

Business Insurance

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Exxon takes \$30 million loss for tanker damage, loss of oil

NEW YORK—Exxon Corp. reported a one-time \$30 million aftertax loss in its first quarter to account for the cost of salvaging and repairing the Exxon Valdez and the value of the oil lost when the ship grounded in Alaska's Prince William Sound March 24.

About 10.1 million gallons of crude oil, valued at about \$5 million, spilled when the tanker, valued at \$137.5 million, ran aground. Exxon probably does not have commercial insurance for the

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Insolvent insurer dumps records on Louisiana officials

By DOUGLAS McLEOD

BATON ROUGE, La.—Louisiana Insurance Department examiners are trying to reconstruct the records of New England International Surety of America Inc. after the insurer's management abandoned the company.

New England International, a unit of Panama-based New England International Surety Inc., was ordered to halt all underwriting April 6 after an examination by the Louisiana department found the insurer was insolvent by \$1.8 million as of year-end 1987.

A hearing had been scheduled for April 17, at which New England International's management was to provide information about the company's finances and operations and respond to various Insurance Department demands.

On April 14, however, the company's management shut its offices, fired its employees and arranged for the prepaid delivery of more than 30 file cabinets of New England International records to the Louisiana department.

On the day of the scheduled hearing, Louisiana Insurance Commissioner Douglas D. Green received a faxed letter from Hendrik Rienstra, the Brussels, Belgium-based president of New England International. In the letter, Mr. Rienstra—who was to appear at the April 17 hearing—cited several reasons for the decision to abandon New England International.

"Be sure that this decision was not taken lightly and is irrevocable," the letter said. "We hope you are happy with our company, its customers and its records."

New England International was ordered into rehabilitation on April 21.

New England International is not related to New England Reinsurance Corp. or New England Insurance Co., both units of Hartford Insurance Group.

Louisiana Insurance Department examiners have begun sifting

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Actuary to endorse reserves: Walbrook

By STACY SHAPIRO

LONDON—The lead underwriter of H.S. Weavers (Underwriting) Agencies Ltd.—the largest U.S. liability insurance market in London—expects the level of its increased loss reserves at year-end 1988 to be endorsed this week by a leading actuarial firm.

The loss reserves of Walbrook Insurance Co. Ltd., the major underwriter on the Weavers line slip, have been reviewed by the London-based unit of the Tillinghast division of Towers, Perrin, Forster & Crosby Inc., it was announced last week.

"This review is not yet finalized but indications, subject to final confirmation, are that Tillinghast will be able to endorse the level of reserves adopted by Walbrook" as of Dec. 31, 1988, announced London United Investments P.L.C., which owns Weavers and Walbrook.

The announcement was made to the London Stock Exchange on April 26, prompted by what LUI said was "uncertainty created in share and insurance markets by various statements, culminating in an article in *Business Insurance*" (BI, April 24).

"I sincerely hope you will find the engagement of Tillinghast a positive move on our behalf which will provide the required level of comfort to those who are critical of our organization," added Peter Wilson, managing director of Weavers, in a separate letter on April 28 to London brokers.

Walbrook's loss reserves will be increased for the second time in two years when LUI announces its 1988 results this week, the LUI statement said.

LUI also announced last week that because of the reserve increase at Walbrook, LUI will report a small profit for the year ending Dec. 31, 1988, and as a result will not declare a dividend to shareholders for 1988.

The amount of the reserve increase was not announced last week.

Readily available LUI financial statements show that annual dividends have been paid since at least 1978.

The April 26 LUI announcement on Walbrook's loss reserves followed letters issued last month by U.S. broker Alexander & Alexander Inc. about Walbrook.

A&A said in the letters to its clients who have or have had coverage with Weavers that A&A is "unable to determine Walbrook's potential to fully meet its future obligations to policyholders." A&A also instructed its brokers to send a similar letter to clients considering coverage with Weavers.

A&A is estimated to have more than 200 accounts currently placed with Weavers.

Walbrook writes 55% of Weavers' line slip, while Anglo-American Insurance Co. Ltd., which A&A says is "adequately capitalized," writes 45% of the slip.

A&A said in its letters that the reasons it could not determine Walbrook's potential to fully meet its future obligations to policyholders were based on Walbrook's financial reports through 1987, which showed:

- Walbrook's reserves for losses incurred in prior years proved to be inadequate and have been strengthened.

- Underwriting losses have increased, with Walbrook reporting a net loss for 1987.

- Business written and liabilities carried have increased in relation to capital and surplus.

A&A further said: "Several changes in accounting for its operations which have been implemented by Walbrook in recent years have complicated our ability to make a complete analysis of its financial condition."

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Words from the 'Wizard'

Berkshire chief foresees prolonged rate cutting

By KATHRYN J. McINTYRE

OMAHA, Neb.—Rate cutting in the property/casualty insurance business could continue for as long as four years, predicts an insurance holding company chairman whose opinion is considered gospel by his enthusiastic shareholders.

Warren E. Buffett, chairman of Berkshire Hathaway Inc., told shareholders at their annual meeting last week that the property/casualty insurance business "will get worse for a considerably longer period of time than a couple of years."

"It could be four years" before insurers raise their rates, Mr. Buffett—the "Wizard of Omaha"—told about 1,000 shareholders from all over the country who packed the Joslyn Art Museum auditorium in Omaha last Monday.

They came in record numbers to hear Mr. Buffett and Vice Chairman Charles

T. Munger answer questions about the company's businesses and their operating philosophies.

Delaying the start of the annual meeting because shareholders were late reaching the auditorium due to parking difficulties, Mr. Buffett said: "Charlie says this proves that a lot more people will turn out to talk about their money than to look at old paintings."

Despite the less than enthusiastic



Mr. Buffett

news about conditions in the property/casualty insurance marketplace, Berkshire shareholders were jovial last week. The stock had closed the previous Friday at \$5,875, up \$825 from its high of \$5,050 in the fourth quarter of 1988.

The stock has more than doubled since a low of \$2,550 in the fourth quarter of 1987 after Black Monday.

The stock was trading at about its book value of \$19.46 in 1965 when Mr. Buffett took over the company.

Berkshire, with \$3.6 billion in statutory capital and surplus dedicated to its insurance operations, ranks among the top five U.S. insurers based on capital and surplus.

While premiums written by Berkshire insurers hit a high of \$1 billion in 1986 when property/casualty insurance rates were at their peak, premiums nose-dived to \$484.7 million last year as

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Pollution ruling for policyholder may help others

By STACY ADLER

SAN FRANCISCO—Policyholders nationwide are expected to benefit from last month's California appellate court ruling that hazardous waste cleanup costs are insurable under comprehensive general liability policies.

Because the decision marks the first time a California appellate court has ruled on coverage available for cleanup costs, it is expected to help several corporations now litigating with their insurers in California trial courts.

In addition, the decision could influence the 9th U.S. Circuit Court of Appeals, which also is reviewing coverage for cleanup costs.

And, the ruling could be cited by courts nationwide. "This ruling is incredibly helpful to policyholders nationwide," said policyholder attorney Eugene Anderson of Anderson Russell Kill & Olick in New York.

He predicted that policyholders in every state attempting to recoup insurance funds for hazardous waste cleanups will cite the California appellate court decision.

However, an attorney for insurers in the case already plans to ask the appellate court for a rehearing and, if that is unsuccessful, plans to appeal the case to the California Supreme Court.

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Pollution liability unknowns keep Lloyd's accounts open
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Employers, labor and insurers agree on California comp bill
Page 3

Update

Exxon tallies vessel, cargo loss

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\$30 million loss, which would likely fall under Exxon's massive aggregate deductible in the London market (BI, April 3).

Exxon Corp. and subsidiary Exxon Shipping Co. have "more than \$400 million" of insurance to pay cleanup costs, damage claims and liabilities resulting from the oil spill, a spokesman said. London sources say that Exxon has \$600 million of commercial insurance to pay pollution cleanup and liability claims.

In addition, Exxon's board has appointed a committee "to determine whether the corporation should commence litigation against any one or more of present or former employees or directors because of the Exxon Valdez oil spill," the company said.

Exxon has received 1,300 claims from fishermen and others and has paid \$400,000 to cover immediate economic losses, a spokesman said. Exxon has not determined whether the payments will be covered by its insurance program, he said.

Exxon also estimates that 31 lawsuits have been filed against the company and that all but two seek class-action status, the spokesman said (BI, April 17; April 10).

Maine boosts guaranty funds

AUGUSTA, Maine—Emergency legislation enacted last Thursday infused sorely needed funds into Maine's workers compensation guaranty fund, enabling it to pay about 1,000 claimants last Friday who otherwise would not have received checks.

The fund had been seriously depleted by the insolvencies of three insurers that wrote workers comp coverage in the state, said Joseph A. Edwards, Maine superintendent of insurance.

The insolvencies of American Mutual Liability Insurance Co. and American Mutual Insurance Co. of Boston earlier this year (BI, Feb. 20; Jan. 23) was "the final straw" for the fund, which had already been depleted by the 1987 insolvency of Mission Insurance Co., he explained.

The emergency legislation, L.D. 750, immediately increased to 2% from 1% of direct net written premiums the maximum amount that the state's guaranty funds for workers compensation, auto liability and all other lines of insurance can assess insurers.

States file antitrust suit briefs

SAN FRANCISCO—Insurance industry defendants cannot claim immunity from antitrust laws under provisions of the McCarran-Ferguson Act because their actions involved a boycott, say state attorneys general in a 121-page brief filed in federal court Friday as part of their antitrust litigation.

The state attorneys general filed the brief in response to motions filed by industry defendants in December that sought dismissal of the litigation citing the McCarran-Ferguson antitrust exemption and denying they engaged in a boycott (BI, Jan. 9).

Industry defendants also had sought dismissal of the litigation under the state action doctrine, which provides immunity from antitrust laws if the anticompetitive restraint reflects a state policy. The attorneys general brief said this was not applicable, however, in cases such as this that involved "boycott, coercion and intimidation."

The attorneys general brief also argued against motions filed in December on behalf of foreign and domestic reinsurers that claimed they should not have been brought into the litigation.

The defendants' responses are due June 16. A hearing scheduled for July 7 is expected to be postponed to give Judge William W. Schwarzer more time to study the motions, according to the judge's clerk.

Touche Ross sued over IMC

TALLAHASSEE, Fla.—The Florida Insurance Department is suing Touche Ross & Co. for more than \$100 million, charging the accountant failed to properly audit now-insolvent International Medical Centers Inc.

IMC was declared insolvent and placed into receivership in 1987 (BI, May 18, 1987; May 11, 1987).

A Touche Ross audit showed the Miami-based health maintenance organization had \$106.7 million in assets and \$101 million in liabilities at year-end 1986. But IMC, once Florida's largest HMO, was \$3.8 million short of its required \$5 million statutory surplus requirement as of Dec. 31, 1986, the department found.

The Insurance Department, which filed suit in Dade County Circuit Court in its capacity as the HMO's receiver, charges Touche Ross with gross negligence, breach of fiduciary duty and negligent misrepresentation in issuing audit opinions on IMC's financial statements "for at least the years 1984 and 1985." The suit charges that the department would have "instituted insolvency proceedings" sooner if not for misleading audit information.

A Touche Ross spokesman, who called the suit "absolutely baseless," said the firm had adequate insurance to cover any potential award.

In 1987, Touche Ross had \$20 million in errors and omissions liability coverage written partly by H.S. Weavers (Underwriting) Agencies Ltd. in London with an undetermined amount of coverage above that layer (BI, March 16, 1987).

Banks sue Lloyd's syndicates

LONDON—Five banks are suing dozens of Lloyd's of London syndicates for failing to pay a \$34 million political risk insurance claim.

Morgan Grenfell & Co. Ltd. of London; Morgan Guaranty Trust Co. of New York; Orion Royal Bank Ltd. of London; The Bank of Scotland and The Bank of Tokyo Ltd. are suing at least 46 Lloyd's syndicates in London's High Court.

The trial began last week against the syndicates, which are led by Chris Rome, underwriter for syndicate 662, managed by C.W. Rome (Underwriting Agency) Ltd., and Ian Thomson, underwriter for syndicate 33, managed by Roberts & Hiscox Ltd.

Lloyd's of London broker Willis Faber & Dumas Ltd. also is named in the suit for alleged breach of duty in placing the policy.

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Some Lloyd's syndicates won't close 1986 accounts

By CAROLYN ALDRED

LONDON—Uncertainty surrounding U.S. pollution liabilities will force some Lloyd's of London syndicates to leave open their 1986 underwriting accounts, market observers say.

The accounts should be closed this year under Lloyd's three-year accounting system.

In addition, many of the syndicates that kept open their 1985 accounts last year because of uncertainties over future losses again will be unable to close their accounts this year, observers note.

And, while several syndicates will be able to close past underwriting accounts after renegotiating the terms of runoff reinsurance policies written by underwriter Richard Outhwaite, other ceding syndicates still are disputing runoff claims with the Outhwaite syndicates.

Several other syndicates are keeping accounts open because of disputes over runoff reinsurance policies written by underwriter Stephen Merrett.

More than 76 syndicates last year left a total of 120 account years open for 1985 or previous underwriting years, causing concern among Lloyd's members and agencies (BI, Aug. 29, 1988).

Now, as underwriting agents begin to inform members of their likely results for 1986, it seems that escalating reports of potential pollution claims during the last year will further increase the number of open syndicate accounts, some observers predict.

Lloyd's syndicates close their underwriting accounts after three years to allow underwriters to better assess

future liabilities. To close one underwriting year, underwriters pay a premium, known as reinsurance-to-close, into the following underwriting year's account to cover liabilities arising from the closing year and previous years.

However, if an underwriter is unable to quantify the syndicate's liabilities, he cannot close the account by transferring the liabilities to members of the following underwriting year because he has to treat members of the syndicate in each underwriting year in a fair and equitable manner.

In recent years the number of underwriting accounts left open by managing agents has increased dramatically, and the issue is causing great concern for investing members of Lloyd's who remain liable until the account is closed, underwriting agents agree.

This is one of the factors that led to the resignation of about 1,750 of Lloyd's 32,080 members last year, and several executives in the Lloyd's market predict the number of resignations will double this year. However, even if a member resigns, he still is held liable for losses on any outstanding open accounts.

"Anything as uncertain as open years must give rise to doubts on the part of names," said Ken Randall, managing director of Merrett Holdings P.L.C.

"We know this is an area of deep concern to the capital base of Lloyd's," said John Gordon, chairman of Lloyd's Underwriting Agents' Assn., referring to the members who invest in the syndicates.

"It is probable that most syndicates with open years likely will keep those years open and there will be

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Agent/broker survey forms due soon

Business Insurance will publish its 18th annual directory of agents and brokers in the June 26 issue, which will contain a spotlight report on the commercial retail insurance brokerage business and profiles on the largest brokers in the United States and around the world.

The directory is published as an editorial service and there is no charge to be listed; however, to be included brokers must request and return a questionnaire supplied by *Business Insurance*.

If your company generated at least \$500,000 of its 1988 gross revenues from commercial retail brokerage and you have not yet received a questionnaire, please request one by writing Marilou Jones, Directory Editor, *Business Insurance*, 740 N. Rush St., Chicago, Ill. 60611-2590; or by calling 312-649-5279.

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

Ruling may imperil ERISA pre-emption

By GLENN HUNTLEY

LOS ANGELES—A California appellate court ruling could leave some employers without ERISA protection from punitive damage claims by employees denied health care insurance benefits, employee benefit experts say.

A three-member appellate court ruled that an employer-paid group health insurance policy covering a worker at a Southern California company is not regulated by the Employee Retirement Income Security Act of 1974 because the employer had no role in administering the benefit and because the coverage was not offered as part of a formal benefit plan.

The California 2nd District Court of Appeal's decision in *Sayble vs. Blue Cross of Southern California* could signal an end to ERISA pre-emption of state insurance laws under certain circumstances, particularly when employers purchase coverage through multiple employer trusts, some benefit experts say.

The case centers around the denial of benefit claims to Gilbert J. Sayble, an employee of Los Angeles-based Swiss American Credit Jewelers Co. Swiss American provided Mr. Sayble with a health insurance policy underwritten by Blue Cross of Southern California through the National Employers Security Trust, a multiple employer trust. Swiss American paid the premiums for health insurance policy from 1976 through 1982.

Mr. Sayble in February 1984 filed suit against Blue Cross, alleging the insurer improperly denied benefit claims arising from his son's hospitalization during the early 1980s. The suit sought payment of the claims and unspecified punitive damages.

While the suit also names Los Angeles-based Biles & Cook Administrators Inc., the third-party administrator for the NEST/Blue

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Photo: Michael A. Marcotte
Maurice R. Greenberg, left, T. Richard Kennedy and John R. Dunne discuss the future of the insurance industry.

Insurers losing control of destiny, panelists contend

By STACY ADLER

CHICAGO—Legislative and judicial onslaughts against the insurance industry are threatening to destroy the free enterprise system for insurers, contends a panel of insurance industry experts.

Legislation mandating insurance "charge" rollbacks, statutes creating joint underwriting associations and judicial decisions that force insurers to bear the cost of cleaning up hazardous waste sites are dismantling the free market system, they say.

The panelists made their remarks last week at the fifth annual Harold H. Hines Jr. Memorial Symposium. The symposium, titled "Great Expectations: Can the Insurance Industry Survive Society's Demands?" was co-sponsored by the Chicago and Northeastern Illinois Chapters of the Risk & Insurance Management Society Inc. and The Insurance School of Chicago.

"Setting rates in the polling booth is a mindless act, and it violates the free enterprise system," said Maurice R. Greenberg, president and chief executive officer of American International Group Inc. in New York, referring to Proposition 103 in California.

"Proposition 103 is one of the most superficial and short-sighted regulatory efforts we have ever seen," agreed New York state Sen. John R. Dunne, R-Garden City.

Proposition 103, among other things, calls for a rollback of nearly all property/casualty insurance "charges" to 20% below November 1987 levels (BI, Nov. 14, 1988).

Bills modeled after Proposition 103 have been introduced in Indiana, Ohio and New Mexico, and consumer organization are pressing for similar reforms in about a dozen other states (BI, March 6; Jan. 16).

"Most of the strident advocates of Proposition 103 and similar propositions have in the back of their minds the elimination of the free enterprise private insurance industry," Mr. Dunne said. "They believe government should be running this kind of business exclusively."

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Employers, labor agree on California comp plan

By GLENN HUNTLEY

SACRAMENTO, Calif.—California employers, insurers and labor groups are backing a sweeping proposal to reform the nation's largest state workers compensation system.

However, the proposal is vehemently opposed by attorneys for workers compensation claimants and so far has received a cautious response from state legislators.

The proposal would increase benefits to injured California workers by an estimated \$2 billion over three years, create a new state agency to manage the workers comp system and reduce the expense provisions insurers use when calculating workers compensation insurance rates.

The compromise measure, dubbed the Workers Compensation Improvement Act of 1989, was finalized last month.

"We believe as employers that the reforms in this package will stabilize the underlying cost increases and allow the increased benefits" to flow to injured workers, said Ed Mangiafico, president of Californians for Compensation Reform, an employer coalition.

However, the future of the workers comp reforms remained uncertain last week as state legislators studied the proposal. In addition, the California Applicants' Attorneys Assn. announced it would oppose the reform package.

The labor-management-insurer task force that drafted the proposal said its plan would greatly increase benefits to workers while controlling employers' and insurers' costs by:

- Reducing the number of litigated cases. Higher benefit levels will mean that fewer employees will contest workers compensation claims.
- Reducing the portion of premiums paid to workers

comp insurers for overhead costs.

• Limiting stress claims to only those demonstrated to have caused observed physical symptoms.

• Providing incentives to employers and employees to use the most effective methods of vocational rehabilitation.

• Designating approved physicians as "impartial medical evaluators" to decide the existence and degree of a worker's disability.

The California workers compensation system has alarmed employers, insurers and labor representatives in recent years as the costs of the system rose steadily while the maximum weekly disability benefit remained unchanged at \$224, or 45th in the nation.

Written premiums for workers compensation insurance in California have almost doubled to \$7.4 billion in 1988 from \$3.9 billion in 1984 according to the California Department of Insurance. And, this does not include the increasing amount of workers compensation risk that is self-insured.

Gov. George Deukmejian called for the task force review last year following several unsuccessful efforts to draft acceptable legislation. The task force resumed its work earlier this year after failing to reach agreement before the Legislature adjourned last August (BI, Aug. 22, 1988; April 11, 1988).

Employers are optimistic that the proposal unveiled last month will lead to substantial reform, said Joseph Markey, executive director of Californians for Compensation Reform and legislative advocate for the California Self-Insurers Assn.

"We have come close (to gaining reform approval), but we've never had united support before," Mr. Markey said. "When it (the reform package) sees the light of day, it's going to be difficult to oppose."

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Bank seeks active role in insurer

By JUDY GREENWALD

WASHINGTON—Insurance trade groups and a bank holding company are battling before the Federal Reserve Board over the bank's efforts to take an active role in the ownership and control of a financial guarantee insurer.

