May 8). Rates will be judged on the historic basis that they cannot be "excessive, inadequate or unfairly discriminatory."

To charge higher rates than allowed by the rollback, an insurer must prove to the Insurance Department that rates for each line of business would be "confiscatory" and would deny each company "a fair and reasonable return" on its business, Ms. Gillespie said last week.

However, rather than establish a maximum allowable rate of return, the Insurance Department will determine what constitutes a "fair and reasonable" rate of return on "a case-by-case basis," she said.

"There is no one number. Insurance companies are very different" from one another, Ms. Gillespie explained.

The rate review process will be structured to ensure that all rate relief applications are reviewed and decided by November, when the Proposition 103 rate rollbacks will expire and the prior approval system will be established, she said.

"What the law wants is speed right now. We won't let anyone pour molasses in the gears," Ms. Gillespie said.

Asked at the news conference whether she thinks consumers will see any refunds because of Proposition 103, Ms. Gillespie said "that I cannot answer," explaining that various parties could challenge the department's regulations in court.

"What we're going to be doing is processing our cases and they will be out of here prior to November. That is all I can tell consumers," she said.

However, Voter Revolt, the Los Angeles-based consumer group that sponsored Proposition 103, doubts Ms. Gillespie will order insurers to lower rates to comply with the rate rollback, said a spokesman for group. "We don't trust her," he said following the Insurance Department's press conference. "The Department of Insurance is not pro-consumer."

The spokesman labeled the department's decision to apply a "fair and reasonable return" standard to each line of insurance written by an insurer as "a loop-

hole big enough to drive a truck through."

"Our interpretation is different. You look at the overall health of the company" to determine fair rates, the spokesman said, warning that Voter Revolt would respond if insurance rates are not rolled back according to the terms of Proposition 103.

"If in two years there are no rollbacks, no action, then they will force us to take more drastic action," the spokesman said, without specifying the "action" the group would take.

In addition, consumer advocate Ralph Nader last week called for Ms. Gillespie's resignation and state Controller Gray Davis released a report alleging that the Insurance Department was not prepared to implement Proposition 103 (see story, page 46).

However, Ms. Gillespie responded: "All I can say to Ralph Nader or anyone else is look at the court decision. We are going to do just what the court said."

Ms. Gillespie said the Insurance Department can be relied upon to uphold Proposition 103 earnestly because its actions "will be getting a lot of scrutiny."

Insurers late last week said they thought the Insurance Department's procedures for rate relief generally were fair.

"It appears the process is being handled very well by the Insurance Department," said a spokesman for Transamerica Insurance Co. in Los Angeles.

The procedures outlined by the department mean "we're likely to get fair judgment," he said. "Because of the complexities (of ratemaking), you can't do it in a cookie-cutter fashion. We're pleased she recognizes that."

Transamerica expects to file rate relief applications for all lines regulated by Proposition 103, the spokesman said.

Proposition 103 governs all property/casualty insurance rates except workers compensation, ocean marine and reinsurance.

Allstate Insurance Co. officials are pleased that Ms. Gillespie will "take a couple of months to look at this and take it on a case-by-case basis," said a spokesman for the Northbrook, Ill.-based insurer.

Other insurers said Friday they had not yet made any hard decisions.

A spokesman for Hartford, Conn.-based Travelers Corp. said: "It is likely we will file rate applications in many lines. However, it is too early to say which lines and what the rates will be."

The rate information required by the department's review process is "extensive and will take time" to compile, the spokesman said. "We are examining our affected lines and available data."

Fireman's Fund Insurance Cos. in Novato, Calif., is continuing to review its options.

"We are taking our time to look at" the department's

Continued on next page

## Reform campaigns

Continued from previous page

focusing all of their attention on auto insurance is Texas. "There's not as much concern about auto rates in Texas as there is in California," noted CU's Mr. Hildreth.

Instead, consumer activists are backing a wide-ranging package of insurance law changes rather than focusing on auto insurance, said Mike Haga, executive director of Austin-based Texas Citizen Action, which formed only a few months ago (see story, page 35).

According to Mr. Haga, the group supports legislation that would:

- Eliminate the current state antitrust exemption for insurers.

- Give the Office of Public Insurance Counsel, which represents consumers in rate hearings before the Texas Board of Insurance, new powers and the ability to deal with life/health insurance matters as well as property/casualty insurance.

- Mandate that insurers pay interest on claims that are not paid promptly.

- Require the State Board of Insurance use "independent data" when examining rate requests.

- Allow more information about insurers with financial problems to be made public.

The antitrust exemption "is the real heart of the matter," Mr. Haga said. If insurers want to act like other businesses and price in a manner that maximizes their profits, they have to be subject to the same rules as other businesses, he said.

Abolition of the antitrust exemption is also high on the list of the Ohio Citizen Action group. The group is supporting measures introduced in the state House by Rep. Barbara Pringle, D-Cleveland, as H.B. 465, and in the state Senate

by Sen. Mike White, D-Cleveland, as S.B. 163.