Insurers fear that if the bank's efforts are successful, other banks would be encouraged to encroach upon insurers' turf.

"There are a lot of true believers who believe the banks should be kept out of non-banking activity," said Michael Lovendusky, counsel to the Washington, D.C.-based American Insurance Assn.

The AIA is one of several insurance trade groups that oppose the efforts of Fleet/Norstar Financial Group Inc., a Providence, R.I.-

based bank holding company, to gain a more active role in the affairs of San Francisco-based Capital Guaranty Corp., the parent company of financial guarantee insurer Capital Guaranty Insurance Co.

Mr. Lovendusky noted that the outcome of Fleet/Norstar's application also could affect efforts by New York-based Citicorp to retain control of AMBAC Indemnity Corp., which has more than \$1 billion in assets. Insurance trade groups also have disputed Citicorp's ownership of AMBAC (BI, Jan. 23; Sept. 5, 1988).

Citicorp, in fact, was one of several bank holding companies that filed statements supporting Fleet/Norstar's application, noted Robert J. Dilworth, an attorney with New York-based Cleary, Gottlieb,

Steen & Hamilton in New York who represents Fleet/Norstar.

Mr. Dilworth contends that financial guarantee insurance is closely related to banking and, therefore, federal law dictates that banks should be permitted to write and sell the insurance.

Fleet/Norstar wants permission from the Federal Reserve Board to convert its primarily non-voting investment in Capital Guaranty to a fully voting investment. This would give the bank holding company about 35% of Capital Guaranty's outstanding voting capital stock.

Fleet/Norstar also wants to appoint two directors to Capital Guaranty's board.

The Fed oversees enforcement of the Bank Holding Company Act,

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States' health benefit costs escalate

By KARI BERMAN

The average cost of health care plans covering state employees rose in 1988 at a rate more than double that of medical care cost inflation despite the introduction of new cost containment programs, a survey reveals.

However, state governments' employee health care costs did not increase as much in 1988 as private employers' health care plan costs, the survey shows.

The total cost of state-sponsored, employee-only health care plans—including employer and employee contributions—increased 14.1% in 1988, compared with only a 6.2% rise in the medical care cost component of the Consumer Price Index, according to the "1988 Survey of State Employee Benefit Plans," conducted by Martin E. Segal Co. of New York.

By comparison, costs for public sector employee-only health care plans rose only 5.3% in 1987 and 3.5% in 1986—less than the respective 7.5% and 6.9% increases in the medical care component of the CPI in 1987 and 1986.

But costs may have increased even more in 1988 had states not implemented cost containment measures, such as hospital admission precertification, second surgical opin-

ions and utilization review programs, points out John P. Mackin, senior vp of Martin E. Segal and the survey's author.

In addition to employee-only care, the survey looked at the costs of dependent and retiree-only health care coverage, as well as participation in health maintenance organizations among state employees and retirees.

The survey examined average cost increases in health care plans that covered 3.9 million active state employees and 778,000 retirees in all 50 states.

The overall cost of public sector employee-only coverage averaged \$93.15 per employee per month in 1988, up 14.1% from \$81.62 in 1987, according to the survey.

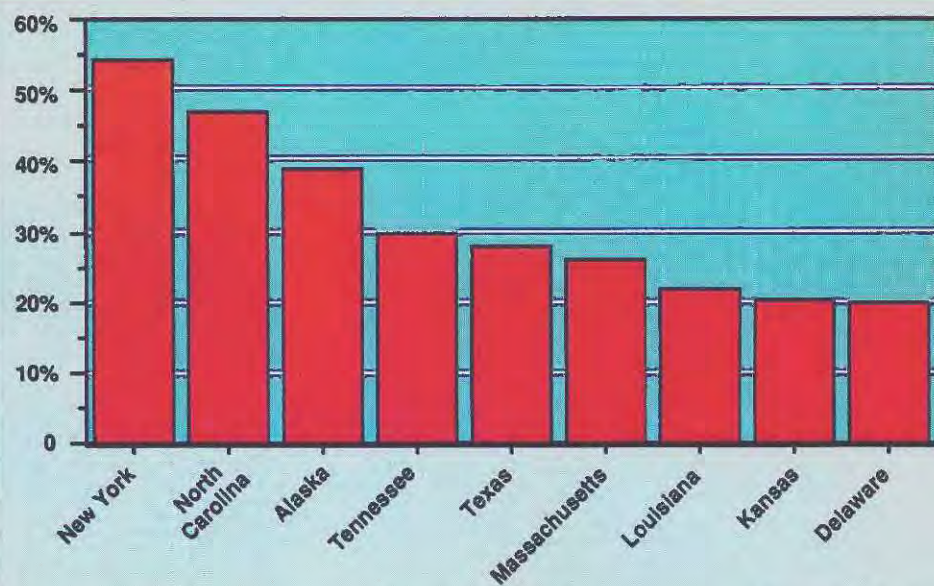
Overall costs for employee-only coverage rose in 1988 for 43 of the 50 state plans surveyed, while seven states reported no change in plan costs.

In 1987, increases in overall plan costs were reported by only 23 of the state plans, while 21 plans' costs remained unchanged and six states actually saw overall plan costs decrease, according to the survey.

In addition, state contributions toward employee-only health care coverage rose last year in 41 states. The states reporting the largest increases in contributions were:

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1988 increases in states' health care plan contributions*



*Employee-only coverage

Source: Martin E. Segal Co.

Chart: Holly E. Seguire

Creditor group seeks new Mentor liquidator

By ROGER SCOTTON

HAMILTON, Bermuda—A dissident group of Mentor Insurance Ltd. creditors wants to call a special creditors' meeting to appoint an additional liquidator for the insolvent Bermuda-based reinsurer.

The group, represented by London-based solicitor Francis Mackie, is demanding the appointment "probably of a senior accountant" from a firm other than Arthur Young & Co., whose partners Charles Kempe and Michael Arnold were named Mentor's liquidators by a 1985 Bermuda Supreme Court order (see earlier story, page 15).

In letters written on behalf of the dissident creditors and circulated earlier this year to Mentor's British creditors, Mr. Mackie says the new

appointment "may well entail one of the existing joint liquidators standing down."

But the letters say that the dissident creditors believe that Arthur Young should be retained "as an integral part of the liquidation team."

The group also seeks an increase in the membership of the Mentor Committee of Inspection, which represents the largest creditors and is charged with overseeing the liquidation.

In response to the dissidents, Messrs. Kempe and Arnold released a statement late last week that said "any disruptive moves can only have a negative impact on the conduct of the liquidation and, ultimately, the amount which genuine creditors receive by way of distribution."

The dissident creditors' demands are described in the letters as being the main issues to be discussed at a proposed "special meeting" of Mentor's creditors, which are owed about \$686 million by Mentor.

Mentor is a subsidiary of Ocean Drilling & Exploration Co. of New Orleans.

"The joint liquidators will be requested to call such a special meeting, failing which, an application to the Bermuda court will be necessary," wrote Mr. Mackie, a partner with the London law firm of Clyde & Co.

"The court will be informed of the terms of the resolution to be put to the meeting and an order will also be sought prohibiting the liquidators from using proxy votes held by them in voting on the resolution and that the liquidators'

present deadline of 31 May 1989 concerning the return of certain accounts and underwriting information by all creditors be adjourned for the time being, pending the outcome of the special meeting and the resolution to be voted upon by all creditors," Mr. Mackie continued.

The letters added that the cost of "the exercise" is to be spread among Mentor creditors who support the special meeting.

The dissident group represented by Mr. Mackie first signaled its displeasure with Mentor's liquidation at an annual meeting of Mentor's creditors last fall in Bermuda, at which time Mr. Mackie introduced a surprise motion of no confidence in the liquidators' 1988 report (BI, Sept. 26, 1988; Sept. 19, 1988).

Though the motion was defeated by a 54-20 vote, Mr. Mackie made it clear that his clients were unhappy with the costs of the liquidation, including legal fees, and the length of time the liquidation was taking.

For the year ended June 30, 1988, Mentor's liquidation costs totaled \$8.6 million, up from \$6.8 million for the previous year.

While a motion at a creditors' meeting can be approved only if a majority of creditors—both in number and in terms of the value of claims owed—votes in favor of the motion, a special meeting can be called under the Bermuda Companies Act if approved by creditors owed at least 10% of Mentor's liabilities.

"We would certainly be able to muster 10%," Mr. Mackie said last week.

However, he could not say when "the exercise" would be started nor would he identify the Mentor creditors he represents.

"I am acting for a group of creditors in London and the U.S. which seriously questions the strategy of the liquidation," he said, adding that "it is utter nonsense to suggest that I am acting for" ODECO or Pinnacle Reinsurance Ltd. of Bermuda, both of which have been named as defendants in a \$700 million fraud lawsuit filed by the liquidators in U.S. District Court in New Orleans.

That suit, which was dismissed on grounds that Bermuda would be a more convenient forum, is on appeal.

Mr. Mackie accused the liquidators of "grossly misunderstanding the feeling in the market as to how this liquidation is being run."

He urged the liquidators to "think in terms of changing the strategy of the liquidation" and to demonstrate a commitment to what he described as "democratic consultation" with the group of creditors.

Mr. Mackie also has refused to comment on what was discussed at an April 19 meeting he held with Mr. Arnold, though the liquidators' statement issued last week said that "a full and frank discussion took place" and that the meeting "finished on a friendly note."

In their statement, issued to respond to "misinformation circulating in the reinsurance world" concerning the Mentor liquidation, Messrs. Kempe and Arnold said they do not believe the appointment of an additional liquidator would be cost-effective. They added that they oppose a special meeting of creditors because of the "cost and diversion from their task of progressing this complex liquidation."

However, the statement does not indicate how or to what extent the liquidators will oppose the dissident creditors' actions.

"The liquidation is progressing as fast, if not faster, than any other of a similar size and complexity," the liquidators' statement says.

Messrs. Kempe and Arnold say they will not oppose efforts to increase "numbers representing creditors on the committee of inspection from five to seven." And, they say they have "undertaken to hold consultations for those creditors who are having difficulty in complying with requirements for the filing of proofs of claim and underlying information" by the May 31 deadline.

In addition, the liquidators point out that they "are uncertain as to the true intent and motives of those who are unable to name those creditors for whom they act. Arnold and Kempe are aware that top names of Lloyd's underwriters are not, repeat not, amongst those clients," the statement says. ■



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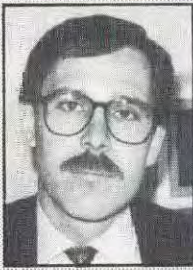
At issue

Is OSHA doing a good job as a loss control/safety agency?



Jesse Pagonis
director-corporate
insurance
Engelhard Corp.,
Edison, N.J.

OSHA on balance does a good job, especially in dramatizing the more acute problem areas. However, in recordkeeping and hazard communication, the effectiveness of programs has not yet been proved. I'm not sure how educating the employee has translated into fewer injuries. And, the cost burden on employers hasn't been fully appreciated by the government.



Randall J. Foster
director-safety/
environmental
compliance
Echlin Inc.,
Branford, Conn.

No. Despite OSHA's efforts, the most recent data shows no improvement in the loss incidence rate for manufacturing. Compliance with OSHA's regulations alone will not result in the type of comprehensive loss control program industry requires to cope with the complex personnel, technological and legal issues facing it.



Douglas Marsh
safety manager
H.B. Fuller Co.
St. Paul, Minn.

OSHA's intent is very good. However, most accidents are associated with unsafe behavior and most OSHA regulations address unsafe working conditions. That is why OSHA has not made much progress when you look at its statistics. The real determining factor in a safety program's success is not rules and regulations; it's top management's involvement.



John Wisniewski
corporate safety
manager
Modine Manufacturing Co.,
Racine, Wis.

OSHA as a whole is an effective loss control agency. There are a number of OSHA inspectors who know their jobs well and understand the manufacturing mentality. However, a larger number of OSHA inspectors are inexperienced and in need of more extensive training.

Compiled by Christine Woolsey

Bank battle

Continued from page 3

the 1956 law that limits bank holding companies' non-banking activities to those that are "closely related" to banking.

It also oversees implementation of the Garn-St Germain Depository Institutions Act of 1982, which went further than the BHCA to explicitly prohibit bank holding companies from selling insurance, except in seven narrowly defined instances that do not include financial guarantee insurance.

Under a Federal Reserve Board policy, bank holding companies cannot own more than 25% of an insurer's stock, and included in that amount, a bank can own no more than 4.9% of an insurer's voting shares, Mr. Dilworth explained.

Fleet/Norstar found itself in violation of the Fed's policy in January 1988, after Fleet Financial Group and Norstar Bancorp Inc. merged. The companies had separately owned small percentages of Capital Guaranty's stock before their merger.

A key issue in the debate is whether financial guarantee insurance is truly insurance.

Fleet/Norstar contends it is not, arguing that:

- Financial guarantee insurance, which is based exclusively on a credit evaluation, is not a traditional insurance product that transfers risk and that its regulation by state insurance departments is "irrelevant."

- Financial guarantee insurance is "functionally similar" to letters of credit, which are widely issued by banks.

- Because financial guarantee insurance is closely related to banking, participation in the business is permissible under the Bank Holding Act.

- Fleet/Norstar's participation in the financial guarantee business will enhance competition in the financial guarantee insurance industry. Capital Guaranty now has only a "very small share" of the financial guarantee market, according to Fleet/Norstar.

In addition, Fleet/Norstar also contends that it will help the public if it is allowed to offer financial guarantees, because the bank holding company plans to target small, regional bond issuers as policyholders, which it contends are underserved.

- Congress did not intend the Garn-St Germain Act to prevent the Fed from allowing bank holding companies to provide financial guarantees. Instead, Congress was concerned about banks' entry into the "traditional" areas of property/casualty and life insurance.

Several insurance industry trade associations have filed counterarguments with the Fed in two statements.

The AIA, along with the Alliance of American Insurers and the American Council of Life Insurance, jointly submitted a statement opposing Fleet/Norstar's application and seeks a full hearing by the Fed's board of governors on the issue.

The second statement, which presented similar arguments, was jointly submitted by the National Assn. of Casualty & Surety Agents; the National Assn. of Surety Bond Producers; the Independent Insurance Agents of America Inc.; the National Assn. of Life Underwriters; the National Assn. of Professional Insurance Agents; the New York State Assn. of Life Underwriters; the Professional Insurance Agents of New York Inc. and the Independent Insurance Agents of New York Inc.

Among the groups' arguments are that:

- Financial guarantee insurance is not merely an extension of credit but involves spreading risk in the

Continued on page 12

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Bank battle

Continued from page 10

same sense that "traditional" insurance products do.

- State regulation of financial guarantee insurance is not irrelevant but rather an "overriding factor" in determining that a financial guarantee is a type of insurance.

- There are "significant differences" between financial guarantee insurance and standby letters of credit that "render them operationally and functionally dissimilar."

The most fundamental difference between the two instruments is that a financial guarantee insurance contract creates a secondary liability as opposed to the primary liability created by a letter of credit, the groups explained. As a consequence, a financial guarantee insurer is obligated to pay the holder of the financial guarantee only when the issuer defaults, and not merely upon the presentation of documents as with an LOC, the insurer groups explained.

- The sale of financial guarantees by bank holding companies is prohibited by the BHC Act and the Garn-St Germain Act, and this reflects Congress' intention.

- Fleet/Norstar's claim that its involvement in financial guarantee insurance will enhance competition are unsubstantiated "self-serving assumptions."

A Fed spokesman said there is no way of knowing when the agency will take any action on the issue.

Attorney Jonathan B. Sallet of Washington, D.C.-based Miller, Cassidy, Larocca & Lewin, who represents the agent groups, said he believes this is the first time the Fed has been asked to define insurance. "It's very important this analysis get off on the right step," he said.

"This is the first case where they've been asked to say something is not within the purposes of the act," Mr. Dilworth agreed. He noted that Fleet/Norstar plans to file a response to the insurance groups' comments no later than May 12. ■

Hines symposium

Continued from page 3

Joint underwriting associations also "could mark the end of the insurance free enterprise system as we know it today," because they force insurers to offer certain lines of coverage at woefully inadequate rates, said T. Richard Kennedy, a managing partner with the law firm Werner, Kennedy & French in New York.

As an example, Mr. Kennedy cited the New York State Medical Malpractice Insurance Assn., which insures 70% of the state's physicians. The MMIA has a \$3 billion deficit and by the year 1995 could have \$10 billion deficit, he said.

"The insurance superintendent from 1975 to 1985 never set a rate that was more than 75% adequate," Mr. Kennedy asserted.

And the New York Court of Appeals, the state's highest court, ruled in December that JUAs are creatures of the legislature and, therefore, have no constitutional rights, he said. The

court said JUAs could be compelled to operate at a loss.

"If the \$3 billion deficit turns out to be true, the large members of the JUA will incur \$300 million each" in assessments to make up the deficit, Mr. Kennedy said.

"This is deficit financing—pure and simple," he said.

Mr. Kennedy, who represents the JUA, is appealing the New York Court of Appeals decision to the U.S. Supreme Court (BI, Jan. 19, 1987). The high court has not yet agreed to review the case.

AIG's Mr. Greenberg also noted that court decisions forcing the nation's property/casualty insurers to bear the cost of cleaning hazardous waste sites are threatening the insurance marketplace.

"If insurers must pay for society's ills, no one will invest in property/casualty insurers," Mr. Greenberg said.

"This issue goes to the root of our economic system," he asserted.

Mr. Greenberg said one alternative to forcing insurers to bear the burden

of the cost to clean the environment would be assessing commercial policyholders for the cost of cleanups.

AIG has proposed assessing all commercial property/casualty insurance policyholders a flat fee equal to 2% of their premiums to set up a trust fund to pay for cleaning up the nation's 1,000 most-polluted sites. Self-insured companies would be assessed "an equivalent" amount determined on an as-yet undecided basis, under Mr. Greenberg's plan (BI, March 6).

"Sixty percent of all Superfund expenditures to date have been for litigation," he said. "Nothing is getting done, and the legal profession now has a new annuity."

The Comprehensive Environmental Response, Compensation and Liability Act, also known as the Superfund Act, empowers the federal government to force all parties responsible for a polluted site to pay for cleaning up the site. The act makes all responsible parties jointly and severally liable for the site's cleanup.

Policyholders nationwide that have been forced to contribute to hazardous waste cleanups under Superfund have sued their insurers for indemnification of these costs. Courts nationwide are split on the issue.

Mr. Greenberg said AIG's proposal would end this massive litigation and place the costs of pollution cleanups on society as a whole because commercial insurance buyers will pass on their costs by raising the prices of their products.

"There is no perfect solution. There are lots of people who criticize this proposal, but not many who come up with alternative solutions," Mr. Greenberg observed.

All of the speakers agreed that the root of the many problems plaguing the insurance industry is the industry's poor public image.

"The loss in California unleashed a national torrent of frustration," Sen. Dunne said, referring to the passage of Proposition 103.

He said Proposition 103 "was a product of pent-up public opinion that the insurance industry is a big fat cat."

If the insurance industry does not improve its public image, it will be regulated out of existence, Sen. Dunne predicted.

"The (insurance company) CEOs fail to make the necessary correlation between regulation, legislation and public image and the collective impact which those elements have on the corporate bottom line," he said.

But, part of the problem is that insurance buyers do not understand the function of insurance, said Mr. Greenberg.

"There is a misconception that insurance is designed to absorb losses," he said. "Most corporate CEOs, if they buy a policy and haven't had a loss, feel cheated."

"But insurance spreads losses—it doesn't absorb losses," Mr. Greenberg explained.

The dramatic swings in insurance prices also fuel public confusion about the insurance industry, according to the panelists.

The current soft market is not going to help matters either, Mr. Greenberg predicted.

"A rising tide does not help a ship that has sunk," he quipped.

After the panel discussion, the Insurance School of Chicago presented John A. Corneli, retired director of risk management for Santa Fe Southern Pacific Corp. in Chicago, a scroll of appreciation for dedicated service to the insurance industry.

Edwin S. Overman, president emeritus of the Insurance Institute of America and the American Institute for Property & Liability Underwriters in Malvern, Pa., moderated the discussion.

The Harold H. Hines Jr. Memorial Symposium is presented annually in memory of Mr. Hines, who was considered a scholar of the insurance industry and risk management. Mr. Hines was president and chief executive officer of Chicago-based broker Rollins Burdick Hunter Co. when he died in June 1984. ■

Standard & Poor's invites you to a seminar: Insurance into the '90s: An Industry at the Crossroads

Through the decade of the 1980's, the insurance industry has been battered and bloodied by financial upheaval, regulatory strife, and consumer rebellion. At the threshold of the 1990's, many leading industry observers are asking: Can the industry respond to face the new realities? Or will the coming decade be one of continued strife and financial stress?

Please join industry spokespersons and the senior insurance analysts of Standard & Poor's Insurance Rating Services at a full-day's symposium at The Westin O'Hare in Chicago on Wednesday, May 17, 1989. Together we will be exploring the critical issues confronting the industry into the 1990's.

WEDNESDAY, MAY 17, 1989

8:00-8:30 a.m./Registration/coffee & danish

8:30-8:45 a.m./Introduction & welcome
Roy Taub, managing director, S&P

8:45-9:15 a.m./Surveying the landscape: industry outlook

Property/Casualty & Reinsurance
Alan Levin, senior vice president, S&P

Life insurance
Mark Puccia, vice president, S&P

9:15-10:30 a.m./Insurance regulation in transition: state vs. federal regulation

Consumer protection vs. solvency maintenance
Robert Mebus, managing director, S&P

Robert Hunter, president, National Insurance Consumer Organization

John Shelk, minority counsel, U.S. House of Representatives

John Washburn, Illinois Commissioner of Insurance

10:30-10:45 a.m./Coffee break

10:45-12:00 noon/Insurance regulation in transition (cont'd):

Regulatory detection of troubled insurers
Regulatory supervision of financially impaired insurers

Role of guaranty funds

Roy Taub, managing director, S&P

Ronald Chronister, deputy commissioner, Pennsylvania Department of Insurance

Paul Gulko, president, Guaranty Fund Management Service of Boston

Philip Tsang, vice president, S&P

Robert Smith, assistant vice president, S&P

1:30-2:45 p.m./Concurrent sessions

Session 1:

Health-care crisis in America: who will survive?

John Fagnoli, senior vice president, S&P

Timothy Clark, assistant vice president, S&P

Frederick Cue, senior vice president, Blue Cross/Blue Shield

Joseph Duva, corporate director, Employee Benefits, Allied Signal Inc.

Session 2:

Riding the property/casualty cycle: crash landing ahead?

Michael Frinquelli, managing director, Salomon Brothers

Dr. Terrie Troxel, senior vice president, National Association of Independent Insurers

John Iten, assistant vice president, S&P

2:45-3:00 p.m./Coffee break

3:00-4:30 p.m./Concurrent sessions

Session 1:

Solvency evaluation of life insurers: a view from the private sector

Mark Puccia, vice president, S&P

James Hiner, principal, Mercer Meidinger Hansen

Andrew Pfeiffer, vice president, PRIMCO Capital Management

William Cavanagh, assistant vice president, S&P

Karen Knoller, assistant vice president, S&P

Session 2:

Solvency evaluation of property/casualty & reinsurers

Alan Levin, senior vice president, S&P

Marjorie Horowitz, vice president, Marsh & McLennan

Marshall Pinnix, senior financial analyst, Alexander & Alexander

Robert Bailey, senior vice president, E. W. Blanch

Robert Smith, assistant vice president, S&P

The registration fee of \$375 each participant includes handout materials, luncheon, and Wednesday evening's reception. Multiple discounts are available.

To register, FAX a letter to Donna DiGrandi at (212) 208-0076 or call (212) 208-1703 for hotel and seminar information.



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Hilton names Patton assistant treasurer

Michelle Patton, 38, has been promoted to assistant treasurer-risk management for Hilton Hotels Corp. in Beverly Hills, Calif. She will be responsible for the development of Hilton Insurance Corp., a Vermont-based captive insurer, and will continue to oversee the risk management department, including claims administration, loss prevention and the property/casualty insurance program. Ms. Patton replaces **Walter L. Robinson**, who left the company, and reports to Maurice J. Scanlon, senior vp-finance. Prior to joining Hilton in 1986 as director of risk management, Ms. Patton was corporate insurance manager at Carl Karcher Enterprises Inc. in Anaheim, Calif. Prior to that, she served five years as corporate risk and insurance manager for Max Factor & Co. in Hollywood, Calif. Ms. Patton attended the University of California at Los Angeles and Santa Monica City College. Ms. Patton is a past director of the Los Angeles Chapter of the Risk & Insurance Management Society and serves on the risk management committee of the American Hotel & Motel Assn.

Also at Hilton Hotels Corp.: **W. David Little**, 31, named director of risk management. He will handle property/casualty insurance programs for the company's international operations and franchise locations, as well as development of premium allocation and cost of claims systems. Mr. Little replaces and reports to Ms. Patton. Prior to joining Hilton Hotels, Mr. Little was risk manager at Calcomp Inc. in Anaheim, Calif. He holds a bachelor's degree in risk management and a master of business administration degree in finance from the University of Georgia at Athens. He holds the Associate in Risk Management designation, is a deputy member of the Risk & Insurance Management Society and serves on the American Hotel & Motel Assn.'s risk management committee.

Timothy Pecsénye has been promoted to manager-benefits and compensation services at Libbey Owens Ford Co. in Toledo, Ohio. In this newly created position, he is responsible for the design, implementation and administration of employee benefit programs for the glass manufacturer. He also continues to be responsible for payroll administration and the human resources information system. Mr. Pecsénye reports to Randall D. Berg, director of compensation and benefits. Mr. Pecsénye joined LOF in 1984 as a human resources information system staff analyst

and was promoted to manager-compensation administration and systems in 1986. He received a bachelor of arts degree from Siena Heights College in Adrian, Mich., and currently is pursuing his master of business administration degree at the University of Detroit. Mr. Pecsénye is a director of the Great Lakes Chapter of the Assn. of Human Resource Systems Professionals.

Diane S. Webster, 34, promoted to associate vp at A.G. Edwards & Sons Inc. in St. Louis. Ms. Webster, as manager of risk and insurance, will continue to oversee risk management and property/casualty insurance, as well as workers compensation claims management. Ms. Webster also serves on A.G. Edwards' Disaster Recovery Task Force. She reports to Bob Proost, vp. Prior to joining A.G. Edwards, Ms. Webster was insurance manager at Carboline Inc. in St. Louis. Ms.

Comings & goings: buyers

Webster holds the Associate in Risk Management designation, and is a licensed insurance broker. She has served as treasurer and a director of the St. Louis chapter of the Risk & Insurance Management Society.

Dotty Peck, 40, named vp/administration and risk management at Personnel Pool of America Inc. in Fort Lauderdale, Fla. In this newly

created position, she oversees the firm's property/casualty insurance and risk management programs, handles facilities management, purchasing and administrative services. She reports to John B. Smith, senior vp. Ms. Peck, who joined Personnel Pool in 1977 as insurance coordinator, most recently served as senior director/administration and risk management. She holds the Char-

tered Property & Casualty Underwriter designation.

Michael J. Andersen, 25, named supervisor-corporate risk management at Harris Corp. in Melbourne, Fla. He oversees the administration and coordination of Harris' worldwide insurance programs, reporting to Donald J. Sullivan, manager-corporate risk management. Prior to joining Harris—which produces advanced communication, information processing and microelectronic products, systems and networks—Mr. An-

dersen served in the risk management department of Akzo America Inc. in New York. He holds a bachelor of science degree in finance from Fairfield University in Fairfield, Conn.

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Ruling may trigger new tobacco liability suits

By MICHAEL SCHACHNER

ST. PAUL, Minn.—A Minnesota Supreme Court ruling that federally mandated health warnings on cigarette packages do not protect tobacco manufacturers from some product liability lawsuits will set off a new wave of litigation against tobacco manufacturers, legal experts predict.

In a decision that plaintiffs' attorneys say is a significant stride forward for victims of smoking-related diseases seeking damages from tobacco companies, the Minnesota Supreme Court ruled last month that the Federal Cigarette Labeling and Advertising Act of 1965 does not preempt claims for misrepresentation, strict liability, defective design and breach of warranty.

But, the court upheld the federal pre-emption of suits that claim tobacco companies failed to warn consumers since 1966 of the health risks associated with smoking.

Plaintiffs' attorneys expect that the avenues the court left open to plaintiffs to pursue claims against the tobacco industry will be accepted in other jurisdictions, as well.

If plaintiffs are able to prove that tobacco companies misrepresented their products even though they displayed health risk warning labels on cigarette packages or breached warranty by marketing a defective product, the tobacco manufacturers could face liabilities similar to those confronting asbestos manufacturers (*BI*, June 20, 1988), some say.

Product liability insurance covering health risks has been largely unavailable to most cigarette manufacturers since the 1970s, and most of the large tobacco companies now self-insure their product exposures.

In addition, whatever coverage is available to tobacco companies may not be sufficient if damage awards start to pour in.

The Minnesota ruling centers around a March 1985 lawsuit filed by John Forster of Minneapolis against Winston-Salem, N.C.-based R.J. Reynolds Tobacco Co., a subsidiary of R.J.R. Nabisco Co. of Atlanta; Minneapolis-based Holiday Station Stores Inc., a distributor of Reynolds' tobacco products; and Erickson Petroleum Corp., Holiday's parent.

Court papers say that Mr. Forster, who died of lung cancer in June 1985, began smoking Camel cigarettes in 1953 at the age of 15, before health risk warnings were required on cigarette packages.

Mr. Forster's lawsuit, which was taken over by his widow, alleges that Reynolds' advertising persuaded him that smoking was glamorous and non-hazardous to one's health. The suit contends that by the time Mr. Forster was made aware that smoking was unhealthy, he was addicted to cigarettes and could not quit.

The Hennepin County District Court in Minneapolis ruled in July 1987 that Mr. Forster's suit was barred by the federal pre-emption of product liability suits against tobacco manufacturers granted by the 1965 labeling and advertising act.

However, the Minnesota Court of Appeals unanimously reversed that decision last May (*BI*, May 9, 1988).

In partially upholding the appellate decision, the state Supreme Court ruled April 14 that the 1965 federal law does not bar plaintiffs from seeking damages from tobacco manufacturers on several grounds.

For example, regarding a claim in the Forster suit that Reynolds misrepresented its product, the court ruled: "The claim, it should be noted, is not for fraudulent concealment of information, which would really be a variation of the duty to warn and hence pre-empted. It is based, rather, on affirmative statements made which are allegedly untrue. Such a claim would not be pre-empted."

And, the court ruled that the 1965 law does not shield tobacco manufac-

turers from strict liability for a plaintiff's ill health as a result of smoking. The court ruled: "Strict liability assumes the product is useable and asks only if it has been safely designed. . . . It is unclear what the plaintiffs have in mind here, but if plaintiffs can prove a defective condition or a defective design—apart from any claim of inadequacy of warning—we see no conflict with the federal Act."

The case has been remanded to the Hennepin County District Court for trial.

Michael Weiner, an attorney with the Minneapolis firm of DeParcq, Hunegs, Stone, Koenig & Reid, who represented Mr. Forster, said the decision was of paramount importance.

"It's a major victory, although it's not as complete as the court of appeals' decision, which rejected all

pre-emption," he said.

Other plaintiffs' attorneys and opponents of the tobacco industry label the decision a triumph for plaintiffs in product liability litigation against tobacco manufacturers.

"From a plaintiff's standpoint, this is the most helpful ruling yet," said Alan Darnell, an attorney with the Woodbridge, N.J., firm of Wilentz, Goldman & Spitzer.

Mr. Darnell was a co-counsel for Antonio Cipollone, who was awarded \$400,000 in damages last summer by a federal court jury in Newark, N.J., in litigation with the Durham, N.C.-based Liggett Group. Mr. Cipollone had filed a lawsuit on behalf of his late wife, Rose, who died of lung cancer in 1984 after smoking the tobacco company's cigarettes since before 1966 (*BI*, June 20, 1988).

Legal experts believe lawyers will

have a good shot at proving in court that despite warning labels, cigarette manufacturers continued to advertise and represent their product as glamorous and healthy.

"Misrepresentation should be quite easy to prove," said Richard Daynard, a law professor at Northeastern University in Boston, and chairman of the Tobacco Products Liability Project, a group of lawyers, doctors and academicians that encourages litigation against tobacco companies.

"You'll have a lot of smokers saying the definitive word wasn't in by 1966, and meanwhile, the tobacco company P.R. was to persuade them to keep smoking until the word came in," he said.

Mr. Weiner said he would proceed on the grounds of strict liability, claiming that cigarette makers are guilty of faulty design because ciga-

rettes are not made of pure tobacco. He said cigarettes are known to contain additional chemicals and pesticides that could be linked to diseases.

A Reynolds spokesman, though, played down the significance of the Minnesota decision, saying that it only gives Mr. Weiner the opportunity to try the case in court.

"When the case is returned to the trial court, a central element of the proceedings will be the established adequacy of federally mandated warnings as a matter of law. We are confident that we will ultimately prevail," Reynolds said in a statement.

The Reynolds spokesman would not comment on the company's product liability coverage, nor would he say whether Reynolds' insurers are paying the defense costs for the litigation. ■



Jury misinformed, Mentor liquidators say

By ROGER SCOTTON

HAMILTON, Bermuda—The liquidators of insolvent Mentor Insurance Ltd. are asking a federal court to grant a new trial in a fraud complaint the liquidators filed against an underwriting manager and other defendants.

Mentor liquidators Charles Kempe and Michael Arnold are seeking the new trial in part because a U.S. District Court jury received "improper communications" from a court official before returning its verdict, according to the retrial motion filed by the liquidators last month.

In March, the federal court jury ruled against the Mentor liquidators in their suit against underwriting manager World American Underwriters: James R. Wining, former president of WAU; and broker Fi-

nancial Guardian Group Inc., WAU's parent.

Mr. Wining later left WAU to form Royal American Managers Inc., a managing general agent that subsequently purchased WAU's reinsurance business. RAM was criticized last year in a report by Illinois and Nebraska regulators for abuses that led to horrendous losses for Omaha Indemnity Co. between 1983 and 1985 (*BI*, Dec. 12, 1988; April 28, 1986).

The Mentor liquidators' lawsuit accused the three defendants of fraud, breach of agency contract and fiduciary duties owed to Mentor, and negligent performance. The suit sought up to \$40 million in actual and punitive damages.

At the heart of the dispute was a reinsurance contract covering liability risks of Wal-Mart Stores Inc. The

'Improper communications' took place while the jury was deliberating, the liquidators say.

complaint says the defendants acted as agents for Mentor in underwriting and managing the reinsurance agreement.

The business was offered to Mentor in October 1981 in a telex from Mr. Wining, the suit says. Mr. Wining said that Mentor could expect to collect premiums equal to 20 cents per \$1,000 of Wal-Mart's sales, the suit said, adding that Mr. Wining indicated that projected sales for the 16-

month contract would total \$4.5 billion.

However, the suit alleges, Mr. Wining understated the number of stores the contract covered while overstating Wal-Mart's sales.

The suit also alleges that in January 1982, Mr. Wining telexed Mentor to suggest changes in the Wal-Mart reinsurance account. He proposed dropping a provision excluding false arrest claims made against Wal-Mart, the complaint said. He also recommended that a \$1,000 per-claim deductible be established for all false arrest claims, retroactive to Oct. 15, 1981, the suit said.

Mentor agreed to these changes and later received confirmation of the changes in a letter from Mr. Wining that said the \$1,000 deductible "would make the Wal-Mart account more profitable in the future to Men-

tor."

But, the deductible was never included in the contract between the ceding insurer and Wal-Mart, the suit alleges, even though the false arrest exclusion was deleted. "Instead, WAU and Wining issued or caused to be issued an endorsement to Wal-Mart deleting the exclusion without enacting any deductible," the suit said.

The complaint further contended that Mr. Wining in May 1982 wrote to Mentor to say that losses incurred by Mentor had been overstated by \$175,000 through May 7, 1982.

"Wining further represented in this May 25, 1982, letter that Wal-Mart's sales receipts, upon which Mentor's premiums were based, were up 59% at that time," the liquidators charged.

However, the suit said, "at the time of Wining's May 25 letter, losses had in fact not been overstated. Instead, an artificially low reduction in reserves... gave the appearance that the Wal-Mart business was better than it actually was."

In September 1982, Mr. Wining telexed Mentor that the reinsurance contract was to be canceled on Oct. 1 and invited Mentor to renew the agreement for a three-year period, according to the liquidators. The telex said that Mentor had suffered losses equal to only 70% of premium at that point, the suit said.

Mentor agreed to the renewal.

In April 1983, Mr. Wining informed Mentor of Wal-Mart's sales for the periods up to April 1, 1983, but the numbers he provided did not agree with figures in Wal-Mart's annual reports, the suit alleged, claiming that Mr. Wining overstated Wal-Mart's sales by \$792 million and \$560 million in two separate years.

Mentor eventually canceled the reinsurance agreement effective Sept. 30, 1983, after becoming suspicious over what the liquidators claimed was a unilateral attempt by the defendants to assign their underwriting and management duties to another entity without notifying Mentor.

Mentor's loss ratio on the account has been as high as 500% since the contract was canceled, the liquidators note.

They add that Mentor lost about \$10 million over the course of the agreement.

Financial Guardian denied the allegations. In court papers it argued that Mentor's financial difficulties were "self-inflicted," largely as a result of cash-flow underwriting. In addition, FG claims that Mentor could have canceled the account earlier, but did not.

In its March 24 verdict, the jury found in favor of the defendants on all charges.

However, since then, the Mentor liquidators say they have obtained sworn statements for two jurors, including foreman Thomas Cox, indicating that "improper communications" took place between the court's law clerk and the jury while it was deliberating.

"This court's law clerk on two separate occasions communicated the clerk's interpretations of how the negligence instructions were to be construed in connection with the other instructions" to the jury, the motion says.

"Although the jurors wanted to return a verdict in favor of the plaintiffs, they erroneously believed, after the discussions with the law clerk, that the jury could not find separately for the plaintiffs on the negligence claims."

The liquidators also argue that the written court instructions to the jury erroneously referred to a statute of limitations provision, which the liquidators say was improperly added to the instructions at the insistence of the defendants.

Mr. Kempe refused to comment on the action.



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Stop-loss cover costs up for Lloyd's members

By STACY SHAPIRO

LONDON—Lloyd's of London members who have had difficulty finding or affording personal stop-loss insurance now have several options, but the price for the coverage still is much higher than last year.

As of mid-February, only a handful of the 17,000 Lloyd's members who buy personal stop-loss coverage had been able to renew their coverage because capacity was so limited (BI, Feb. 20).

Lloyd's traditional leading stop-loss insurance broker, Holman Wade Ltd., which did not complete its stop-loss line slip until March, is offering a three-year stop-loss policy written by Lloyd's underwriters led by syndicate 872 underwritten by

Eric Pieri.

Limits on the first layer of Holman Wade's coverage have been reduced to 100,000 pounds (\$171,400) per year excess of 10% of the member's allocated premium income capacity or his largest syndicate participation, said Edward Vale, Holman Wade's marketing director. Last year, the broker offered 250,000 pounds (\$428,500) of coverage.

However, Holman Wade will offer a second layer for 150,000 pounds (\$257,100) excess of 100,000 pounds that is currently being completed, said Mr. Vale.

Premiums for the coverage have increased by 30% to 40% from last year for members who write more than 250,000 pounds (\$428,500) in premium volume at Lloyd's; and have as much as doubled for members who write less than 250,000 pounds, said Mr. Vale.

Holman Wade, which had placed as many as 11,000 of the 17,000 stop-loss policies written for Lloyd's members, placed 3,000 January renewals this year and has about 2,500 members still waiting for quotations.

"We're not sure we will have the capacity" to place the rest of the members' coverage, said Mr. Vale.

Another leading Lloyd's stop-loss insurance broker, Carritt & Partners, only recently completed its stop-loss insurance line slip for coverage that—like other policies—is backdated to Jan. 1, 1989, when the coverage should have been placed. Carritt also offers limits of 100,000 pounds per year excess of 10% allocated premium capacity for members with more than 250,000 pounds (\$428,500) of premium capacity and excess of 15% for members will less than 250,000 pounds of capacity.

The Carritt line slip is 75% placed at Lloyd's and 25% placed in the London insurance market, including 10% with Municipal General Insurance Ltd. and 5% with Independent Insurance Co., confirmed Carritt Director Paul Fletcher.

However, the premiums are approximately double what they were last year, he said.

"We have placed 70% (of the members' policies) that we were expecting," said Mr. Fletcher. "We are running out of capacity quite quickly now."

In addition, Lloyd's broker Robert Fraser Insurance Brokers Ltd.'s novel personal stop-loss insurance policy launched in February and led by Zurich International Ltd. and reinsured by Centre Reinsurance Holdings Ltd. in Bermuda has generated a tremendous amount of interest, according to Chairman Garth Bearman.

Last month, Robert Fraser had received approximately 10,000 requests for information on the policy and at least 700 quotations had been made to potential buyers, he said. With no capacity problem, Robert Fraser will try to place all those interested in the coverage, "but if we place 30% of those interested we will be happy," he said (BI, April 10).

Meanwhile, the Assn. of Lloyd's Members has announced that London-based Charles Taylor & Co. has set up The Stop-Loss Mutual Insurance Assn. Ltd. to enable members to meet their personal stop-loss insurance needs through a group self-insurance plan.

John Rowe, director of Charles Taylor, gave details about the association in April's ALM news bulletin, but he was unavailable to comment on it last week.

The mutual, which is expected to be launched in June, has the blessing of Lloyd's, says Mr. Rowe. However, Charles Taylor is awaiting its license from the British Department of Trade and Industry.