Both bills would abolish the antitrust exemption as well as codify a number of what Mr. MacDowell called "fairness provisions" including prohibiting surcharges for accidents in which the policyholder is not at fault and prohibiting tie-ins whereby a customer would have to buy homeowners or other coverages from the same company that sold them their automobile insurance, he said.

The bills do not, however, call for a rate rollback, even though another measure—H.B. 76 sponsored by Ron Mottl, D-Parma—does call for a 10% rollback of property/casualty rates.

Mr. MacDowell said his group did not include a rollback in its legislation because "we thought it did not have a good chance legally." He added that Ohio Citizen Action wants to focus on long-term reforms rather than one-time rollbacks.

The Maryland Citizen Action Coalition has set abolition of insurers' antitrust exemption as its "highest priority," said Executive Director Jannelle Cousino in Baltimore.

Her group, which supports "effective regulation or effective competition," is pleased that the state is returning to a system of prior approval for most property/casualty insurance rates as of July 1, but does not think prior approval goes far enough without an end to the exemption, she said.

Maryland will return to the prior approval system because its open competition law unexpectedly was allowed to expire under a sunset provision, said Insurance Commissioner E. Susan Kellogg said.

Ms. Cousino added that the passage of Proposition 103 also has

spurred public interest in electing the state's insurance commissioner, even though this reform has not been a high priority for her group.

Election of the insurance commissioner is a higher priority for the Madison, Wis.-based Wisconsin Action Coalition, said David Ahrens, the group's associate director and legislative representative, who feels an elected commissioner would be more responsive to consumer desires.

WAC's main drive, however, is to prohibit territorial rating for auto insurance.

The drive to abolish territorial rating is particularly strong in the metropolitan Milwaukee area, Mr. Ahrens said. "It just got a real boost with 103," he added.

Mr. Ahrens added that Ralph Nader will speak at a WAC rally in June to promote changes in Wisconsin's insurance regulations such as banning territorial rating and to oppose any changes in the state's tort laws.

"The importance of 103 is confirmation that this can work, that this can be done. The insurance industry can be beaten," said Mr. Ahrens.

But Wisconsin Insurance Commissioner Robert Haase said he doubts that auto insurance reform advocates will be able to garner enough legislative support, except in Milwaukee where rates are higher, to pass Proposition 103-type legislation in his state.

Among other states mentioned by activists and insurance industry observers as ripe for Proposition 103-like efforts are Arizona, Florida, Maine, Massachusetts, Nevada, New Mexico, South Carolina, and Washington.

Los Angeles Bureau Chief Donna DiBlase contributed to this story.

## Update

### Hedien to take helm of Allstate

NORTHBROOK, Ill.—Allstate Insurance Co. President Wayne E. Hedien will become chairman and chief executive officer of the Northbrook, Ill.-based Allstate Insurance Group on July 1.

Mr. Hedien succeeds Richard J. Haayen, who will retire June 30. Mr. Hedien will be succeeded as president of Allstate Insurance Co. by Raymond H. Kiefer, currently head of the insurer's personal property/casualty insurance operations.

In addition, Robert A. Leibold, head of Allstate's business insurance operations, announced last week that he will retire Aug. 31. John D. Callahan, senior vp-field administration, personal lines, will succeed Mr. Leibold.

### Three indicted for mail fraud

LOS ANGELES—Three men are facing criminal fraud charges stemming from an alleged scheme to sell more than \$144 million in mortgage loans backed by financial guarantees from the now-defunct Glacier General Assurance Co. and Pacific American Insurance Co.

The sale of the mortgage-backed certificates by Palos Verdes, Calif.-based National Mortgage Equity Corp. forced BankAmerica Corp.—which acted as an escrow agent and trustee on the deals—to take \$95 million in charges against its 1984 earnings (BI, March 11, 1985).

Indicted last week on 20 counts of mail fraud were David A. Feldman, NMEC's president; Kent B. Rogers, who allegedly controlled Pacific American as well as corporations that borrowed funds through NMEC and brokered NMEC mortgage deals; and George C. Ash Jr., who controlled another broker involved in the deals and was an officer of some of Mr. Rogers' companies.

The indictment charges that the three men fraudulently induced 20 banks and savings and loans to invest a total of \$144 million in mortgage-backed certificates sold by NMEC.

Among other things, the indictment alleges that the three men falsely represented that NMEC, the mortgage broker/lenders producing the loan business and the insurers—which guaranteed the loans—were independently reviewing borrowers' creditworthiness and the value of real estate securing the loans.

In fact, the indictment charges, the loans were not independently underwritten since the same individuals, including the three defendants, controlled the borrowers, broker/lenders and insurers. About 75% of the investors' money went to fund loans for the benefit of the broker/lenders, insurers or parties related to them, the indictment charges.

In early 1982, Mr. Feldman also approved the use of investors' money to fund \$37 million in loans to fictitious borrowers. This money was then diverted to Glacier General, which needed the cash to pay off obligations on prior defaulted loans, the indictment alleges.