The mutual will offer 100,000 pound limits per member at "competitive" rates, said Mr. Rowe. ■

Trial to begin for 2 former Howden execs

By STACY SHAPIRO
and CAROLYN ALDRED

London

LONDON—Kenneth V. Grob, former chairman of Alexander Howden Group P.L.C., and Ian R. Posgate, former Lloyd's of London underwriter, will stand trial this week on charges they misappropriated underwriting funds from Howden and Lloyd's syndicates.

The trial—which comes after seven years of allegations against the two former executives—is scheduled to begin Tuesday in Southwark Crown Court in London, confirmed a spokesman for the Serious Fraud Squad.

Mr. Grob, who was arrested and extradited from France in 1987, faces 55 charges, including that on various occasions between 1980 and 1982 he stole more than \$6.2 million from Lloyd's syndicates 126 through 129.

Mr. Posgate, once considered Lloyd's most successful underwriter and a former member of the Committee of Lloyd's, faces three charges that between Oct. 1, 1979, and Sept. 1, 1982, he conspired with Mr. Grob, former Howden executives Ronald Comery, Alan Page and Jack Carpenter to "steal sums of money" belonging to Mr. Posgate's syndicates 126-129 and 701.

Altogether, the police arrested five defendants in July 1987 in connection with the theft of Howden and Lloyd's underwriting funds (BI, July 20, 1987).

However, the charges against former Howden executive Mr. Page were dropped in the pretrial hearing at the Guildhall Magistrates Court last year because he was terminally ill (BI, June 13, 1988).

And, last week the Serious Fraud Squad spokesman said that it was likely the charges against Mr. Carpenter would be dropped because he, too, is seriously ill.

Mr. Comery died in a car accident before the arrests were made.

Meanwhile, former Lloyd's underwriter Colin Hart, who faces six charges of dishonesty in regard to the Howden incident, will have a separate trial after Mr. Grob and Mr. Posgate are tried, said the spokesman.

Payne rumors denied

Reports that the chairman of London-based reinsurance broker E.W. Payne Cos. Ltd. has resigned from the board of parent Sedgwick Group P.L.C. are being emphatically denied by Sedgwick.

However, E.W. Payne Chairman Jim Payne has taken over the everyday management of the company's London Market Excess of Loss reinsurance unit since the departure last year of the head of the department, Colin Bryan, a Sedgwick spokeswoman confirmed.

Mr. Payne told all E.W. Payne personnel in a memo published in the last month that he will relinquish some of his normal executive duties to devote his time to running the LMX office, which is one of the most profitable departments in the company.

Steel Burrill Jones

Lloyd's of London broker Steel Burrill Jones Group P.L.C. has grown by acquisition in the last month in an attempt to create a balanced force in the London market.

Last month, the group announced that it acquired a controlling interest in a new insurance brokerage set up by six North American property brokers who recently left C.T. Bowring & Co. Ltd. George Moore, former deputy chairman of Bowring North America Ltd., is chairman of the

new company, SBJ North America Ltd. Bob Brown, former executive director of Bowring North America, is managing director.

Other executives include former Bowring brokers Howard Barnes, who will be a director, and David Cooper and Graeme Nicoll, who will be associate directors.

Also, late last month, SBJ bought Devitt Group Ltd. for 20.6 million pounds (\$35.3 million) in new SBJ ordinary shares and cash.

Devitt owns two Lloyd's brokers: Howson F. Devitt & Sons Ltd., which provides a wide range of insurance brokering services, and Meacock Samuelson & Devitt (Reinsurance Brokers) Ltd., which specializes in non-marine excess of loss reinsurance in the Lloyd's and London market. Devitt reported 1983 revenues of 9.75 million pounds (\$16.7 million) and a pre-tax profit of 1.65 million pounds (\$2.8 million).

The three acquisitions complement SBJ's core marine reinsurance brokering operations and help complete the company's strategy to become a more well-rounded broker, the executives say.

The strategy has been carried out by SBJ Chief Executive George Bočen and Finance Director Tony Keys, who both joined SBJ in October 1988 from broker Stewart Wrightson Holdings P.L.C.

Auto fleet coverage

London-based insurance company Eagle Star Insurance Co. Ltd.

is launching an auto fleet insurance policy this month to provide uniform automobile insurance coverage throughout the European Community.

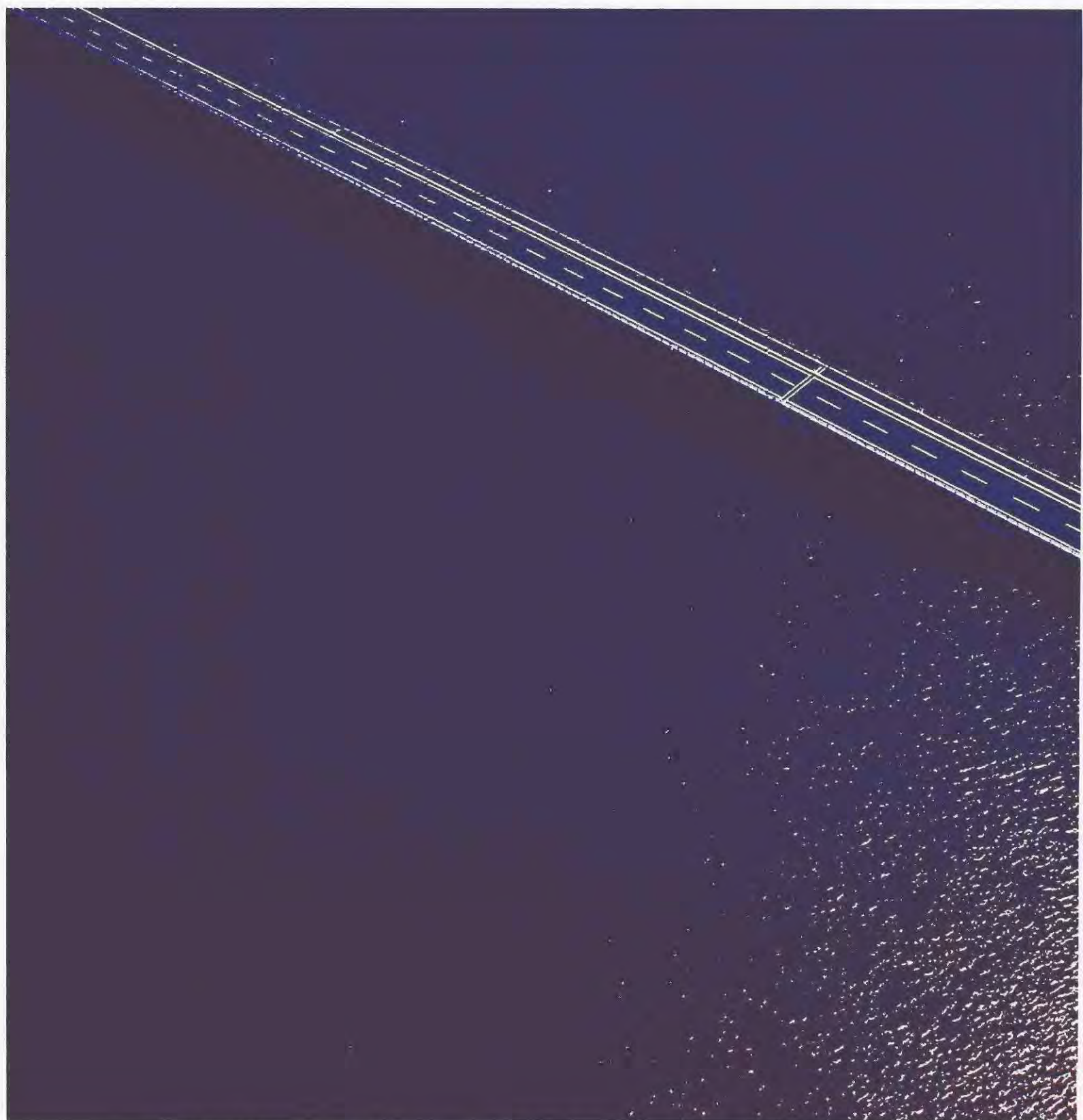
The policy was instituted to "meet the changing needs of fleet operators brought about by" an increase in European travel as companies expand in Europe in preparation for the forthcoming removal of trade barriers within the EC, according to Eagle Star, a subsidiary of B.A.T. Industries P.L.C.

The new policy offers:

- The same level of insurance

Continued on next page

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Continued from previous page coverage throughout the 12 EC member countries in addition to the non-EC nations of Austria, Czechoslovakia, Finland, East Germany, Hungary, Norway, Sweden and Switzerland.

"There will be no need to inform us of each trip, no separate premium to pay," according to Eagle Star.

- A 5 million pound (\$8.6 million) per-occurrence liability limit for damage to third-party property caused by commercial vehicles.

- An optional coverage administered by Allianz Legal Protection Insurance Co., which provides up to 50,000 pounds (\$85,700) per loss for professional fees and legal costs in pursuing uninsured losses and personal injury claims for drivers and authorized passengers.

Aviation brokerage

Alexander Howden Group Ltd., the London-based subsidiary of Alexander & Alexander Services Inc., is combining the aviation brokering divisions of Alexander Howden Ltd. and Alexander Howden Reinsurance Brokers Ltd.

The combined operation, Alexander Howden Aviation, will be a division of Alexander Howden Reinsurance Brokers. Alan F. Griffin will be chairman of the division.

New Lloyd's office

Lloyd's of London opened a second contact office in Italy last month.

The new office in Milan will operate as an extension of Lloyd's Rome office and will be managed by Ga-

brielli Alliata, former assistant representative at Lloyd's Rome office.

The new office will give Lloyd's "a presence in Italy's industrial heartland where it sees important opportunities for securing further insurance business in Italy," said a statement from Lloyd's.

Explosion fund

London-based Imperial Chemical Industries P.L.C. has set up an "ex-gratia fund to alleviate any immediate personal hardship" caused by an explosion of a van carrying 800 kilograms of commercial explosives in Peterborough, England.

Meanwhile, "the question of liability for the accident is being investigated urgently," the company said.

A fireman was killed, more than 80 people were injured and dozens of automobiles and buildings were damaged when the seven-ton van carrying explosives and detonators caught fire and exploded March 23 in an industrial park.

The van, which was making deliveries to a local fireworks factory, was owned by Noble's Explosives Co. Ltd., a Staffordshire, England-based subsidiary of ICI.

ICI's auto liability insurance is written by Guardian Royal Exchange P.L.C., said an ICI spokesman.

Direct-action suits

An injured British employee of a defunct company cannot sue the employer's insurer if the employer's liability had not been determined before

the company was wound up, the House of Lords ruled.

The House of Lords, Britain's highest appellate court, by a 4-1 majority upheld a Court of Appeal decision refusing to grant an order for discovery in a case filed by Doris Bradley of Bolton, England, against Eagle Star Insurance Co. Ltd.

Ms. Bradley was employed at various times between 1934 and 1970 in a cotton mill owned by Dart Mill Ltd. In August 1970, Ms. Bradley was diagnosed as suffering from a respiratory disease caused by the inhalation of cotton dust.

Dart Mill was voluntarily wound up in 1975 and dissolved in 1976.

Ms. Bradley's lawyer in 1984 sued Eagle Star Insurance Co. Ltd., Dart Mill's employers liability insurer during the years of Ms. Bradley's employment, under the Third Parties (Rights Against Insurers) Act of 1930.

That law states that "in the event of the insured becoming bankrupt (or) in the event of a winding-up order being made, or a resolution for a voluntary winding-up order being passed, . . . any such liability . . . incurred by the insured (shall be) transferred to and vest in the third party to whom the liability was so incurred."

To pursue the litigation, Ms. Bradley's lawyer applied to the High Court for an order that Eagle Star disclose the terms and conditions of the insurance contracts.

The order was granted by the court but later denied by the Court of Appeal after an appeal by Eagle Star, a decision that was upheld in the House of Lords last month.

According to Lord Brandon of Oakbrook, one of the five law lords deciding the issue, the Court of Appeal had ruled that the existence and amount of Dart Mill's liability for Ms. Bradley's injury had never been established and no longer was capable of being established. Therefore, the liability could not be transferred to Eagle Star.

If Ms. Bradley's case against Eagle Star could not succeed on these grounds, "it would therefore serve no useful purpose to make the order for preaction discovery," said Lord Brandon.

Comings & goings

Michael Kier and **Peter Presland** have been appointed group managing directors of London broker C.E. Heath P.L.C. Mr. Kier, former managing director of subsidiary Heathfield Insurance Brokers Ltd., will continue to have overall responsibility for the group's brokering activities. Mr. Presland, who had been group finance director, continues to be responsible for all other operations, including underwriting and computer services, corporate development and litigation issues.

Robert Alldis and **Melvin Deakin** have been appointed joint deputy managing directors of C.E. Heath (North America) Ltd.

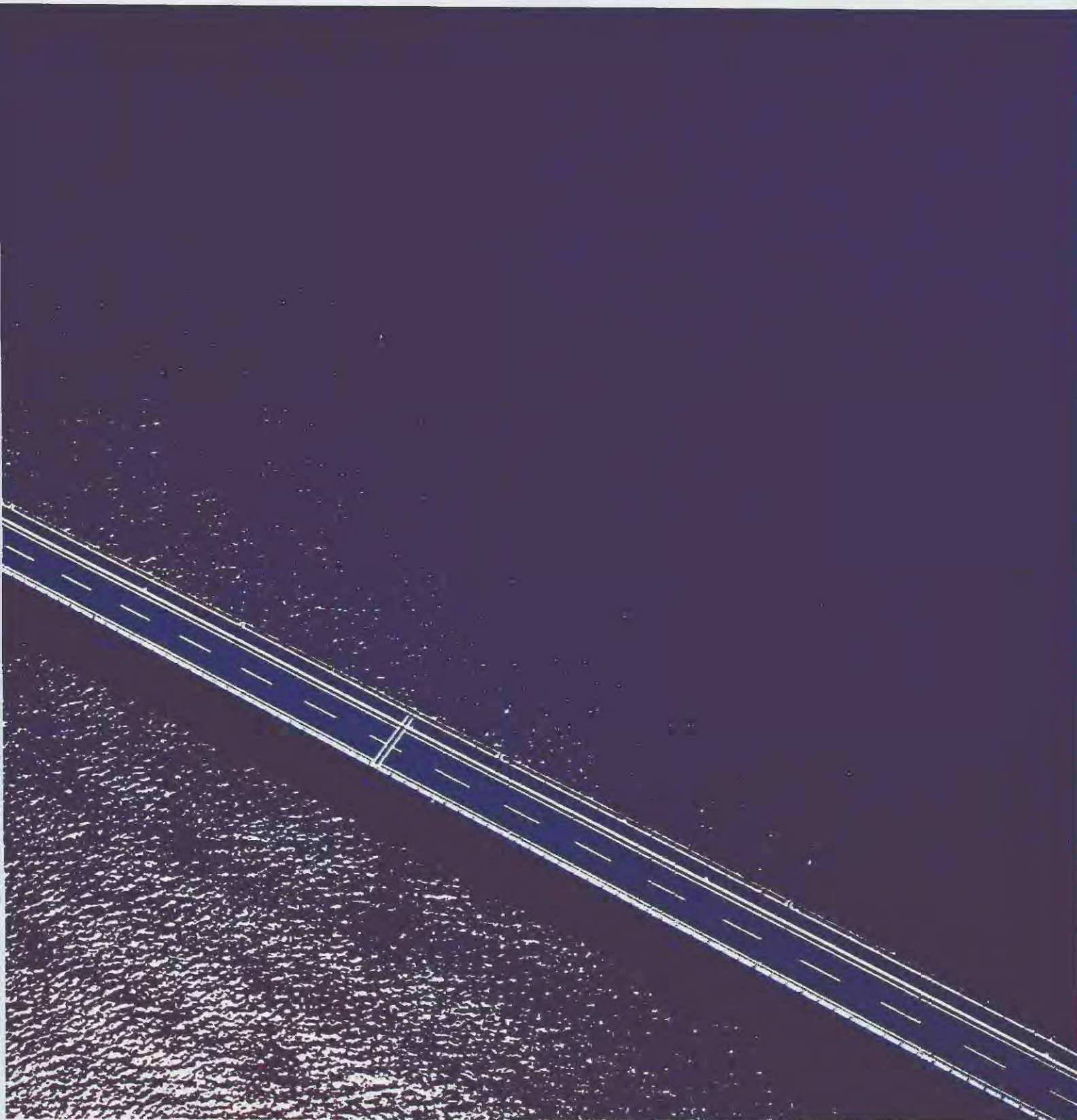
Ian Marshall has been appointed to the new position of general manager for London broker Bain Clarkson Ltd. As general manager, Mr. Marshall, a former official of advertising agency Ogilvy & Mather, will be responsible for cost control, financial and administrative functions.

Derek Prince, currently deputy chairman of Bain Clarkson, has retired but still acts as non-executive deputy chairman of parent Inchcape Insurance Holdings. **David Berliand** and **John Turner** have been named directors of Inchcape Insurance Holdings and **Brian Waters** and **Astley Whittall** have been appointed non-executive directors.

Peter Askew, **Peter King**, **Jonathan Morley Cooper**, **Michael Radford** and **Alan Routledge** have been appointed directors of Bain Clarkson Ltd.

Also, **John Turner** has been appointed chairman of the Bain Clarkson's U.K. division, succeeding **Michael Martin**, who remains a non-executive director of Inchcape Insurance Holdings.

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Health benefits stop after policy is canceled

A group health insurer was not liable, upon termination of an insurance contract, for medical expenses that arose out of an accident that occurred while the policy was in force but that were incurred beyond the contractually agreed upon date, a Louisiana appellate court held.

Pamela Mezzacappo was severely injured in an automobile accident on April 16, 1983, and incurred numerous medical expenses and was certain to incur more in the future. On the date of the accident, Ms. Mezzacappo was covered by a group insurance policy issued by Travelers Insurance Co. and administered by Hammond Administrative Services Inc.

Her employer continued to pay premiums on the policy until the company was sold in the fall of 1983. The last premium paid was October 1983. Upon the sale of the company, all employees were terminated.

Travelers paid Ms. Mezzacappo's medical expenses through Dec. 31, 1984, except for \$200 deemed excessive. Travelers refused to pay and denied responsibility for any medical expenses incurred after Dec. 31, 1984. The group policy provided that insurance would terminate when employment terminates.

Ms. Mezzacappo sued Travelers seeking payment of past medical expenses and any future medical expenses incurred in connection with the injuries arising out of the April 1983 accident. The trial court ruled in her favor but only as to those expenses incurred but not previously paid.

The appellate court said that there was a distinction and important difference between "cancellation" of an insurance contract by the insurer and "termination" of coverage under a contract of insurance. According to the court, "termination" of coverage connotes cessation of coverage under an insurance policy by reason of passage of the policy period. Here, the court said the insurer did not cancel the coverage; rather, Ms. Mezzacappo's coverage ceased according to the terms of the policy when her employment terminated upon sale of the company. Thus, under the contract terms, the court said that Travelers was liable only for expenses incurred to Dec. 31, 1984, under the extended-benefits-after-termination provision of the policy.

Mezzacappo vs. Travelers Insurance Co., Court of Appeals of Louisiana, April 6, 1988, rehearing denied May 5, 1988

Legal briefs

(BI/03/Dec.-\$10).

Fatal kiss compensable

An employee's death from a rare, non-occupational disease contracted when he kissed a co-worker who was leaving for maternity leave was a compensable injury arising in the course of employment, according to a Pennsylvania appellate court.

Earl A. Sallie was employed by the city of New Castle, Pa., as a supervisor for the city's weatherization program. On June 4, 1981, Mr. Sallie returned home from work feeling ill. He was hospitalized and diagnosed with meningococcal septicemia. By the following morning, he suffered a cardiopulmonary arrest and died. His death was listed as cardiopulmonary arrest caused by septic shock, which was the direct consequence of the meningococcal sepsis.

The following day, throat and nasal cultures were taken from 21 of his co-employees. One employee tested positive for the *Neisseria meningitidis* bacterium and was determined to be a carrier of the disease, since she was asymptomatic. Several days before Mr. Sallie died, he was observed kissing the employee on the cheek prior to her departure for maternity leave.

Mr. Sallie's widow filed for workers comp benefits, claiming that he had contracted the fatal disease from the co-employee while he was at work and in the course of his employment. A referee awarded benefits, which was affirmed by the compensation board. The city appealed.

The appellate court said that Mr. Sallie was in a place where his employer required him to be and died as a result of what ordinarily would have been merely a harmless act of good will. Thus, the court said that his act was merely an innocent or inconsequential departure from his line of duty. The court further concluded that a disease contracted solely because a co-worker has communicated that disease was compensable. *City of New Castle vs. W.C.A.B. (Sallie)*, Commonwealth Court of Pennsylvania, July 20, 1988 (BI/02/June-\$10).

Insurable property interest

The Supreme Court of Missouri held that a lessee of property with an

unexercised option to purchase had an insurable property interest in that property.