By June 1984 more than 89% of the NMEC loans were in default, according to the indictment.

Pacific American was ordered liquidated in January 1985, while Glacier General entered liquidation in November 1985.

Rodney Perlman, a lawyer with Wehner & Perlman in Los Angeles representing Mr. Feldman, called the charges "unfair" and said the NMEC program "operated the way it was supposed to." He said Mr. Feldman will plead not guilty at an arraignment scheduled for today.

Mr. Rogers, Mr. Ash and their lawyers could not be reached. A civil fraud lawsuit BankAmerica filed against NMEC, Mr. Feldman, Mr. Rogers and several others in 1985 is still pending, Mr. Perlman said.

### Briefly noted

Insurers are asking the California 1st District Court of Appeals to reconsider its landmark decision that hazardous waste cleanup costs incurred by **Aerojet-General Corp.** are insurable under comprehensive general liability policies (BI, May 1). . . A U.S. Bankruptcy Court in New York has denied a petition by 4,000 shipyard workers seeking to enjoin the **Manville Personal Injury Trust** from making further cash payments to asbestos claimants. The workers claimed the trust was using more than half of its available cash to pay only 15% of the claimants. . . James B. Lockhart III, treasurer at Alexander & Alexander Services Inc. in New York, reportedly is under consideration to become the **Pension Benefit Guaranty Corp.**'s executive director.

### Dupont Plaza settlement

Continued from page 4

Reynolds Metal Co., all of which manufactured cables used in the hotel's wiring; architects Warner Burns Toan Lunde; chemical manufacturer Mobey Corp.; and floor wax manufacturer Tarkett Inc. Terms of those settlements remain confidential.

The remaining defendants in the litigation include companies that installed equipment like alarms, elevators and sprinklers in the hotel; suppliers of furnishings such as paint, wallpaper and carpeting; and furniture manufacturers and their component suppliers.

Judge Bechtel said that since the "claims against the hotel involved a different set of defenses and facts to a great measure, under different grounds and different legal principals," he is not sure if the settlement will encourage the remaining defendants to settle out of court as well.

But Mr. Gauthier predicted that the settlement with the hotel family probably will encourage many of the remaining defendants to set-

tle, although "the liability of some of the products defendants will be tried because (their liability) can't be resolved out of court."

"I would say there are 10 to 15 defendants who will not settle and those cases will be tried," Mr. Gauthier estimated.

Remaining defendants also include New York-based Alexander & Alexander Services Inc., the broker for the San Juan Dupont Plaza Corp., which placed the \$1 million in liability coverage with AIG.

"There is a very live and viable action remaining against A&A in the action based on their failure to properly inspect the hotel," Mr. Gauthier alleges.

However, A&A "vigorously denies the allegations," according to a company spokesman.

In light of the settlement with the hotel family, a new jury will be appointed to hear the second phase of the trial, which Judge Acosta said will begin in late June or early July. That phase will involve those defendants who supplied products and services to the hotel. ■

## Proposition 103

Continued from previous page regulations, a spokesman said. "The commissioner's announcement added further areas for us to study."

Insurers seeking relief from Proposition 103's rate rollback must file separate applications for rate relief for each line of business they write. The information to be submitted must be based on only the insurer's California business, she said.

Besides information on rate development and history, losses, trend factors, expense data and investment income, each application must include:

- A calculation of the rate of return, expressed as a percentage of equity, that will result from the Proposition 103-mandated rate level. This information also must be expressed as a percentage of earned premium.

- Justification as to why the Proposition 103-mandated rate level results in a "confiscatory" rate of return.

- A calculation of the rate of return, expressed as a percentage of equity, that will result from the rate level sought by the insurers. This information also must be expressed as a percentage of earned premium.

- Justification as to why the rate level for which the insurer has applied will result in a "fair and reasonable" rate of return.

Insurers will be charged \$2,500 for each "filing," though a filing is defined as all "applications submitted simultaneously by a single insurer." The maximum filing fee for a group of affiliated insurers for all applications submitted simultaneously is \$5,000. Filing fees will be applied toward the hourly fees the Insurance Department charges to review the applications.

About 100 insurers had filed for rate relief with the Insurance Department as of late last week, but those requests will have to be refiled to conform to the department's forms, she said.

Hearings on rate applications are expected to begin by late June with decisions on all applications to be made by Nov. 8.

Emergency regulations on rate hearing procedures will be filed with the state Office of Administrative Law this week, she said. A public hearing on those procedures will be scheduled in August prior to adoption of permanent regulations.

Ms. Gillespie indicated that not all relief applications will require a public hearing, but she did not specify what will trigger a hearing.

In some cases the Insurance Department will audit the figures supplied by insurers, she said.

"Some of these companies we're very familiar with (from past ex-

aminations). Others we're not so comfortable with, so there will be some double checking," Ms. Gillespie said.

Contrary to what some critics have said, the Insurance Department is ready to move ahead with Proposition 103 enforcement, Ms. Gillespie said.

"Now at least we know what we need to do and we're ready to do it. It's a big job," Ms. Gillespie said.

A spokeswoman for the Insurance Department noted last week that damage to the Department's Los Angeles office caused in March when a fire broke out on the floor above the office has had "no impact whatsoever on what we're doing now."

The department's Los Angeles staff recently moved to new offices, a move that was planned before the fire to accommodate expanding staff, the spokeswoman said.

To allow the Insurance Department to implement Proposition 103, Gov. George Deukmejian has approved an increase in the Insurance Department's 1989-90 budget to \$59.5 million, about \$24.1 million higher than the budget first proposed, Ms. Gillespie said.

The department will spend more than half of the additional money to hire 263 more staff members, including 165 rate analysts, 18 policy analysts, 29 attorneys, 28 administrative workers, 19 fraud unit employees and four others.

In addition, a "state-of-the-art" computer system will be installed at a cost of \$3.5 million to handle rate filings.

The department already had increased its 1988-89 budget by \$1.8 million to hire 66 employees and make other improvements to implement Proposition 103.

Observers agreed last week before Ms. Gillespie's news conference that most property/casualty insurers in California will seek relief from the rate rollbacks.

"It's fairly safe to say that a 20% rollback is not the fair rate of return promised in the court decision. I think you will see a lot of filings," said Colin McRae, senior vp and general counsel for Transamerica Insurance Co. in Woodland Hills, Calif.

Many insurers announced last week that they had already filed for relief from the rollback, even though the department had not yet issued instructions.

"We believe our current rates will be found reasonable and we won't be required to make any refunds," said a spokesman for Bloomington, Ill.-based State Farm Group, the largest auto insurer in California.

"For the moment we don't see any change for our policyholders," he said.

State Farm has applied for relief at its current rates for all lines, including a 9.6% increase for per-

sonal auto insurance implemented in January and currently under review by the Insurance Department.

With the Supreme Court directing that rates must be adequate, Proposition 103 has become more acceptable to insurers, according to several companies.

"We believe we can live under this decision," the State Farm spokesman said.

Following the court decision, Seattle, Wash.-based SAFECO Insurance Co. concluded the rollback provision had been adequately modified and is "not quite as serious as we first thought," a spokeswoman said.

"The idea of rolling back rates as much as required by Proposition 103 was more than we were prepared to handle," she said. But now SAFECO "will learn to live with" California's new regulatory system, she said.

However, Aetna Life & Casualty Co. in Hartford, Conn., told its agents last week prior to Ms. Gillespie's news conference that it had stopped writing new property/casualty insurance business—including commercial lines—in California.

Aetna officials decided to stop writing new business because the Insurance Department had not determined what standards it would use to determine adequate rates, an Aetna spokesman said. The company had not resumed writing new California business as of Friday.

"We're just not writing new business for the time being, to see how things work out," an Aetna spokesman said. Meanwhile, the company continues to renew existing policies as usual, he added.

Aetna wrote \$450 million in net premiums in commercial lines in California last year. Personal lines premium volume in California totaled \$166 million.

The company lost \$3 million last year on California auto insurance, the focus of the California insurance debate, the spokesman said. The insurer has lost \$15 million on California auto insurance since 1984, he added.

Kemper Group's national property/casualty companies in Long Grove, Ill., also are concerned about the regulatory conditions in California, said Gerald L. Maatman, president and chief insurance officer.

Kemper has "an awful lot of unanswered questions" about what will constitute fair and adequate rates under Proposition 103, Mr. Maatman said earlier last week, though he added "we don't see a lot of immediate impact on our commercial lines of business."

Competition already has forced rate reductions for most commer-

## Agency unprepared, controller charges

SACRAMENTO, Calif.—The California Insurance Department is not prepared to implement Proposition 103, state Controller Gray Davis charges.

The department, under Insurance Commissioner Roxani Gillespie, did not work to increase its staff and did not establish a procedure for rate review while the insurance law was under court review, an 11-page report issued by Mr. Davis' office alleges.

"This inaction means rate rollbacks for consumers are seriously and needlessly jeopardized. Furthermore, many consumers may actually experience premium increases during the next several months," Mr. Davis said.

The report recommends the Insurance Department:

- Hire a Big Eight accounting firm to assist in setting rate regulations and examining rate applications.

- Establish a monitoring program to assess the Proposition 103 implementation.

- Review other department functions, such as insurer liquidation and fraud investigation.

- Review regulations and procedures "for improvement in the efficient and effective operation of the implementation process."

At a press conference last week, Ms. Gillespie shrugged off recent criticism of her performance as commissioner. "I'm just not going to pay that much attention" to the criticism, she said.

However, she noted that the accounting firm of Price Waterhouse has been working with the department since last fall to help carry out Proposition 103's mandates. Mr. Davis' "very own office has been cutting the checks for Price Waterhouse," Ms. Gillespie said.

In a strongly worded response released earlier in the week, the department accused Mr. Davis of "political grandstanding."