L.K.N. Corp. leased a commercial building from G.M. Battery & Boat Co. for a term of two years, commencing March 1, 1982, at \$1,500 per month. The lease granted L.K.N. an option to purchase the property during the term for \$145,000, with a credit on the purchase price of one-half of the rental paid during the second year. L.K.N. also agreed to maintain insurance on the building at its own expense in the amount of \$75,000 payable to the landlord.

L.K.N. failed to comply with the insurance requirements of the lease but did purchase a policy from St. Paul Fire & Marine Insurance Co. effective June 1, 1983, covering the building on the leased premises for \$125,000 and the contents for \$70,000. GMB was not named as the loss payee, but the Mark Twain State Bank, which had lent money secured by inventory, was so named.

In August 1983, the building and its contents were destroyed by fire. GMB collected \$75,000 in coverage that it had obtained on the building from an insurer other than St. Paul. St. Paul denied liability for any part of the building loss, claiming that L.K.N. had no insurable interest in the building. It admitted liability for the building contents.

GMB sued L.K.N., St. Paul and others. L.K.N. cross-sued St. Paul. The trial court awarded L.K.N. \$125,000 on the entire building coverage but also held L.K.N. liable to GMB in the amount of \$75,000 for breach of contract in failing to secure the required insurance.

The appellate court said that an option holder has an insurable interest if there is a potential for loss in the destruction of the subject property. The court said that it was patent here that "L.K.N. could suffer loss if the building on the leased premises were destroyed. It had bound itself to furnish insurance payable to GMB and has actually been held to pay damages for breach of this covenant." The court stated that L.K.N.'s failure to literally comply with the lease should not redound to the benefit of St. Paul. *G.M. Battery & Boat Co. vs. L.K.N. Corp.*, Supreme Court of Missouri, March 15, 1988, rehearing denied

April 19, 1988 (BI/05/Dec.-\$10).

Retaliation not an occurrence

A suit alleging retaliatory and discriminatory conduct by a policyholder against an employee was not within the definition of "occurrence" under a comprehensive general liability insurance policy, an Oregon appellate court ruled.

Falkenstein's Meat Co. was covered under a CGL policy issued by Maryland Casualty Co. The policy covered bodily injury or property damage caused by an "occurrence."

In 1984, a Falkenstein's employee complained that the employer was not providing a safe place of employment and that the vehicle he was assigned to operate was unsafe.

Thereafter, the employer removed the employee from his assigned position and reassigned him to a permanent on-call position. The employee's work hours were thus reduced to an average of 22 hours per week from an average of 45 hours per week. The employee sued Falkenstein's, asserting that the reassignment was in retaliation for his complaints and constituted an unlawful employment practice.

Falkenstein's tendered the defense to the insurer, which refused. Falkenstein's then brought this suit seeking a declaration that the insurer had a duty to defend. The trial court ruled for the insurer.

The appellate court noted that the policy definition of "occurrence" was "an accident... which results in bodily injury or property damage neither expected nor intended." The court said that retaliatory or discriminatory conduct are acts from which an intention to cause harm must necessarily be inferred. Thus, the court ruled, such conduct cannot be said to be accidental or that the resulting harm was unexpected or unforeseen by the employer. The trial court judgment was affirmed. *Falkenstein's Meat Co. vs. Maryland Casualty Co.*, Court of Appeals of Oregon, May 18, 1988 (BI/01/Jan.-\$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.

Insurance pricing decisions based on old information

Continued from previous page
financial results of Accu-Rate. It is, of course, quite reasonable to object that this model is far too simplistic. And it is. Yet, it illustrates the problems that face a casualty insurer in properly pricing its products. When we add complicating factors to this model, we see, for example, that the same model, when used in an inflationary environment, results in wider savings in results. High investment yields can lengthen a soft market (just as occurred in the early 1980s), while higher taxes can shorten the soft market.

There are other models that also can explain the underwriting cycles—such as those involving capital and underwriting capacity, which also have much

validity. The advantage of the pricing model illustrated here is its extreme simplicity. All we need is one assumption (a two-year time lag) to simulate cyclical behavior.

Given that a new hard market is coming soon, how should you respond if you are interested in some form of risk retention alternative? History has several tips.

Waiting until the market hardens to begin working on alternatives presents several problems. It often takes 12 to 24 months to put together an alternative. When a market hardens, it happens very quickly, leaving insurance buyers at its mercy. While a new hard market generates a lot of interest in an alternative, its onset leaves no time to put one

together. The best time to begin the process is now, so that it will be in place (or nearly so) when it is needed.

Another advantage of beginning now is that it is far easier to line up reinsurance (or excess coverage) on favorable terms in a soft market. When the hard market comes, reinsurance may well not be available for a new alternative. Without it, an otherwise sound alternative becomes unwise or infeasible.

The prime disadvantage of beginning now is that it can be difficult to interest other potential participants unless memories of 1985 are still fresh in their minds. History can and will repeat itself. The cost of not being prepared can be high.

Employers offering child care benefits that few use: Study

By LINDA J. COLLINS

While a significant number of employers are offering child care benefits, only one in five of those employers were pressured by employees to introduce the benefit, according to a recent study.

And, few employees are using the benefit, according to the survey. "The Family as a Corporate Issue—Child Care and Parental Leave," conducted by the International Foundation of Employee Benefit Plans in Brookfield, Wis.

Forty percent of employers responding to the survey say they offer some type of employer-sponsored child care benefit.

But, more than half of the respondents offering child care benefits reported that less than 5% of their employees use the benefit, according to the survey.

The 234 respondents to the survey represented a wide range of businesses and organizations throughout the United States.

"I thought the most significant finding revealed in the survey was the fact that 40% of the respondents indicated that they have already addressed child care issues in some way," said Melody A. Carlsen, associate director of research for the IFEBP.

"I was pleasantly surprised to the extent at which employers have already provided progressive practices to address work/family conflicts," Ms. Carlsen said.

"Another significant finding is that of the respondents who were not associated with employers offering child care benefits, a third (32%) indicated that something was under consideration. I think this all definitely points to a trend toward greater employer awareness of their possible role in providing child care benefits to their employees," Ms. Carlsen noted.

She attributes this to a recognition among employers that offering child care benefits to employees makes good business sense.

Ms. Carlsen observed that a parent's work often suffers when he or she is worried about finding good and affordable child care. For example, Ms. Carlsen said, employers that have addressed other employee concerns, such as emotional disorders or drug or alcohol dependencies, usually find those programs are cost-effective.

The survey found that 47% of employers that offer child care benefits first assessed the specific child care needs and preferences of their employees to determine whether or not there was sufficient interest, but only 26% said they designed their child care benefits based on specific needs identified by employees.

The survey reveals that employers offer a variety of child care benefits to meet employees' needs. "Employers have a lot of choices other than offering full-fledged, on-site day-care centers."

Of those employers that offer child care benefit programs, 80% offer some type of dependent care financial assistance programs, with 74% allowing workers to set up flexible spending accounts for child care expenditures.

Child care FSAs allow employees to defer up to \$5,000 of their pretax wages to an account from which they can pay child care expenses.

In addition, 21% of survey respondents offer child care resource and referral services; 9% offer on-site child care services; and 7%

offer near-site child care services.

In addition to formal child care programs, 51% of respondents said their organization offers flex-time; 29% offer voluntary part-time employment; 24% offer flexible leave policies; 14% offer job sharing programs; 6% offer compressed work weeks; and 2% allow employees to work from home.

Seventy-two percent of survey respondents advocate a federal policy that encourages the adoption of these practices.

Companies that have large

Continued on next page

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Child care

Continued from previous page
workforces and that employ mostly women are more likely than other companies to offer child care benefits, the survey found.

Ninety-one percent of the firms that provide child care benefits have more than 250 employees; 7% have 50 to 249 employees; and 2% have 10 to 49 employees. Sixty-three percent of survey respondents said women comprise a majority of their workforce; 28% said men comprise a majority of their workforce; and 9% said their workforce was equally split between males and females.

Ms. Carlsen predicts a growth among employers seeking innovative arrangements for providing sick child care benefits to their employees. "This issue is important, and because of its dimensions, it's a likely target for innovation."

For example, "36% of respondents said we are likely to see a growth in sick child care benefits as a separate option under flexible benefit plans." However, Ms. Carlsen was surprised "that pressure from employee groups wasn't a stronger motivator in establishing child care benefits."

In fact, only 20% of survey respondents cited employee pressure as a primary reason for establishing child care benefits.

There will be a growth among employers seeking innovative arrangements for providing sick child care benefits to their employees, predicts Ms. Carlson. 'This issue is important, and because of its dimensions, it's a likely target for innovation.'

Fifty-three percent of the survey respondents said they introduced their child care plan because of the resulting employee tax advantages, 40% said they established the benefit to retain quality employees with child care needs; 19% said they use the benefit as a recruitment tool; 18% said they offer the benefit for their own tax advantage; and 7% said it helps them foster peak on-the-job performance among their employees.

But employees are not taking advantage of the benefit, the survey found. Of those employers offering child care benefits, 51% said less than 5% of their workforce uses child care benefits; 29% said between 5% and 10% of their workforce uses the benefits; 11% said between 11% and 15% of their workforce uses the benefits; and 9% said between 16% and 25% of their workforce uses the benefits.

But, commentaries some respondents attached to their surveys offer some possible explanations

for this low participation, Ms. Carlsen noted.

For example, a company's child care programs may be poorly communicated or designed, she said. Or the employees may not understand the benefit offered or its tax advantages. Or the program may be designed for healthy toddlers, precluding newborns, pre-teenagers or sick children.

Employees also may be reluctant to make some of the concessions necessary to take advantage of the child care benefits, such as having to use an employer-sponsored child care facility that is not conveniently located.

Also, employees may simply be hesitant to bring family issues into the workplace, she noted.

Among survey respondents that do not offer child care benefits, 27% said they were discouraged by legal and/or liability factors, ac-

cording to the survey.

Other obstacles hindering the development of child care benefits for employers include operational costs, insufficient tax incentives, and a difficulty in recognizing the responsibilities and problems their employees may face outside of the workplace, she added.

The survey also found that a majority of employers oppose federally mandated family leave policies. "Employers have demonstrated a flexibility that they feel would be lacking in mandated child care benefits," she said. "Sixty-three percent of all respondents believe that a mandated leave policy would reduce the flexibility" of those plans.

Seventy-two percent of survey respondents were concerned that a federally mandated leave policy may inadvertently cause employers to shy away from hiring workers who would be most likely to use those leaves, and 62% predicted that a mandated leave policy would reduce overall employer flexibility to meet the needs of a changing workforce.

And, in the absence of a formal leave policy, 72% of respondents said their companies informally accommodate workers who are ill or have seriously ill children.

Thirty-eight percent expect that the "offset rule" in the Family Support Act of 1988—which directly reduces the amount of federal tax credit an employee may take for child care expenses by the amount an employee contributes to a flexible spending account—will discourage employers from establishing flexible spending plans.

Among the elements of 1988 child care legislative proposals that employers would most like to see Congress reconsider in 1989 are: tax incentives for businesses to establish child care programs, supported by 60% of survey respondents; tax credits to subsidize child care for low- and middle-income families, 58%; state risk pools for more affordable day-care center liability insurance, 20%; federal funding and regulation of child care providers, 18%; and child care benefits as a mandated option in flexible benefit plans, 10%.

Copies of the survey, "The Family as a Corporate Issue—Child Care and Parental Leave," are available at no charge from the International Federal Employee Benefits Plans Public Relations Department, 18700 W. Bluemound Road, P.O. Box 69, Brookfield, Wis. 53008-0069; 414-786-6700.

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Agent/Broker Topics

A monthly editorial section sent exclusively to agents and brokers

Reaching a market

Combination of promotional techniques keeps agencies' names in the public eye

By LAURA MAZZUCA

The term "marketing" conjures up classic "hard sell" techniques for many agents and brokers: making cold calls, sending out direct-mail promotions, knocking on doors.

But to others, this is only half of the agency marketing picture. To these agents and brokers, tooling around town in an antique fire truck, footing the bill for a charity marathon or presenting educational seminars for their clients are just as integral to the marketing function as telemarketing and bulk mailings.

Although it's true that community and client involvement doesn't sell insurance directly, marketing experts point out that it does enhance the public image the agency presents to both existing and potential clients, which could lead to increased sales.

Especially today, with the insurance industry coming under increasing scrutiny and criticism by the public, "more and more agents are realizing the importance of building relationships over time rather than just selling products," noted Kathleen A. Pasley, president of The Market Planning Group in Boston.

This interest is borne out by the popularity of organizations like Insurance Marketing Services of Santa Monica, Calif., which hosted 700 attendees last month at the group's 16th national convention in Scottsdale, Ariz. (see stories starting on page 24B). IMS' membership has grown 12.5% to 4,500 agents in 1989 from 4,000 in 1988.

Ms. Pasley explained that there are two kinds of marketing: "response" advertising, in which an agency uses direct mail and telemarketing to prospect for a specific niche, and "awareness" advertising, which is "the reinforcement over time of your image in the marketplace."

To enhance name recognition as well as sales, Ms. Pasley recommends that agencies actively undertake both types of marketing.

And, while some agents are reluctant to invest time

and money in awareness marketing because the payoff isn't immediate, Ms. Pasley likens the process to any large retailer's long-term ad campaigns.

For example, "When I say red-and-white soup cans, what company do you think of?" she queried, referring to the Camden, N.J.-based Campbell Soup Co.

For imaginative agents who follow this definition of marketing, the applications are limitless: Long-term television and radio advertising campaigns, newspaper and trade publication advertising, newsletter mailings to clients, hosting seminars and sponsoring community events are all ways for an agency to build a positive image over time.

"The more they have your name in front of them, the more they will eventually come to you," said Cindy L. Briggs, marketing coordinator for Koehler Insurance Corp., a \$4.6 million premium volume agency in South Bend, Ind.

In addition to using direct mail and radio advertising, Koehler keeps its local profile high in sports-loving South Bend by offering free South Bend White Sox baseball tickets to any prospect requesting a policy review.

The agency is spending about \$30,000 on all its advertising/marketing promotions this year.

Others agree that it is important to keep the agency in the eye of the public.

The most important asset of an agency "is the agency's reputation; that's one thing you can't buy," said Robert Ellis, vp of Palmer & Cay/Carswell Inc., a \$100 million premium volume brokerage in Savannah, Ga., and the nation's 46th-largest in terms of gross revenues (BI, June 20, 1988).

To project a "warm feeling" reputation, Palmer & Cay/Carswell uses several forms of "awareness" marketing, including an agency newsletter for personal lines clients, print advertising in both local consumer and trade publications, giveaway items and sponsoring an annual 10-kilometer run that benefits the Sa-

Continued on next page



SHILLER 1989

Agent/broker topics

Small agencies

Continued from previous page

"These farms have been around for two and three generations; they're not the kind you read about in the papers," said Mr. Mefford. "And if there's anything that will make a farmer happy, it's a free cup of coffee."

So for less than \$20 a month, the agency has become a part of this particular "good old boy's network," which results in walk-in inquiries from farmers coming in to thank them for the coffee. "It's just another way of keeping your agency in front of your potential clients," he added.

In another promotion, the agency sponsors "McReed's Book Club," a children's summer reading program through the town's public library. Since these sessions are well-attended by new families in town, it's a good way for the agency to familiarize newcomers with the agency, he said. The library also distributes information on the reading program through the town's Welcome Wagon service, which also helps to spread the McCune & Reed name.

Although the agency footed the bill for these programs, at other times it uses its insurers to help promote a product.

"We (agents in general) don't use our companies like we should," said Mr. Mefford. "We should go to them like to the bank to borrow money; tell them what you want and why."

For instance, one insurer wanted

to increase more sales of personal lines products. So, Mr. Mefford asked the insurer to rent space on a billboard near a school where many parents picked up their children.

The billboard featured the "McReed" character pointing to a large gift tied with a bow and labeled "package insurance."

And even though the agency didn't sell any of the insurer's package coverage as a result of the billboard, it met the agency's needs by generating recognition of the agency's name and "McReed" logo.

In addition to reaching individual buyers for personal lines sales, the agency also administers several large group accounts of personal auto and homeowners coverage sold through credit unions and underwritten by ALLIED Mutual Insurance Co. of Des Moines, Iowa. The insurer regularly provides the agency with preprinted envelopes and self-mailer quote cards, as well as preprinted information on auto and homeowners insurance, for McCune & Reed to use for prospecting.

Even though the credit union for local public school and community college teachers includes about 2,500 members, only about 20% of the membership is covered through the ALLIED program, so it's beneficial for both the agency and insurer to prospect membership by direct mail, said Mr. Mefford.

And, the response rate is high for direct mail promotion: About 2% request a quote, he said. ■

Agents' E&O claims grow despite competitive market

By LAURA MAZZUCA

SCOTTSDALE, Ariz.—Although a soft property/casualty insurance market historically produces fewer errors and omissions claims than a hard market, agents and brokers are finding little relief from rampant E&O litigation in the current marketplace, an underwriter says.

In fact, the number of E&O claims filed against independent agents has almost doubled in the past five years, according to James D. Wallace, underwriting administrator for the SAFEPRO E&O program at E&O Professionals in Kansas City, Mo., an underwriting manager for SAFECO Corp. of Seattle. E&O Professionals is a subsidiary of Media Professional Insurance Inc., an underwriting manager specializing in slander and libel insurance for the media.

Citing SAFEPRO statistics, Mr. Wallace noted that the number of E&O claims against agents increased to 18 per 100 policies in January 1989, from 10 claims per 100 policies in September 1984.

The current E&O claims frequency is even higher than the number of claims filed against in-



dependent agents at the height of the hard market—15 claims per 100 policies in March 1985—said Mr. Wallace during the 16th national Insurance Marketing Services convention last month in Scottsdale, Ariz.

Mr. Wallace attributes the increase in claims frequency "simply to social inflation or the tendency for people to file E&O claims."

In addition, there is "also an increased tendency of insurance companies to bring E&O claims against their agents, something we hadn't seen before," he said.

For example, an agent may mistakenly not place renewal coverage for a client that files a claim. The insurer may pay the claim and, in turn, sue the agent for the error, Mr. Wallace explained.

It has become "more common now than it used to be," for insurers to sue agents, he said.

Unlike a hard property/casualty insurance market, when most E&O claims are filed by clients unable to obtain coverage, the soft market risks produces E&O claims related to the increasing competitiveness of agents, said Mr. Wallace.

Such practices as price cutting, carrying large accounts receivable, overselling policies and aggressive marketing of agency services all can generate E&O claims, he said.

For instance, common E&O exposures include quoting inadequate premiums and misclassifying premiums to obtain a lower rate, said Mr. Wallace.

The first exposure refers to the practice of estimating a low premium when providing a quote, so the client will be attracted by the low numbers, he said. However, when the final premium billed is much higher than the estimate, the client may sue, he explained.

The second exposure results when agents "fudge" on rating classifications to offer the client a lower premium, Mr. Wallace said.

Another E&O exposure for agents in a competitive market comes under the heading of agency promotion. As more agencies focus on "value-added" services for their clients and aggressively advertise those services, they may also be placing themselves at a higher risk for an E&O claim because they cannot deliver on their promises, said Mr. Wallace.

"This is more likely to occur during the soft market, when we're all trying harder to sell and guilty of overpromising," he added.

To avoid such marketing exposures, agents should exercise caution when putting together brochures, direct mail pieces or broadcast advertising, toning down the grandiose statements that frequently promise more than an agency can deliver, Mr. Wallace said.

Agents should also resist the temptation to switch a client's risk from one insurer to another on the basis of lower price or a higher commission, Mr. Wallace said. If the new insurer or coverage turns out to be inadequate for the risk, the agent may be socked with an E&O claim, he noted.

Continued on next page

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Underwriter details avoidable errors

SCOTTSDALE, Ariz.—Many errors and omissions claims can be prevented, an E&O underwriter contends.

James D. Wallace, underwriting administrator for the SAFEPRO E&O program at E&O Professionals in Kansas City, Mo., related several actual E&O cases that he recently handled, all of which he said could have been prevented by the agency.

For example, an agency with a written procedure requiring it to deal only with insurers that had an A-plus rating from A.M. Best Co. was sued by a client when one of the agency's insurers became insolvent. The agency had dealt with this insurer, which carried a poor Best's rating, because no other insurer would accept the client's risk. Mr. Wallace told attendees of the 16th national Insurance Marketing Services convention last month in Scottsdale, Ariz.

"The alleged error appears more obvious since the agency's procedures were iron-clad with regard to company ratings," said Mr. Wallace. "The agency was trapped by its own procedure."

In another case, an agency's client asked the principal not to report an auto accident because the client didn't want his rates to go up and thought he could collect from the other driver.

"Not only did they not collect, but a lawsuit was filed by the other driver," said Mr. Wallace. "Now, both client and (insurance) company blame the agent for turning in a late claim report."

The solution here is obvious: The insurance agent should never act as a lawyer, specialty adviser, actuary, engineer or anything else for a client who needs such services, according to Mr. Wallace. Instead, the agent should refer a client to such experts, he said.

In another example, an agent accepted a premium payment for property insurance from a client for submission to an excess/surplus brokerage market. Photos of the client's house were required before the application could be bound, so the agent held the premium money and application while waiting for the client to provide the photos.