"We are shocked at the controller's temerity to question department plans for implementation as he has in no way been associated with our process," the statement said.

An "insurance watch" program suggested by Mr. Davis to monitor the department's activities "may have more to do with his 'candidate's watch' on the governor's seat," the Insurance Department said.

—By Glenn Huntley

cial lines, especially property coverages, that meet the Proposition 103 rollback, Mr. Maatman said. In addition, Kemper's largest line in California is workers compensation, which is exempt from the rate rollback.

"We intend to remain in the California marketplace," Mr. Maatman stressed.

In other Proposition 103 developments last week:

- The California state Assembly again rejected a bill that would heavily penalize insurers for violating Proposition 103 by refusing to renew auto insurance policies.

Under Proposition 103, insurers cannot cancel or fail to renew auto insurance policies, except for non-payment of premium, fraud or misrepresentation by the policyholder or a substantial increase in the risk insured.

A.B. 103, which previously was passed by the Senate, was five votes short of the two-thirds majority it needed for Assembly approval. The Assembly rejected the

same bill in April (BI, April 17).

The legislation would levy penalties of up to 50% of premiums if an insurer cancels or declines to renew an auto policy in violation of Proposition 103.

- Attorneys representing the insurance industry will not decide until next month whether to ask the U.S. Supreme Court to review the state Supreme Court decision upholding the bulk of Proposition 103, said Allen Katz, attorney for the Assn. of California Insurance Companies.

- Ms. Gillespie hinted at her news conference that she may consider running for insurance commissioner, despite earlier comments that she was not interested in the elective post.

"No, I haven't ruled it out," she said. "I just haven't given it any thought," she told reporters.

Under Proposition 103, candidates for insurance commissioner will be selected in the June 1990 primary and run in the November 1990 general election. ■

## Captive tax ruling

Continued from page 2

Phillips claimed that it was entitled to an offset for the excise tax payments under the doctrine of "equitable recoupment," arguing that it would otherwise be subject to double taxation on the same premiums.

In its arguments, the oil company cited an IRS private letter ruling in a case involving another taxpayer in which the government allowed a claim for a refund of income taxes in an amount equal to an overpayment of excise tax. In this case, the theory of equitable recoupment was applied because the time limit had passed for the taxpayer to file a direct claim for a refund of excise taxes and such a claim would have been barred.

In the tax court case brought by Phillips, however, the IRS filed a motion to dismiss the claims on jurisdictional grounds, and Special Trial Judge Peter J. Panuthos agreed in a May 4 ruling.

The tax court's jurisdiction is strictly limited by statute, the judge noted, and while the court does have authority in cases involving certain types of excise tax, it has no jurisdiction in disputes over the particular type of excise tax involved in the Phillips case.

Judge Panuthos also ruled that the tax court has no authority to apply the doctrine of equitable recoupment.

The ruling noted that during oral arguments, an IRS lawyer suggested that Phillips might receive a credit for the excise taxes by filing an administrative claim with the IRS for a refund under the equitable recoupment theory.

Tax lawyers contacted by *Business Insurance* suggest that Phillips may file an administrative claim with the IRS under the equitable recoupment theory for a partial refund of income taxes for years in which direct claims for refund of excise taxes have been time-barred. For other tax years, Phillips may file direct claims for refund of the excise taxes.

Phillips' excise tax claims are time-barred for one of the four years at issue in its case, Mr. O'Toole said.

Separately, the IRS earlier this month issued a clarification to Revenue Ruling 88-72 on deductibility of premiums paid to captive insurers (BI, March 13; Nov. 28, 1988).

The ruling denies a parent corporation a deduction for premiums paid to a wholly owned insurance subsidiary regardless of how much third-party business the insurance unit writes.

In a discussion of insurance economics in the original ruling, the IRS noted that the increase in average loss predictability that results from a captive insuring third-party risks "helps protect the (insurance) company's solvency."

Noting that this statement "could cause confusion," a May 8 IRS bulletin says that such third-party underwriting also increases an insurer's potential total loss and the uncertainty over the amount of that overall loss.

While average loss predictability may rise with the addition of third-party business, it is accompanied by a reduced probability of the insurance company's solvency, the IRS said. ■

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# Iowa seeks to blunt Prop. 103 effect

By MEG FLETCHER

At least one state—Iowa—is reacting to the California Supreme Court ruling upholding the bulk of Proposition 103 by attempting to protect insurers and policyholders from "oppressive" regulation by other states.

"We want to protect Iowa domestic insurers from being adversely affected from a solvency standpoint and keep Iowa motorists from subsidizing California motorists," said Iowa Insurance Commissioner William Hager.

"We see the California decision as imperiling Iowa policyholders, especially motorists in Iowa," Mr. Hager said.

Meanwhile, regulators in other states say they are waiting to see what transpires in California before taking any type of action.

And, some suggested that the California Supreme Court ruling, which says insurers do not have to prove that Proposition 103's mandated 20% rate rollback would render them insolvent before they could obtain rate relief, will greatly reduce the initiative's impact on insurers.

In Iowa, Mr. Hager last week sought legislative approval of a proposed amendment to the state administrative code aimed at protecting policyholders and Iowa-domiciled insurers from out-of-state voter initiatives and rate regulations.

Under the amendment, which Insurance Division officials expect to be approved this summer and could take effect by late August:

- Iowa-domiciled insurers would be barred from selling any type of insurance in any state in which insurers expect to lose money consistently and thereby impair their financial health.

That proposal was originally introduced in December and was discussed at a Feb. 14 public hearing (BI, Dec. 19, 1988).

The Iowa Insurance Division would consider an insurer impaired or threatened with financial insolvency if it experienced a minimum 5% reduction in surplus in any 12-month period "as a direct result of the regulatory environment in another state," according to the proposal.

However, such a finding can only be made after the commissioner has given the insurer notice and an opportunity for hearing.

- Insurers doing business in Iowa would be required "to delete or segregate" in their Iowa rate filings any data from a state found by the commissioner to have a "consistently oppressive and confiscatory regulatory environment."

That data would allow Iowa regulators to make sure rates in the state are not increased to counterbalance losses from other states, which Mr. Hager anticipates some insurers will

incur in California under Proposition 103.

Iowa has a prior approval system for most property/casualty rates, though the state has a use-and-file system for automobile and homeowners coverages.

In addition, the proposal also would authorize the commissioner to require Iowa-domiciled insurers to report their business volume in states that are deemed to have oppressive regulatory environments.

Mr. Hager last week rejected adopting the measures on an emergency basis because the California court decision is not expected to hurt Iowa insurers immediately.

Written comments on the proposals may be sent by June 20 to Fred Haskins, Iowa Division of Insurance, Lucas State Office Building, Des Moines, Iowa 50319.

Mr. Hager's concern stems from the fact that some Iowa-domiciled insurers, like ALLIED Mutual Insurance Co., generate a significant percentage of their business in California.

In addition, he fears that Iowa motorists potentially could subsidize drivers in other states. Iowa had the lowest average automobile insurance premiums in the United States during 1987, according to data released by A.M. Best Co. earlier this year.

The precise impact of the rate rollback mandated in Proposition 103 remains unknown as insurers seek relief from the rollback in light of the California Supreme Court ruling that guarantees insurers a "fair rate of return" despite the mandated 20% rate rollback.

However, Mr. Hager observed last week: "I think you can anticipate that getting rate adequacy will be a real problem. A climate has been created for the imposition of confiscatory rates for insurers."

Regulators from other states have expressed an interest in Iowa's approach and requested hearing transcripts, Mr. Hager said.

However, other regulators said last week they do not think such action is needed in their states yet.

"I think initiative and rollback legislation are illusory if they are subjected to the same type of analysis as that of the California court," said Nevada Insurance Commissioner David Gates, who is president of the National Assn. of Insurance Commissioners.

"You don't get anything from a rollback unless an insurance company has been extraordinarily profitable," he said.

"Changing the grounds on which a company can ask relief mitigates the impact of the 20% rollback," said Maryland Insurance Commissioner E. Susan Kellogg.

"I think it will be a few years before we know the outcome," said Pennsylvania Insurance Commissioner Constance Foster. The court's ruling that insurers are entitled to a fair rate of return is "an invitation to two more years of litigation," she said.

Although insurers are now saying that Proposition 103 won't significantly change the way they do business in California, Ms. Foster does not think that the California Insurance Department will "nullify by the back door" the rate relief that voters sought.

State insurance regulators also are divided over whether they anticipate more Proposition 103-type initiative and legislative efforts.

Populist initiatives and legislation "will be much more viable now than before the decision," Ms. Foster said, adding that a wide range of parties have contacted her about insurance reform since the May 4 California decision.

Illinois Insurance Director John Washburn said whether Proposition 103-type changes gather steam "depends upon how California shakes out."

Illinois and Pennsylvania are two of the states in which legislation to reform insurance regulation already is pending (see story, page 44).

Reform proposals that would remove insurers' protection from antitrust laws particularly concern some regulators.

Large insurers may cite the lack of antitrust protection as an excuse for not reporting loss data to insurance departments, Mr. Gates said.

That would give those insurers a competitive edge by making it more difficult for small and medium-sized insurers to properly price a risk, Mr. Washburn said.

Others noted that Proposition 103 has increased concern about insurance.

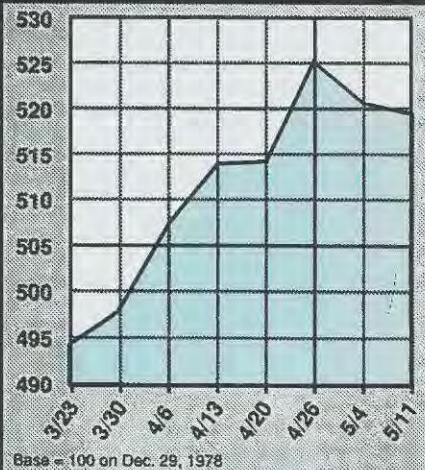
"In a bizarre kind of way, one of the blessings of Proposition 103 is it increased people's curiosity and interest in the area of insurance," said Maryland's Ms. Kellogg.