Meanwhile, though, a fire destroyed the house, and the agent was blamed for not processing the submission more promptly, Mr. Wallace said. The moral of that story is that an agent should never hold a check unless the related coverage is effective, he said. Instead, the agent should have returned the client's check and told him that photos of the property were required before the policy could be bound, he added.

"You don't take money without having coverage in effect. There are some exceptions, but that's a good general rule," he said.

—By Laura Mazzuca



NAI

IMS meeting attracts 700

SCOTTSDALE, Ariz.—More than 700 participants from across the country met for the 16th national Insurance Marketing Services convention, held April 5-9 in Scottsdale.

Speakers included Mark McCormack, sports marketer and author of "What They Don't Teach You at Harvard Business School," who talked about celebrity clients such as Arnold Palmer and Jack Nicklaus; and Boston attorney William E. Bailey, special counsel for the Insurance Information Institute, who discussed the myriad legislative problems facing the insurance industry today.

Attendees also heard from the 1988 IMS Marketeer of the Year, Fred Berger, president of Insurance Planning Inc. in Hays, Kan. Mr. Berger turned his agency with \$15,000 in borrowed cash into a business producing more than \$1.7 million in commissions over the course of 20 years. The agency now places \$12 million a year in premium volume.

Session topics included developing personal lines business, errors and omissions claims prevention, how to get the most out of a consultant and tips on direct mail marketing.

The convention featured a trade show with 22 exhibitors, including specialty consultants, insurers and software manufacturers.

When agents weren't attending workshops, they basked in temperatures above 100 degrees and enjoyed the desert sunshine.

—By Laura Mazzuca

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E&O exposures

Continued from previous page

Since an insurer insolvency can open an agent to a flood of E&O claims, agents must check the Best's rating of all insurers with which they do business, said Mr. Wallace.

"An insolvency can have a devastating impact on an agency, which can affect many of its clients," he said. "It has a long tail connected with it and can have claims come in the future, when the company will still be insolvent."

Surplus lines brokers, too, also can become insolvent, especially in the soft market when "brokers go broke" because business slackens, he said.

Insurance wholesaler insolvencies are particularly bad news for retail agents and broker, since the surplus lines market does not have the standards and regulations of the traditional market behind it, according to Mr. Wallace.

Regardless of the reason for an E&O claim, an agency can be hurt by such claims in several ways, Mr. Wallace noted:

- First and foremost, the agency could lose a valued client.
- An E&O suit breaks down the morale and relationship between agency employees.
- An agent hit with E&O suit can be found to have violated state regulations, which can result in sanctions against the agency.
- Mergers, sales or early retirement could arise from an E&O claim if the agency principal decides to leave the business rather than face the risk of additional E&O claims.
- If an E&O claim is pending, it almost certainly will cost the agency some money, even if it is dismissed.

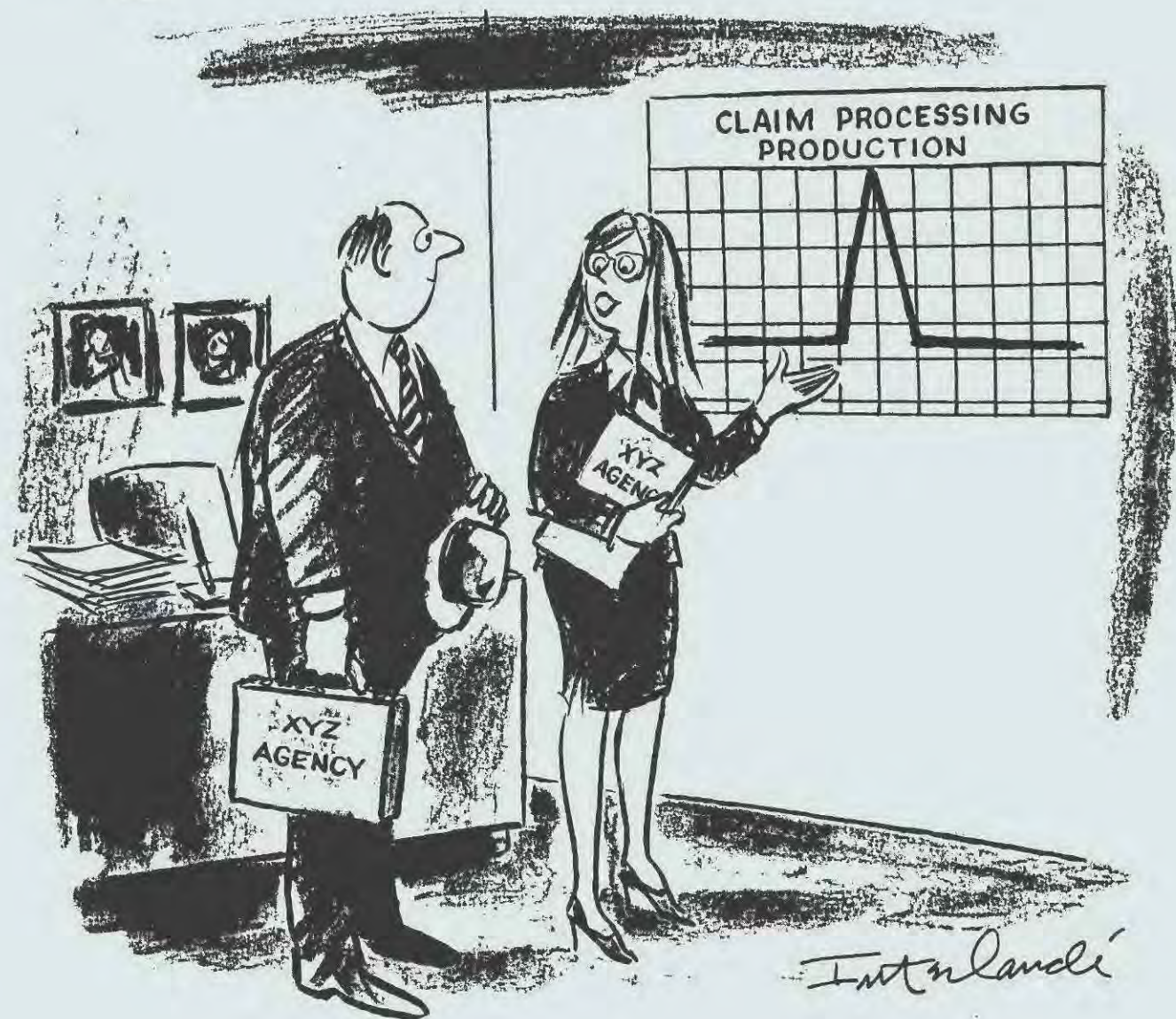
Yet the picture is not all bleak. Agents can diminish their E&O exposures by practicing "systematic management," in which all agency functions are outlined in written policies, according to Mr. Wallace.

"The better the systems in the agency, the more the agency will be protected," he said.

Systematic management can be applied to binders, renewals, collections, phone reception, employee training or any other office function, he said. Written procedures for these functions must be reviewed, updated and changed, approved by management, accepted by the staff and, most importantly, used by all employees, Mr. Wallace stressed.

While a concerned agency is willing to expend time, money and effort to prevent E&O risks, "the other agency simply looks on E&O claims as something that come out of the blue and can't be prevented," he said.

The time and expense of implementing a systematic management system "will be returned to the agency, not only in terms of higher production and more efficiency, but in lower E&O exposure," said Mr. Wallace. "People who don't know what they're doing are the kind of people who cause E&O claims."



"That blip was a vacation week. There was nobody in claims to slow things down."

Sometimes good things happen for apparently no good reason. Unfortunately, efficient claims handling is not among them. In order to provide claim service that's consistently fast and fair, a company's claim personnel must have the right stuff. Proper training, experience, commitment and a genuine interest in agents' business are the foundation of good service. If

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Agent/broker topics

Consultant outlines agency growth plan

By LAURA MAZZUCA

SCOTTSDALE, Ariz.—An agency can set a very specific five-year personal lines growth plan by taking a look at the uniqueness of the agency, analyzing its written premium figures and planning realistically what its employees can accomplish, according to an agency consultant.

Patty Vaughn, owner of Patty Vaughn & Associates Inc., an agency consulting firm in Clovis, Calif., addressed agents on a "Framework for Personal Lines Success" at the 16th national Insurance Marketing Services convention, held April 5-9 in Scottsdale, Ariz.

Using separate worksheets for agency functions, Ms. Vaughn worked with a single agency case study to analyze "where they are now in personal lines, where they want to go, and what it will take to get there."

The worksheet topics are:

- Five-year personal lines premium/sales goals.
- Five-year human resource strategies.
- Five-year compensation and career path models.
- Five-year strategic marketing plan.

Five-year personal lines premium/sales goals for case study agency

	Current year 1988	Year 1 1989	Year 2 1990	Year 3 1991	Year 4 1992	Year 5 1993
Planned rate of growth:	N/A	50.0%	50.0%	54.0%	74.6%	58.5%
Anticipated premium change:	N/A	9.0%	9.6%	10.0%	10.5%	11.0%
Retention ratio:	N/A	79.0%	81.5%	84.0%	86.5%	89.0%
Written premium goal	\$485,144	\$727,716	\$1,091,574	\$1,681,024	\$2,935,068	\$4,652,083
Net new premium needed		\$309,959	\$441,459	\$672,410	\$1,328,303	\$1,752,529
Average policy size	\$595	\$650	\$712	\$783	\$865	\$961
Number of policies in force	814	1,120	1,533	2,146	3,391	4,843
Number of policies not renewed		171	207	245	290	373
Number of "new" policies needed		306	413	613	1,245	1,451
Total new policies needed-annually		477	620	859	1,535	1,824
Total new policies needed-monthly		40	52	72	128	152

Source: Patty Vaughn & Associates Inc.

• Five-year pro forma projections, or an integration of the preceding four sets of projections.

By breaking down the agency's operations, the agent can systematically pinpoint areas for potential growth and then assemble the resources needed to achieve it.

Before setting any goals, Ms. Vaughn first recommended charting an agency's current statistics. The data areas are: total agency

written premium; personal lines written premium; policies in force; number of clients; retention ratio; number of personal lines employees; lines of business written; total annual personal lines revenue; total annual personal lines expenses; and pretax net profit on personal lines only.

Because this data is used in computing all five worksheets, all subsequent worksheets must be up-

dated and revised if any of the agency's variable data changes.

Ms. Vaughn's hypothetical agency reported \$485,144 in total written premium, 23.1% of which was derived from personal lines. The agency's pretax net profit was \$37,766, a 43.3% return on investment on personal lines.

The agency writes four major types of personal lines coverage: homeowners, auto, personal excess, and all other. The average personal lines commission for all coverages was about 16.5%, and the total annual personal lines revenue was \$87,253, which is a combination of commission, contingency commissions or bonuses, interest and investment income.

The agency wrote 814 personal lines policies for 649 clients, with a "dismal" retention ratio of only 79%. Worst of all, the agency only had one customer service representative for personal lines inside sales, supported part-time by a receptionist and a bookkeeper.

However, noting that 27% of the agency's total revenue—or 23.1% of its written premium—is generated by personal lines "was a clue that personal lines might be a profit center they might want to grow in," Ms. Vaughn said.

To plot the agency's growth, the agent makes "assumptions" and sets growth goals in the areas of written premium, net new premium needed, average policy size, number of policies in force, and number of new policies needed.

For instance, with a current written premium of \$485,144, the agency principal decided he wanted this figure to grow 50% in the first and second years, 54% in the third, 74.6% in the fourth, and 58.5% in the fifth.

The principal also wanted to improve the agency's retention rate to 89% from 79% in five years.

Taking into consideration both anticipated premium increases and current retention rates, Ms. Vaughn estimated that the agency needed to generate 477 new policies in the first year, or 40 per month, to achieve short- and long-term growth and retention goals.

However, with only one customer service representative handling personal lines sales, it is obvious that the principal must hire more outside producers, she said.

"The next step is to determine who are the people who will make this happen," Ms. Vaughn noted.

The sample agency's current single full-time personal lines CSR will not be enough to keep up with the demand to process more applications, since he or she currently is processing fewer than one application per day, or 10 applications per month, based on the assumption that each month contains 20 working days.

Thus, in the first projected year, the agency will have to hire another full-time CSR with greater processing capabilities to meet the demands of 40 applications per month, Ms. Vaughn said.

Based on the growth projections, the agency will need to add five new staffers in all, including part-time employees who will ultimately be promoted to full-time, if the agency is to reach its fifth-year goal of 152 new policy applications per month, Ms. Vaughn said.

To increase each employee's efficiency, new account sales and cross-selling are expected from these employees, who should be compensated by salaries plus incentives.

For example, if the CSRs sell new policies on their own, the agency principal may pay them a first-year commission but would not pay a commission on subsequent renewals, Ms. Vaughn said.

The agency then must calculate whether it can afford to increase its current level of employee compensation, which at the outset was 34.4% of its total revenue.

To project the cost per employee, the principal must consider the agency variable data—including average policy size, anticipated premium changes, retention ratio—to anticipate the impact that salary will have on the agency.

For example, if Employee B, a CSR, is earning a monthly base sal-



ary of \$1,200, as well as a new commission rate of 75% of first-year commission, he could earn a total income of \$18,240 the first year, with the agency earning \$8,460 from this employee.

However, it is not enough to simply calculate the employee's first-year results, because the agency actually might lose money this first year if the employee receives a large split of first-year commissions, such as the 75% used in the example, Ms. Vaughn pointed out.

Therefore, it is important that the agency principal set commission splits carefully, she said.

To establish salaries, goals and commission splits, each employee should complete an "Individual Mission Statement," in which the personal lines manager assists the producer or CSR in developing goals, strategies and activities for the year, Ms. Vaughn suggests. The goals are broken down into monthly production strategies similar to those established by the agency for premium volume.

This statement is signed and approved by both the personal lines manager and the employee and is kept on file so the goals can be periodically reassessed, Ms. Vaughn said.

Then, on a strategic marketing plan worksheet, the agency's projects are divided into categories of service, account selling, cross-selling and new business. The revenue, expense and pretax net profit from each project, employee and profit center in each of the next five years is then determined.

The purpose of developing a workable, yet flexible, strategic marketing plan is to give each personal lines employee, the personal lines profit center manager and ultimately the whole agency a sense of direction, Ms. Vaughn said.

By integrating all of the previous worksheets, the agent can measure performance in critical areas like revenues, compensation, employee

Continued on next page

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Minnesota agent groups pursue merger

By LAURA MAZZUCA

MINNEAPOLIS—A feasibility report is due this month on the proposed consolidation of the Independent Insurance Agents of Minnesota and the Minnesota Assn. of Professional Insurance Agents, according to the board presidents of each group.

Four task forces composed of Minnesota PIA and Minnesota IIAA members have been studying specific aspects of a merger and will issue recommendations to their associations.

The Minnesota action differs from previous, failed attempts to merge state chapters of the Independent Insurance Agents of America and the National Assn. of Professional Insurance Agents in California, Michigan and several other states because few of the other merger attempts progressed as far as the Minnesota proposal.

In addition, there is strong interest from both sides in Minnesota, said Jeffrey M. Yates, executive vp and general counsel for national IIAA in New York.

Proponents of a merger or consolidation say it would reduce costs and strengthen agents' lobbying efforts.

But opponents, especially officials from the national PIA, have said such a move would create a monopoly and would be less effective in lobbying.

The boards of the two Minnesota organizations agreed in March to explore the possibility of consolidating and last month appointed task forces to examine the details, said Edwin J. Martinson, president of the Minnesota IIAA's board, which is based in Minneapolis.

Because between 40% and 50% of the agents in the state belong to both organizations, "there has been very little opposition to it," he added.

The Minnesota PIA has 1,700 individual members and the state's IIAA has 740 member agencies.

"I'm very optimistic that we're going to go with it, and our national organization says if we can do it in Minnesota, it might trigger a number of other states" to take similar actions, said the IIAA's Mr. Martinson.

After five meetings with the Minnesota IIAA, "everything seems compatible," commented

Robert Soule, president of the Minnesota PIA, which is based in Edina.

Already the two Minnesota state associations share political action committee and legislative committee activities.

The interest in a merger is partially in response to a survey conducted two years ago by the Minnesota PIA that indicated more than 80% of the respondents would support a merger, said Mr. Soule.

In response, the two associations formed a joint committee last September that commissioned a feasibility study by an independent consultant, said Mr. Martinson. The consultant concluded that a merger of the two associations in

the state would save both groups money by eliminating duplicate efforts, he added.

The task forces have been studying the following areas: development of a budget; membership communication; response to arguments against a consolidation; and a way to interact with both national organizations, Mr. Martinson said.

The national PIA has rejected a number of attempts by the national IIAA to combine the two organizations, and the PIA passed a resolution in 1983 that prohibits a national-level merger. The PIA also has been reluctant to consider state-level mergers (A/BT, Oct. 3, 1988).

David L. Ream, president of the Alexandria, Va.-based PIA, remains skeptical of the feasibility of even a state-level merger.

"I'm disappointed that, with all the problems the insurance industry faces today, we have to devote our resources to a peripheral issue," said Mr. Ream.

And, although he noted that the impetus for the Minnesota merger arose from a membership survey conducted by the state PIA, Mr. Ream questions the validity of the state survey because he has not seen its final results.

In addition, he questioned the IIAA's motivation in promoting the merger.

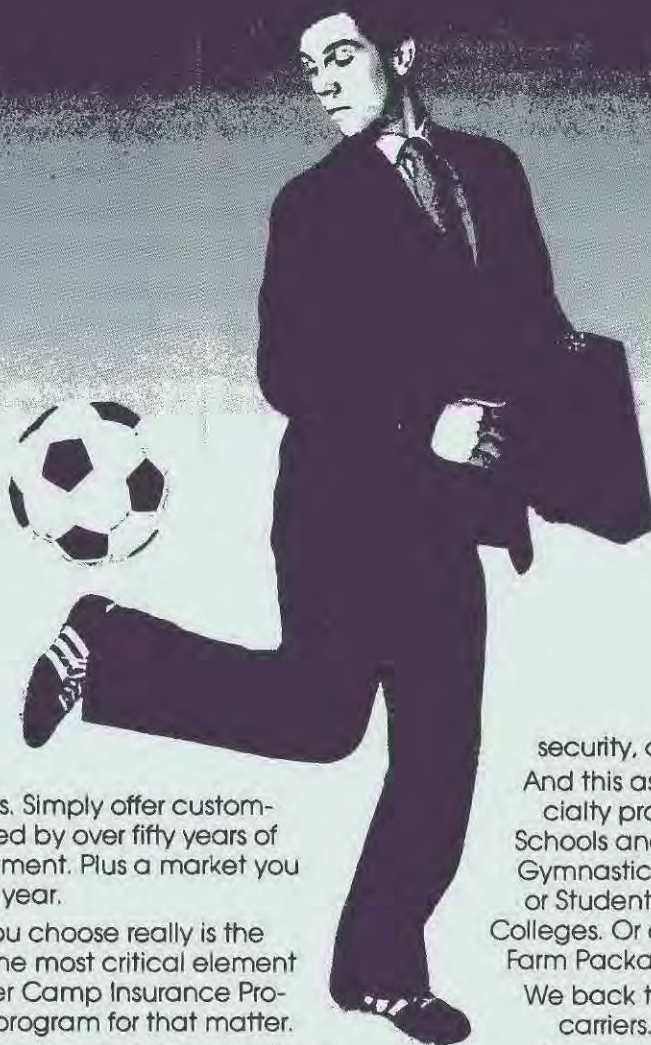
"With the IIAA's move to its new

office (from New York to Alexandria, Va.), it would be desirable for them to spread that (financial) burden to more agents," he stated.

Mr. Ream added that even if a merger is approved by the Minnesota associations, it must still be approved by the national organizations' boards of directors, which may not give approval because of the financial and operational impact a single-state merger might have on both national associations.

"States don't work in a vacuum," he said. A "monopoly won't be allowed to exist" in Minnesota if a merger does take place because "one or two dissident organizations would be formed" to counter the merger, he added.

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Growth plan

Continued from previous page
benefits, selling, operating and administrative expenses, and ultimately pretax net profit, Ms. Vaughn noted.

"Once you have gone through the first four worksheets, this is the proof of the pudding," she said. "This will determine whether this exercise is going to be worthwhile in the next five years."

Again, if the agent's "what-if" calculations are fairly accurate, he can expect to produce total personal lines revenues of \$86,821 in the first year and up to \$889,448 by the fifth year, she said.

And, projected income would rise from \$34,651 in the first year to \$322,919 by the fifth year.

Ms. Vaughn recommends that when estimating figures for this pro forma sheet, the agent use a variety of peer studies to get an idea of how his agency's growth would measure up to others in the industry.

For instance, ACORD, the agency automation association in White Plains, N.Y., offers a "Benchmark" study on agencies by revenue size. Agency associations also offer such information. ■

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Agent/broker topics

Manager is key to successful agency

By LINDA J. COLLINS

CHICAGO—Because employee compensation is an insurance agency's biggest expense, agency owners must know how to manage employees' time effectively, an agency consultant says.