Her department has responded with more speaking engagements and by providing a free newspaper column to area papers.

In addition, Colorado began developing a consumer awareness and education campaign last spring. The effort received a boost last week when the Legislature approved a bill, H.B. 1264, to create a \$300,000 Consumer Protection Cash Fund by raising the fee for insurers' certificate of authority.

The new funds will enable the Colorado commissioner to hire eight additional staff members who will focus on consumer protection through education and market conduct activities.

## BI Insurance Index



Insurance industry stocks continued to slide last week, as the *Business Insurance Index* dropped 1.0 point to 520.3 on May 11, from 521.3 on May 4. Advancing issues were led by United Health Services, up 11%; U.S. Healthcare, up 10%; and FHP International Corp., up 7.8%. Declining issues followed Hanover Insurance Co., down 8.8%; Western Health Plans Inc., 7.4%; and HMO America Inc., 7.1%. The most active issue during the period was: U.S. Healthcare, 4.8 million shares traded. The *Business Insurance Index* lost 0.2% for the period; the Standard & Poor's 500 dropped 0.5%; the New York Stock Exchange Composite lost 0.3%; and the Dow Jones 30 Industrials fell 0.1%.

## British Issues

May 11 Companies	Price	P/E	Div. pence	Yield %	1 Week High-Low
Comm Union	376	13.0	25.3	6.7	384-376
Genl Accident	945	8.8	58.7	6.2	955-945
Gdn Royal Exch	212	10.9	13.3	6.3	212-208
Royal	420	13.1	30.0	7.1	421-418
Sun Alliance	1178	9.2	54.7	4.6	1180-1176

Brokers	Price	P/E	Div. pence	Yield %	1 Week High-Low
Bradstock	220	12.4	9.0	4.1	225-220
CE Health	468	14.9	34.5	7.4	483-468
Hogg Robinson	144	12.7	8.7	6.0	145-144
Lloyd Thompson	220	16.9	8.0	3.6	224-220
PWS Holdings	57	15.4	4.6	8.2	63-57
Sedgwick Grp	248	20.5	16.0	6.5	249-246
Steel Brl Jones	229	19.6	13.3	5.8	229-226
Willis Faber	227	16.8	15.3	6.8	227-226

Source: Philip Olsen/Alan Clifton, Insurance Industry Specialists Kitcat & Aitken Stockbrokers, London

# BI Industry Stock Report

MAY 11, 1989

5/5/89 THRU 5/11/89

### BROKERS

	Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
Alexander & Alexander Svcs	24.75	3.0	5.3	26.50	22.63	138	1.00	4.0	16.7	3.71	6.67
Corroon & Black Corp.	33.63	0.0	8.0	35.00	30.75	269	1.24	3.7	13.1	12.40	2.71
Gallagher Arthur J. & Co.	19.13	-1.3	14.2	19.88	16.13	58	0.52	2.7	13.6	5.33	3.59
Hall Frank B. & Co.	3.50	-3.6	21.5	4.63	2.50	29	0.00	0.0	-2.0	0.00	N/A
Hilb, Rogal & Hamilton	14.38	0.9	-5.7	15.75	13.75	147	0.20	1.4	13.0	4.60	3.13
Marsh & McLennan Cos. Inc.	60.13	-2.2	6.9	64.50	55.13	383	2.50	4.2	14.9	6.48	9.28
Poe & Assoc. Inc.	8.75	0.0	6.1	8.75	8.25	11	0.40	4.6	9.5	0.27	32.41
BROKERS AVERAGE		-0.9	8.0					2.9	11.2		

### CONGLOMERATES & HOLDING COMPANIES

	Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
Berkley WR Corp.	30.50	-2.4	3.4	34.00	29.25	297	0.40	1.3	6.4	20.24	1.51
Berkshire Hathaway Inc. DEL	5800.00	-2.9	23.4	-1717.00	-3567.00	92	0.00	0.0	21.2	2492.68	2.33
ITT (Hartford Group)	56.75	-3.8	13.2	59.50	49.75	2625	1.48	2.6	9.7	56.33	1.01
Sears Roebuck & Co. (Allstate)	44.38	-2.7	8.6	46.88	40.13	2787	2.00	4.5	16.6	36.09	1.23
CONGLOMERATES AVERAGE		-3.0	12.2					2.1	13.4		