But rather than trying to manage their agencies themselves—which takes time away from new business production—agency owners should hire management experts, advises Gary B. Holgate of Holgate & Associates Inc. in Wickford, R.I.

The agency manager's job will be to make sure that everyone in an agency—outside producers as well as in-house sales and customer service representatives—knows what is expected of him or her and is held accountable for performing those duties, he said.

In addition, the manager should see to it that the agency is concentrating on the accounts that generate the greatest premium volume, Mr. Holgate told those attending last month's Chicago "I" Day, sponsored by the Independent Insurance Agents of Illinois and the Chicago Board of Underwriters.

Many agency owners often try to boost agency productivity simply by adding new producers, Mr. Holgate said. However, agencies "don't need a

lot of finders of business, and I don't think you need new producers."

What most agencies need is a smoothly running internal operation where "support people pick up the paper" the current producers generate, he stressed.

According to Mr. Holgate, a typical agency owner/producer is:

- The best producer in the agency, writing about 95% of its large commercial accounts.

- A very poor sales manager, but a good door-opener and sales closer, if given the time to do it.

- A terrible detail person who leaves something to be desired as an overall agency manager.

"How can you possibly hold a management meeting when you are interrupted to handle a telephone call or a walk-in client?" Mr. Holgate asked his audience.

The solution, suggested Mr. Holgate, is to hire an agency manager.

In fact, for an agency to be properly positioned to meet the challenges of the 1990s, "I feel you must have a manager in your agency who does not sell and does not service" customers, he stressed.

"You must have managers that only manage," Mr. Holgate said.

Although agency managers do not need a background in insurance, they should have a strong background in

management, Mr. Holgate stressed. He also suggested that the manager be hired from outside the agency, rather than promoted from within.

Managers promoted from another position within the agency may find the majority of their time spent helping other employees resolve problems associated with the manager's previous job function, he explained.

Once hired, an agency manager should analyze the agency's book of business, Mr. Holgate suggested, observing that the typical agency spends far too much time servicing its least profitable accounts.

Mr. Holgate said that of a typical agency's client base:

- About 80% is personal lines clients generating approximately 30% of the agency's property/casualty commission income.

- About 17% is small, "non-exceptional" commercial lines clients generating approximately 16% of the agency's property/casualty commission income.

- About 3% is large, "exceptional" commercial lines clients generating approximately 54% of the agency's property/casualty commission income. Large commercial accounts usually generate upward of \$10,000 in annual premium volume, he said.

In addition to accounts that generate large premium volume, "except-

tional" accounts also may include those that have the potential of becoming big accounts or are complex in nature. Or, they may be accounts that are tied to a center of influence or one of the agency's exceptional accounts, such as a small business owned by the wife of a major client, Mr. Holgate observed.

Agency managers need to restructure agency operations so that non-exceptional commercial lines accounts are handled the same way personal lines accounts are handled, he said.

For example, both small commercial lines and personal lines accounts should be billed directly by the insurance company, marketed by in-house sales representatives and serviced by customer service representatives, Mr. Holgate suggested.

Instead most agencies lose money on their small commercial clients—which often generate about 50% of their expenses—by using agency billing, having outside producers market the business and by allowing those producers to handle problems, he added.

"These are the accounts that are ruining agencies because agencies have producers out selling and servicing them," Mr. Holgate stressed.

The agency should operate as if there are two agencies within one, according to Mr. Holgate.

"Create one agency for 3% of your customers" representing exceptional accounts, "and overstaff that agency. They generate 54% of your income," he said.

That agency should have "90 different ways of doing business," Mr. Holgate added.

Then, "create another agency for the remaining 97% of your customers that has only one way of doing business," he said.

The latter accounts should only be sold by in-house sales representatives and serviced by customer service representatives, Mr. Holgate said, noting that if the agency's outside producers sell or service non-exceptional commercial accounts, those accounts will be unprofitable.

And, the agency's in-house sales representatives and customer service representatives should input all per-

sonal lines and non-exceptional commercial lines account information directly into the computer at the time the client's call is taken, to avoid duplication of effort, he added.

In-house sales and customer service representatives should handle only those transactions that take place when the client is on the phone, with follow-up work being done by administrative people.

And, personal lines and non-exceptional commercial prospects should be solicited only through direct mailers sent on a regularly scheduled basis "to those prospects who fit your products," Mr. Holgate said.

And, once that prospect becomes a client, an agency manager should require in-house sales and customer service representatives to work on developing new accounts every time they have contact with that client. The manager needs to monitor sales and customer service representatives on a regular basis to make certain this is being done, he emphasized.

Meanwhile, an agency's outside producers should focus their efforts on those accounts identified as exceptional and those accounts profitable enough to warrant separate servicing procedures, Mr. Holgate said.

For exceptional accounts, the agency should appoint account managers to act as go-betweens to the producer and the customer service representative. The account manager can go with the producer when he or she makes the initial sales call and the follow-up sales presentation, he suggested.

The account manager should then be responsible for gathering information, completing applications and helping the producer obtain quotes from insurers, as well as for delivering binders and policies. This gives the producer time to sell, Mr. Holgate explained.

For exceptional accounts, a customer service representative would be responsible only for preparing binders, arranging financing and checking policies.

The agency manager should monitor the activity of all staff to make sure that they are performing their designated duties, Mr. Holgate pointed out. ■

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Business Insurance

Health care costs

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New York, up 54.2%; North Carolina, up 47.0%; Alaska, up 39.1%; Tennessee, 30.0%; Texas, 28.0%; Massachusetts, 25.8%; Louisiana, 21.9%; Kansas, 20.4%; and Delaware, 19.9% (see chart, page 3).

However, these increases do not necessarily reflect each state's claims experience for the previous year, according to Mr. Mackin.

"The health care cost increases that states are having are the result of timing, for the most part," he explained. "Often, rates will stay the same for a couple of years when major insurers are willing to take the losses. However, finally, they decide to recoup some of the losses incurred, rates go up and those states get hit hardest."

Mr. Mackin also cited changing plan demographics and advances in medical technology as other catalysts fueling the increases.

However, while the Segal survey findings indicate that health care benefit costs are hitting public-sector employers hard, private-sector employers are feeling the impact even more. Total per-employee health care costs—including employer and employee contributions—rose 18.6% in 1988, according to the "Health Benefits Survey: 1988," conducted by A. Foster Higgins & Co. Inc. (BI, Feb. 6).

But, while employers in the private sector often respond to increasing employee benefit costs by shifting costs to employees, employers in the public sector are still bearing most of the burden for premium costs.

In 1988, 31 of the 50 states paid 100% of the cost of employee-only coverage; seven states paid between 90% to 99% of the cost; four states paid between 80% to 89% of the cost; and only eight states paid less than 80% of the cost of individual coverage.

"The states paying 100% will probably continue to pay the entire cost because of pressure from active employee groups and unions," Mr. Mackin predicted.

However, fewer states are picking up the entire tab for family coverage, whose total cost—including employee contributions—climbed 12.8% to \$212 per month per employee in 1988, from about \$188 per month the year before.

Only 12 of the 50 states paid the full cost of health benefits for employees and dependents in 1988.

Among the 38 states requiring employees to share in the cost of family coverage, four states paid 80% to 89%; six states absorbed between 70% to 79%; and the remaining states paid less than 70%.

Typically, these employers absorbed less than half of the premium cost for family coverage, with their monthly contributions averaging about \$74 per employee.

While all states provided some level of coverage for employee and dependent care, almost half of the states made no contribution toward retiree plan costs, which last year averaged \$61.97 per month for a single retiree 65 or older qualifying for Medicare. That represents an 11.3% increase from \$55.66 per month in 1987.

Of the 48 states surveyed about retiree benefits, half reported making no contribution.

Indiana and Nebraska were excluded because both states do not allow retirees 65 and over to participate in state health plans.

On the other hand, 13 states cover the entire cost of retiree coverage, while Colorado, Kentucky and New Jersey pay 100% of health care expenses for single retirees with 20 or 25 years of service.

Mr. Mackin predicted that states will probably begin to absorb a larger portion of retiree health care costs based on a retiree's years of service.

Also examined in the survey was employee participation in managed care plans.

HMOs were most popular in Wis-

consin, Arizona and California, where more than 70% of the state's employees are HMO members, according to the survey.

Interestingly, HMO participation trends among public- and private-sector employees are parallel.

While the Segal survey reports about 30%—or 974,000—of active state employees are enrolled in HMOs, the Foster Higgins survey found that when private-sector employers offered HMOs, 33% of employees enrolled.

HMO participation among state retirees is significantly lower, according to the Segal survey. Only 12%, or 91,000, of retired state employees participate in HMOs.

"Usually the older retirees have never tried an HMO and don't want to change their doctor at a late age," Mr. Mackin explained.

Copies of the survey are available free from John P. Mackin, Senior Vp. Martin E. Segal Co., 730 Fifth Ave. New York, N.Y. 10019; 212-586-5600.

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Louisiana insurer

Continued from page 1

through New England International's records to determine the exact types and amounts of business the insurer wrote and the extent of its assets and liabilities, according to a department spokeswoman, who said no decision has been made yet about whether the insurer should be liquidated.

New England International primarily wrote ocean marine, workers compensation and other liability business. It reported gross and net premium volume of \$16.3 million in 1988 and a year-end 1988 policyholder surplus of \$3.3 million.

Its parent company, New England International Surety of Panama, reported assets totaling \$301 million at year-end 1985, including \$250 million in Brazilian real estate that the company acquired by issuing \$200 million in 20-year bonds, according to a 1985 finan-

cial statement obtained by *Business Insurance*.

The Louisiana department has no current information about the parent company, the Insurance Department spokeswoman said.

Mr. Rienstra could not be reached at New England International's Brussels office for comment concerning this story.

New England of Panama was hit in 1986 with cease-and-desist orders and injunctions by several state insurance regulators over its role as an insurer of Dyna Span Corp. of Boca Raton, Fla.

Dyna Span, which claimed to operate as a risk purchasing group under the federal Risk Retention Act, was also the target of numerous cease-and-desist orders and injunctions and later discontinued doing business as a purchasing group (*BI*, May 26, 1986).

New England of Panama also was the reinsurer of Boca Raton-based Insurance Corp. of America, which claimed to operate free from

state regulation under two purported turn-of-the-century federal court decisions. ICA also was hit with cease-and-desist orders by several regulators.

The two court decisions were later branded as phony in criminal and civil court proceedings last year (*BI*, Oct. 31, 1988; June 1, 1987).

The Panamanian insurer had announced in 1987 that it was canceling its business with both Dyna Span and ICA.

New England International Surety of America was incorporated in Louisiana in May 1986 and commenced business on Jan. 1, 1987.

The Louisiana Insurance Department started an examination of New England International in May 1988 and in a Feb. 28 examination report disallowed \$6.7 million of the insurer's \$12.4 million in reported assets and found it insolvent by \$1.8 million as of the end of 1987. Among the disallowed

assets were:

- A \$5 million certificate of deposit from a Panamanian bank. U.S. assets in Panama have been frozen by the Panamanian government, and the Insurance Department challenged the insurer's ability to collect this money, despite assurances from New England International that it could produce the funds if regulators admitted the certificate of deposit, the department spokeswoman said.

- A \$500,000 collateral loan secured by stock in Aguda Financial Services Inc., which the report noted had not been valued by the National Assn. of Insurance Commissioners. Joseph J. Aguda, whose wife signed the note on the loan, was president of New England International until he left the company in January.

Mr. Aguda currently is suing Mr. Rienstra and the insurer for \$1.2 million in commissions allegedly owed to him as an agent of New England International and to

Aguda & Associates Inc., a managing general agency for the insurer.

- \$346,807 in stock in Omne Re, a Belgian corporation 80%-owned by New England International.

Omne Re, in turn, is the sole owner of Omne Underwriting Agency Inc. of Atlanta, a member of Alan Teale's International Underwriting Assn. Inc.

Another IUA affiliate, Federation of Business & Professional Assns. International, last fall reported New England International as the insurer of about a dozen purchasing groups in filings with several state insurance regulators.

However, regulators in Arizona, Kentucky and other states objected to the use of New England International, which was licensed only in Louisiana. A Kentucky Insurance Department official also was told by a lawyer representing New England International that the insurer had not agreed to write coverage for any of the purchasing groups.

FBPA later withdrew the purchasing groups from the various states.

Omne Underwriting Agency was involved in binding coverage for only one purchasing group with New England International, and this coverage was later canceled and replaced, according to David Fulton, an Omne Underwriting vp.

After the New England International examination report was filed, the Louisiana department wrote to New England International and demanded that it add \$2.5 million to its capital and surplus and comply with several other requirements.

The additional capital was not forthcoming, though, and the Insurance Department issued a cease-and-desist order against the insurer on April 6.

In advance of the scheduled April 17 hearing, the department had directed Mr. Rienstra and other New England International officials to provide additional information on the company's finances and operations, including breakdowns of a \$4.9 million surplus infusion reported in its 1988 annual statement and a proposed \$3.3 million surplus infusion needed to reduce its net premium-to-surplus ratio and to bolster loss reserves.

On April 14, however, a local trucking company called the department to ask where it should deliver a prepaid shipment of more than 30 filing cabinets from New England International's offices, the department spokeswoman said.

Louisiana officials later learned that New England had closed its offices and laid off its employees, the spokeswoman said, adding that the insurer's landlord had tried to place a lien on New England's leased furniture.

On April 17, Mr. Rienstra's letter was faxed from Brussels. Among other things, the letter charged:

- The department's initial cease-and-desist order was unjustified.

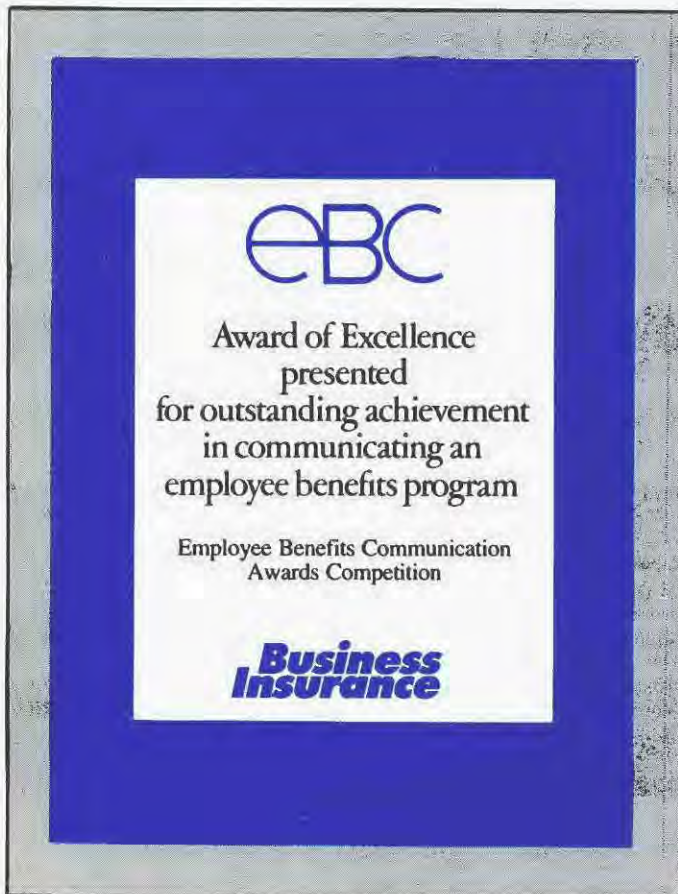
- New England International had complied with Insurance Department directives after the May 1988 audit.

- The Insurance Department had never received a complaint from New England International policyholders about failure to pay claims.

- The insurer's 1988 balance sheet showed it to be within solvency and surplus requirements.

"We have considered to contribute more cash into the company (sic), and to ask you to reconsider your position and to comply with your wishes in every way," the letter said.

"However, we have decided to turn the Louisiana company's business over to you because we have come to the conclusion that you and your staff take decisions which are based not on pragmatic facts but on emotional and politically oriented considerations." ■



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McCormick advises insurance industry to answer its critics

By LINDA J. COLLINS

CHICAGO—California's Proposition 103 is just one of several issues a united insurance industry must address, a property/casualty insurance company executive says.

The insurance industry also is confronted with efforts to repeal the McCarran-Ferguson Act, which grants insurers limited federal antitrust immunity; antitrust suits filed by 20 state attorneys general against several members of the property/casualty insurance industry; the possibility of federal instead of state regulation of insurance; and a host of other problems, observed William M. McCormick, chairman and chief executive officer of Fireman's Fund Insurance Cos. in Novato, Calif.

"There is not a lot of time left for (insurers and agents) to circle the wagons, get an understanding of what the problem really is and, hopefully, march together to deal with the issues facing the industry in a positive way," he warned.

Only then can we "turn the current wave of bad feelings about our industry into the wave of good feelings I think it deserves," Mr. McCormick told insurance industry representatives attending the Chicago "I" Day meeting last month. The gathering was sponsored by the Independent Insurance Agents of Illinois and the Chicago Board of Underwriters.

Addressing the subject of Proposition 103, Mr. McCormick called the measure "unconstitutional."

Immediately after California voters narrowly approved Proposition 103, Fireman's Fund and several other insurers filed suit challenging the law's constitutionality (BI, Nov. 14, 1988). A stay was issued—but later lifted on all but two of Proposition 103's provisions—pending a court decision on the law's constitutionality, which is expected by next month (BI, March 13; Dec. 12, 1988).

Proposition 103 "is unconstitutional because it has in it a number of rules... that would be terrible if they were applied to any industry," Mr. McCormick said.

According to Mr. McCormick, those rules include:

- The rollback of most property/casualty insurance "charges" to 20% below November 1987 levels. The rollback, "as we work it out, is about a 35% price cut," he said.

- The rate rollback represents "illegal confiscation of property without compensation and it also violates private contracts," Mr. McCormick contends.

And, "the government does not have the right to change legal contracts that are properly arrived at between citizens of the country. That's a provision of the federal Constitution and of state constitutions," he explained.

- That insurers may not cancel or fail to renew auto insurance policies, except under certain circumstances.

"This means that once you have a customer, that customer is yours for life, and the only way you can stop serving that customer is if you go insolvent," he said.

- The establishment of a consumer advocacy office funded by insurers. This provision—like the insurance "charge" rollback—currently is stayed.

Such an office, Mr. McCormick predicts, would insure "that every rate hearing will be almost a legal court battle."

Mr. McCormick observed that a number of factors influenced California voters to seek passage of

Proposition 103.

For example, he said that while auto insurance rates in most areas of California have increased only slightly over the last 10 years—to about 4% of per capita income from about 3.5%—Los Angeles-area residents, who provided the proposal with its margin of victory, spend about 7% of per-capita income on automobile insurance. Mr. McCormick acknowledged that hits "the pain threshold."

He attributed high insurance costs in Los Angeles to increased legal costs, a higher theft rate and body shop fraud.

Proposition 103 is just one of several challenges the insurance industry faces, he stressed. For instance, the insurance industry has been the victim of a "burgeoning explosion in litigiousness and lawsuits," he said.

Mr. McCormick noted that Fireman's Fund will soon "be paying more for outside legal (costs) than we pay for our entire inside salary expense. . . . There's a huge societal price for that."

"Our total salary budget at Fireman's Fund is about \$330 million. Our outside legal bill is \$200 million now, but rising far more rapidly than our staffing budget. . . . and those lines will cross within the next five years unless something happens," he predicted.

While insurers can't single-handedly combat the rampant growth in litigation, insurance industry representatives can lead the public in seeking a better definition of liability in an effort to reduce those costs, Mr. McCormick added.

Insurer representatives also must address other issues, he said.

For example, insurers do not present "a very clear voice to the public about how our industry operates," he said. Insurer representatives must band together "to talk wisely about industry problems and what has to be done for the good of society," he said.

Furthermore, wild fluctuations in property/casualty insurance rates anger insurance buyers and cause them to view the insurance industry as "stupid," Mr. McCormick noted.

He suggested that better accounting rules and disclosure could ease this situation. "We need to have better rules on how to do actuarial work, how to keep our reserves proper and how to charge the right rates," he stressed.

Insurers "must take personal responsibility" in resolving this issue, he said.

Insurance industry representatives need to demand that state insurance departments enforce stricter rules, Mr. McCormick said. Insurance industry leaders also should do a better job of self-regulation when they see insurers headed for financial difficulty or insolvency, he stressed.

The industry should also assist the public in viewing environmental issues as a social problem—not just an insurance problem—requiring a societal solution.

But above all, Mr. McCormick urged those in the insurance industry publicly defend the industry.

"This is an industry that provides a necessary service to the public. Without insurance, commerce stops. . . . and we're not telling our story the way we should," Mr. McCormick added.

"If we pick three or four issues and work on them aggressively, I think we can change the way the industry is viewed—the way the regulators view us and the way the public view us," he said. ■



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Lloyd's syndicates

Continued from page 2

several 1986 underwriting accounts also left open, said Mr. Gordon.