### INSURERS/REINSURERS

	Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
Aetna Life & Cas Co.	52.00	-0.5	10.1	54.88	46.75	739	2.76	5.3	8.0	58.11	0.89
American General Corp.	34.38	2.6	15.1	35.75	29.50	672	1.50	4.4	10.4	28.04	1.23
Amer Heritage Life Invr	26.00	-1.9	1.0	27.88	25.00	2	1.20	4.6	10.3	22.47	1.16
Amer Indty Fin'l Corp.	11.25	2.3	7.1	11.75	9.50	1	0.56	5.0	7.2	17.06	0.66
American Int'l Group	78.63	-0.9	16.1	84.25	66.25	820	0.40	0.5	11.0	33.55	2.34
Aon Corp.	32.13	2.0	14.8	33.38	27.00	170	1.40	4.4	11.2	16.67	1.93
Argonaut Group	55.25	1.6	26.3	56.00	43.50	67	0.00	0.0	7.6	36.83	1.50
AVEMCO Corp.	22.75	0.0	-12.1	26.13	22.63	5	0.40	1.8	12.0	9.20	2.47
Baldwin & Lyons Inc.	17.00	3.0	14.2	17.13	14.50	69	0.20	1.2	6.6	17.57	0.97
Belvedere Corp.	5.38	-6.4	19.6	6.50	4.50	14	0.04	0.7	8.2	8.43	0.64
Chandler Insurance	12.00	0.0	29.7	12.75	8.75	175	0.00	0.0	5.6	6.65	1.80
Chubb Corp.	66.38	2.7	14.4	69.00	57.63	451	2.32	3.5	7.7	53.50	1.24
CIGNA Corp.	52.50	0.0	11.4	56.13	45.88	467	2.96	5.6	9.2	53.08	0.99
CNA Fin'l Corp.	65.38	0.2	8.1	66.88	57.63	208	0.00	0.0	10.2	46.40	1.41
Continental Corp.	32.88	-3.0	1.5	36.00	31.50	1334	2.60	7.9	22.4	42.10	0.78
Durham Corp.	33.25	2.3	0.8	33.75	30.00	4	0.92	2.8	19.2	26.32	1.26
Fireman's Fund Corp.	33.00	-1.9	12.8	34.88	29.00	622	0.60	1.8	8.2	32.74	1.01
Forum Re (Bermuda)	1.13	0.0	-30.7	1.75	1.13	0	0.00	0.0	-8.7	2.53	0.45
Fremont Gen Corp.	15.88	-3.1	18.7	18.25	12.13	163	0.60	3.8	10.1	16.06	0.99
Frontier Insurance Group	15.00	-4.8	20.0	16.75	12.25	24	0.00	0.0	7.4	7.53	1.99
General Re Corp.	63.13	-0.6	13.7	68.25	54.38	1473	1.36	2.2	11.9	29.04	2.17
Home Group Inc.	13.38	0.0	21.6	14.50	11.00	293	0.20	1.5	5.4	18.66	0.72
Hanover Ins Co.	25.75	-8.8	-3.7	30.25	25.75	896	0.44	1.7	5.3	31.47	0.82
Harleysville Group Inc.	21.88	0.0	21.6	22.25	17.75	39	0.48	2.2	7.6	18.94	1.16
Hartford Steam Boiler	40.25	3.2	9.5	42.50	34.75	295	1.40	3.5	11.1	13.04	3.09
Kans City Life Ins	35.50	2.2	2.9	35.50	32.75	8	0.00	0.0	12.7	39.22	0.91
Kemper Corp.	34.75	0.0	44.8	35.75	22.75	407	0.84	2.4	8.8	28.91	1.20

	Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
Lawrence Ins. Group	6.75	-1.9	-14.3	8.50	6.63	3	0.24	3.6	14.7	3.19	2.12
Liberly Corp. S.C.	33.50	-1.5	-6.9	38.00	33.63	64	0.80	2.4	19.0	21.17	1.58
Lincoln Nat'l Corp.	47.63	-0.3	8.3	50.63	42.75	156	2.48	5.2	11.8	39.12	1.22
NAC Re Corp.	36.38	-1.7	14.6	38.75	31.00	248	0.00	0.0	13.0	22.81	1.59
Navigators Group	22.75	-1.1	13.8	23.50	20.50	8	0.00	0.0	10.3	15.22	1.49
Nobel Ins Ltd	2.75	4.6	-42.1	5.00	1.50	300	0.42	5.3	-10.6	7.76	0.35
Northwestern Nat'l Life	32.38	2.0	4.0	34.25	26.88	250	1.20	3.7	10.8	37.50	0.86
Ohio Cas Corp.	42.00	0.0	17.5	45.25	35.50	620	2.08	5.0	6.1	33.30	1.26
Old Rep Int'l Corp.	23.63	-4.1	-1.5	28.88	23.38	310	0.74	3.1	13.2	26.50	0.89
Oron Cap Corp.	21.00	-3.4	36.5	22.25	15.38	23	0.76	3.6	7.0	12.93	1.62
Phoenix Re Corp.	9.00	-2.7	-5.3	11.00	8.75	49	0.00	0.0	4.7	12.49	0.72
Protective Life Corp.	14.00	1.8	5.7	14.50	12.88	95	0.70	5.0	70.0	14.54	0.96
Re Capital Corp.	10.75	-1.2	17.7	11.13	9.13	11	0.00	0.0	10.8	12.60	0.85

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