For example, one of Lloyd's oldest syndicates—marine syndicate 65, managed by H.G. Chester & Co. Ltd.—will not close the account for its 1986 underwriting year because of "uncertainty over pollution losses," said agency Chairman Richard Martin.

Pollution "loss advices have been escalating quite dramatically over the last years," but the main problem is the "uncertainty created by the pollution losses," said Mr. Martin.

The syndicate hired actuaries from the London office of Tillinghast, a division of Towers, Perrin, Forster & Crosby Inc., to assess the syndicate's liabilities. The difference between the Tillinghast's most optimistic and pessimistic assessment of the syndicate's pollution and asbestos liabilities is about \$40 million, said Mr. Martin.

The syndicate currently has total reserves of just less than \$100 million and reinsurance arrangements—like time-and-distance policies—worth about \$20 million to cover losses stemming from the 1986 and previous underwriting

years, said Mr. Martin.

Another syndicate forced to keep open its accounts for the first time is marine syndicate 287, managed by Spratt & White Ltd.

Loss advices filed into the London market concerning pollution liabilities arising from old underwriting years has left the syndicate unable to accurately assess a suitable reinsurance-to-close premium for 1986, according to underwriter Malcolm Blair.

Meanwhile, most syndicates with underwriting accounts that have been left open because of uncertainties surrounding U.S. liability losses from earlier years are experiencing further loss deterioration, sources say.

For example, liabilities from past underwriting years of syndicate 604, managed by Lambert Brothers (Underwriting Agencies) Ltd., have further deteriorated, causing the agency to keep open syndicate 604's 1984 underwriting year again this year.

The syndicate also will be asking the 396 members of the syndicate in 1984 to make payments totaling about 5 million pounds to finance increased reserves, principally for U.S. asbestos property damage and pollution loss claims filed during the last year, said Lambert Managing Director Peter Daniels.

Syndicate 604 has been insuring U.S. risks since the 1930s, and there are "increasing uncertainties and continuing claims developments" for which the syndicate must reserve, he explained.

However, at least three syndicates now will be able to close earlier underwriting years after settlements with Mr. Outhwaite over runoff reinsurance policies he wrote to cover the syndicates' past liabilities (BI, Oct. 24, 1988).

Wellington Underwriting Agencies Ltd. this year will be able to close the 1985 accounts of marine syndicates 448 and 406 after renegotiating runoff reinsurance policies ceded to syndicate 317/661 managed by R.H.M. Outhwaite (Underwriting Agencies) Ltd. to cover liabilities arising from past underwriting years.

"Both underwriters feel that they now have a sufficient handle on the old years" to close the accounts, said Guy Norrie, a Wellington director, adding that the syndicates also will be declaring "marginal profits" for the 1985 years.

Similarly, syndicate 28, managed by Murray Lawrence & Partners, this year will be able to close its 1984 underwriting year "with a profit" after a settlement last fall with Outhwaite syndicates, said Managing Partner Paul Archard.

But several other syndicates that have not yet

resolved disputes over Outhwaite runoff policies probably still will be unable to close their accounts, sources predict.

The Outhwaite syndicates wrote more than 50 runoff reinsurance policies, many of which contained no aggregate limits, covering ceding syndicates' and commercial insurers past underwriting years. The Outhwaite agency is disputing several of the policies against which claims have been filed, alleging that the ceding syndicates and insurers did not fully disclose information about the risks (see related story).

Lloyd's underwriter Stephen Merrett also is questioning runoff policies written by syndicates 418/417 and 421, managed by Merrett Underwriting Agency Management, which is forcing other syndicates to keep their accounts open.

For example, syndicate 640, managed by A.B. Dick-Cleland (Underwriting Agencies) Ltd., is leaving its 1986 account open because an unlimited runoff reinsurance policy written by Mr. Merrett is being disputed, said syndicate 640 underwriter Leonard Toomey.

The Merrett agency now is disputing the policy, written to cover syndicate 640's liabilities from 1966 to 1970, because of alleged non-dis-

Continued on next page

Outhwaite names may face '89 cash call

By STACY SHAPIRO

LONDON—Members of Lloyd's of London syndicates underwritten by Richard Outhwaite could be hit in the next month with an unplanned cash call to fund massive losses from 1982 runoff reinsurance policies, a former syndicate member warns.

Members of syndicate 317/661 during 1982, which was managed by R.H.M. Outhwaite (Underwriting Agencies) Ltd., were told last year when they were asked to pay a cash call of 20.7 million pounds (\$35.4 million) that they would have to pay similar amounts every other year—in 1990, 1992 and 1994—according to Outhwaite's 1987 annual report.

Last year, members were told that they are liable for at least 85.4 million (\$146.4 million) of the 263.3 million pounds (\$451.3 million) that the syndicate faces in outstanding liabilities from 51 runoff reinsurance contracts, of which at least 13 were disputed (BI, June 13, 1988).

However, Peter Nutting, chairman of The 1982 Outhwaite Names Committee, predicts the 1,614 syndicate members in 1982 will be asked for a "substantial call" this year.

"I foresee the 1982 year deteriorating considerably," said Mr. Nutting, who resigned from the Outhwaite syndicate this year. "I predict there will be a substantial cash call."

An Outhwaite spokesman said that "it is not possible to say" whether the syndicates will make a "substantial" cash call when Outhwaite releases its results in the next month.

"It is a possibility, but at the moment one couldn't say," because there are too many factors to consider before the accounts are announced, the spokesman said.

The Outhwaite agency has settled seven of the disputed contracts in the last year. The outcome of the settlements could affect the 1982 underwriting year's accounts.

Also, this month an arbitration judgment is expected regarding a

disputed runoff contract written by the Outhwaite syndicate for a Lloyd's syndicate managed by Roberts & Hiscox Ltd., which also could affect the 1982 results.

London market sources have hinted that the agency is trying to find an equitable solution to the members' liabilities, but so far Outhwaite has not given any details.

Meanwhile, Mr. Nutting also wonders whether Outhwaite will have to keep open its 1986 year because of the uncertainties raised in a recent report on whether the 1982 account was legitimately reopened in 1985, the year the account was supposed to close (BI, April 17).

London-based law firm Freshfields last month sent a second report to members' agencies detailing the events that led Mr. Outhwaite to reopen the 1982 underwriting account.

According to the report, the Outhwaite agency's auditor, Ernst & Whinney, recognized in 1985 that based on Mr. Outhwaite's cash-flow

projections, there was "likely to be a significant shortfall during the 1990s as regards the runoff business, which would require funding" prior to the receipt of money from time-and-distance reinsurance policies purchased by the syndicate.

The auditor also questioned whether there was sufficient certainty to calculate a reinsurance-to-close premium on the 1982 account. Although the auditor's private opinion was that the uncertainties made it preferable for the year to be left open, Ernst & Whinney said that it was up to Outhwaite to decide.

The report also says that Mr. Outhwaite decided to close the account with a 97 million pound (\$166.3 million) reinsurance-to-close premium, but Ernst & Whinney added a qualification to the accounts to point out the uncertainties of future losses. The accounts were closed and profits were distributed on June 21, 1985.

However, "after it became known in the market that... accounts were to be distributed with the 1982 year closed but with a qualified audit opinion, it became apparent to Mr. Outhwaite that there was considerable disquiet, particularly among the members' agents," said the report.

Mr. Outhwaite met with several representatives of members' agencies and discovered that "the objections were sufficiently strong, widespread and forceful that Mr. Outhwaite believed that unless he changed his decision, so many names would be withdrawn that syndicate 317/661 would have to cease writing business" as of Dec. 31, 1985.

As a result, Mr. Outhwaite reopened the syndicate and notified members of the decision on July 1, 1985, the report said.

Lloyd's Outhwaite Members' Agents' Steering Committee is seeking further legal advice after the Freshfields report to determine if Mr. Outhwaite legitimately closed the 1982 year, thereby freeing the 1982 members from liability for the losses.

Meanwhile, the 1982 Outhwaite Names Committee also has appointed its London-based law firm, Richards Butler, to review the Freshfields report and see if the 1982 account was legitimately closed, said Mr. Nutting.

But, Mr. Nutting says that if it is found that Outhwaite legitimately closed the 1982 year of account, then the liabilities would have been transferred into the 1983 year, which when it closed would have moved them into the 1984 year, and so on. The liabilities would therefore be in the 1986 account, which would be the only Outhwaite account still open.

"If it transpires that the syndicate was closed and (1982) members are not liable, then the Council of Lloyd's will have to do something," said Mr. Nutting, because 1986 members joined thinking they would not be affected by previous loss years.

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Continued from previous page

closure, though Merrett last year paid a claim filed under the policy, said Mr. Toomey.

Meanwhile, London-based Eagle Star Insurance Co. Ltd., which reinsured syndicate 640's liabilities for 1965 and previous underwriting years, has paid all claims filed so far by the syndicate, Mr. Toomey noted.

"We have joined the growing list" of ceding underwriters whose runoff policies are being disputed by Outhwaite or Merrett, Mr. Toomey said, adding that he is asking the High Court to settle the matter.

Meanwhile, syndicate 544, managed by A.J. Archer Holdings P.L.C., earlier this year failed to obtain a summary High Court judgment to settle a similar dispute arising from the Merrett syndicates' failure to pay claims from a 50% share of a runoff policy (BI, Dec. 12, 1988).

The Merrett agency has "voided the policy and instituted arbitration proceedings," said Ken Randall, managing director of Merrett Holdings P.L.C.

However, Archer has filed suit against Merrett. A preliminary High Court hearing will occur in June.

As a result of the dispute, syndicate 544's 1986 underwriting account will remain open.

Mr. Randall would not say how many of the 11 runoff policies underwritten by Merrett syndicates are disputed, but "we have made considerable progress in the last 12 months in clearing points of difference with some cedants."

Mr. Randall also would not comment on whether Merrett-managed syndicate 418, Lloyd's largest syndicate, this year would close its 1985 account, left open last year.

Merrett will produce a statement soon, Mr. Randall said last week.

However, many members agencies predict the syndicate's 1985 year will remain open.

Meanwhile, the whole issue of underwriting accounts left open throughout the market is "an appalling situation and is getting worse," agreed Mr. Randall.

Lloyd's agents are "very concerned about the problem of open years, and we are addressing the problem and trying to come up with some solutions," said Mr. Gordon.

However, any solution probably will have to come from the Corporation of Lloyd's itself, he noted.

Lloyd's Chairman Murray Lawrence said in a newsletter sent to members earlier this year that the Committee of Lloyd's has been monitoring the situation carefully and is "considering what steps to take." However, we "cannot force an underwriter to close a year if he really feels unable to arrive at a figure for reinsurance-to-close which would be fair and equitable as between the ceding and assuming Names; to do that would be to put him in breach of the law of agency," he explained.

Instead, the committee is "attempting to find ways and means by which we can try to ensure that leaving a syndicate open is very much the last resort and never an easy option," Mr. Lawrence added.

The market "has to decide during the next year what to do," warned Robin Gilkes, chairman of underwriting agency Lloyd-Roberts & Gilkes Ltd. and former chairman of the LUAA.

The problem of open years is "becoming a disease and the market has to deal with it. Environmental pollution presents a range of probabilities which some people feel is too great," he said. Leaving accounts open may be the right solution "academically" and may keep the syndicates' auditors happy, but it leaves members in a position "with no way out," he noted.

Although a syndicate is justified in keeping an account open if it is involved in a major dispute that could materially affect the syndicate's accounts, uncertainty over a whole class of business should not prevent a syndicate from closing its accounts, argued underwriting

agency executive Mr. Archard.

"Agents should think long and hard about keeping open an account, and problems surrounding pollution is not a good reason in my opinion. It should be possible to arrive at a reinsurance-to-close figure, he said.

However, although "no agent wants to keep a year in runoff, he needs to provide some degree of certainty for new names. An agent has a duty to ensure that he is not giving an unreasonable uncertainty to assuming names," countered Mr. Daniels.

"The issues are very difficult and will require some tough talking and thinking by management," said Mr. Randall, noting that the two problems causing most concern are the uncertainty surrounding the validity of syndicates' runoff contracts and environmental liabilities.

"Management has to take a view and if the level of uncertainty is too great," the syndicate accounts must be left open. However, that decision should not be taken as the "easy option," said Mr. Randall. ■

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ERISA ruling

Continued from page 2

Cross plan, as a defendant, it does not name Swiss American.

A Los Angeles County Superior Court ruled in October 1987 that Mr. Sayble's claims were pre-empted by ERISA.

But the appellate court in March reversed that ruling, allowing the case to go to trial in California Superior Court under state insurance law.

"Due to the lack of participation by Swiss American in the administration of the subject insurance benefit, the regulatory concerns of ERISA are not implicated," the appellate court ruled.

"ERISA's fiduciary standards were intended to prevent abuses of the special responsibilities borne by those dealing with such plans, and to shield employees from self-dealing, imprudent investing and misappropriation of plan funds. Where there is no administrative activity potentially subject to employer abuse, pre-emption does not serve the overall purpose of ERISA," the court ruled.

"It is manifest that Swiss American did not administer the subject health program, and its role was essentially limited to paying the policy premiums," the decision stated.

Quoting from a U.S. Supreme Court ruling in a case over disputed severance payments, the California court said: "To do little more than write a check hardly constitutes the operation of a benefit plan."

In addition, the California court ruled that "due to the lack of an express agreement by Swiss American to provide health insurance for its employees," it is "questionable" whether Swiss American had made a commitment to pay the premiums.

"The purchase by Swiss American of health insurance for Gilbert (Sayble) did not constitute a plan under ERISA; accordingly none of the Sayble causes of action are pre-empted thereby," the court said.

The defendants filed a motion for reconsideration with the appellate court last month. If the court does not reconsider the case, the ruling likely will be appealed to the California Supreme Court, said attorney Peter R. Taft of Munger, Tolles & Olsen in Los Angeles, who represented Blue Cross.

Although the lawsuit filed by Mr. Sayble does not name Swiss American as a defendant, some benefit experts believe the appellate court's decision, if it stands, could leave employers open to punitive damage claims over routine benefit denials.

"Effectively, (the judges) are saying that pay-

ing for an employee benefit doesn't make an ERISA-style plan," said attorney Dan S. Brandenburg of the Washington, D.C., firm of Sanders, Schnabel & Brandenburg.

The appellate court's ruling is "somewhat startling," said Henry Saveth, a principal at benefit consultant A. Foster Higgins & Co. Inc. in New York.

Employers and insurers generally have believed that the act of providing health insurance to employees was sufficient to bring a plan under ERISA jurisdiction, he said.

However, the Sayble decision "seems to say that's not necessarily the case—that it takes something more than paying the premiums" to qualify as an ERISA plan, Mr. Saveth said.

However, "the average employer" only pays the premium, said Claude J. Dorais, an attorney with Dorais & Wheat in Los Angeles. Even employers with as many as 500 covered employees could fit within that definition, he said.

Plaintiff's attorney William M. Shernoff of Shernoff, Scott & Bidart in Claremont, Calif., said the Sayble ruling draws an appropriate line between benefits offered by small employers that are not part of a benefit plan—and therefore not regulated by ERISA—and employer-administered plans regulated by ERISA.

"To me it's perfectly sound and reasonable," he said. "I think it's going to have substantial

impact."

Mr. Shernoff represents Joseph V. Juliano, a San Diego man who has sued Commercial Life Insurance Co. for the bad-faith denial of benefit claims (BI, Dec. 26, 1988). The state Supreme Court ruled in December that ERISA pre-empted Mr. Juliano from seeking relief under state law. Mr. Shernoff has since asked the U.S. Supreme Court to review the case (BI, Jan. 9).

However, application of the Sayble decision could be restricted by other factors, pointed out attorney Michael Geibel of Daniels, Baratta & Fine in Los Angeles, who represents Mr. Sayble.

The Sayble case was unusual because Swiss American had no express agreement to provide employee benefits, he said. Most employers have contractual obligations to provide benefits or a readily identified employee benefit plan, which brings those plans under ERISA regulation, he said. As a result, those employers are protected from punitive damage claims, Mr. Geibel said.

The Sayble decision is "interesting" but is not yet a major cause of concern for employers and insurers, Mr. Brandenburg agreed.

He also noted that the decision carries the weight of law only in the appellate court's Los Angeles-area jurisdiction and is subject to review.

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Risk/Employee Benefits:
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Sub-total 23,959

Associations 548
Government, Unions and Educational Institutions 1,299
Commercial Consumers
Sub-total 25,806

Insurance Agents and Brokers 10,745
Insurance Companies 7,557
Actuaries, Consultants, Attorneys, Adjusters, Appraisers and Third Party Administrators 3,580
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Berkshire Hathaway

Continued from page 1

Berkshire insurers refused to drop their rates to maintain business.

"At Berkshire, we simply will not write policies at rates that carry the expectation of economic loss," Mr. Buffett told shareholders in his folksy, 18-page letter to them in the company's annual report. "We encounter enough troubles when we expect a gain."

About half of Berkshire's aftertax net earnings of \$399.3 million was generated by its insurance operations: \$196.7 million. Net aftertax investment income swelled to \$197.8

million from \$136.7 million while the net aftertax underwriting loss was slashed to \$1 million from \$20.7 million in 1987.

Other Berkshire operations include The Buffalo (N.Y.) News, World Book Encyclopedia, home furnishings retailing, home cleaning systems, uniform manufacturing and distribution, candy manufacturing and, most recently, an 80% interest in an Omaha jewelry store.

"Insurance will be very volatile," Mr. Buffett told about 100 shareholders, who had remained to ask more questions after the formal question-and-answer session was halted on schedule at noon, almost 2½ hours after beginning the annual meeting.

Mr. Buffett said he was closing the formal question-and-answer session at noon to permit shareholders to visit two Berkshire operations (see story, page 32).

As promised in the annual report, however, Mr. Buffett and Mr. Munger remained available to answer questions until all questions had been "dealt with."

This year, it was 12:50 p.m. before they left the stage, after Mr. Buffett asked, "Is that it?" and no one asked another question.

In that last hour of fielding questions that ranged from seeking guidance on the best sources of investment information to an assessment on the effect of interest rates on Berk-

Continued on next page

California work comp reform

Continued from page 3

Workers compensation insurers are in "complete support" of the reform package, said Robert A. Puccinelli, chairman of Industrial Indemnity Co. in San Francisco, a unit of Crum & Forster Inc., and one of the task force members.

"We believed the benefit had to be raised to an appropriate level," he said. Small benefit payments are a "frictional" factor that have led to litigation as injured workers sought to recover more money from the system, Mr. Puccinelli said.

The proposal calls for "a very measured, balanced contribution by all the parties," he said.

For their part, insurers will reduce the expense provision used in calculating workers compensation insurance rates by one percentage point per year for three years, cutting the expense provision to 32% in 1992 from the current 35%.

Employers are supporting the proposals even though they would increase most work comp costs.

According to the task force's analysis, the proposed benefit increases alone would boost insured employers' total work comp premiums to \$9.26 billion in 1992, a 17.2% increase from the estimated 1989 premiums of \$7.9 billion, excluding changes in premium volume due to size of the workforce, wage hikes or loss experience.

However, when the reforms included in the package are factored in, employers' 1992 workers comp premiums grow to \$8.42 billion, or only a 6.6% increase over the current costs. This is partially because the reduction in the insurers' expense provision is expected to save \$376 million in 1992.

California Senate President Pro Tem David Roberti, D-Los An-

geles, found the proposal "very interesting," a spokesman said.

"Some positive work has been done by the task force," the spokesman said. However, Sen. Roberti was reserving further comment until the plan has been carefully analyzed.

The Senate president was considering whether he will sponsor the reform package or some version of it, but "don't read anything into that," his spokesman said.

While Gov. Deukmejian urged legislators to act quickly on the proposal, the measure still lacked a legislative sponsor last week.

The proposal faces strong opposition by the California Applicants' Attorneys Assn., a Sacramento-based group that represents about 700 attorneys who specialize in workers compensation cases.

"This proposal is clearly an employer/insurance company protection scheme," said CAAA President Merle Rabine.

The plan would make it more difficult for employees to collect benefits and "shift almost total control over who does and does not get benefits to employers and insurance companies," he charged.

Mr. Rabine suggested that labor groups will not be united behind the reforms. "We believe many public employee unions as well as other rank and file will join us in opposing this 'deal' which primarily benefits some higher-paid workers," he said.

However, the chief officer of the state's largest labor group said union members will back the proposal.

"This is a historic victory from our point of view," said Jack Henning, executive secretary of the San Francisco-based California

Labor Federation, which represents 2 million workers.

The benefit increases are "the greatest dollar gain in the history of the program," he said.

The plan also automatically increases benefits in step with the average weekly wage in future years. "We no longer have to come as political beggars (to ask the Legislature for benefit increases) time and time again," he said.

Specific reforms included in the Workers Compensation Improvement Act of 1989 include:

- Increasing the maximum weekly benefit for temporary and permanent total disability, which is currently limited to \$224. The maximum benefit would be \$322 for injuries occurring on and after Jan. 1, 1990; \$420 effective Jan. 1, 1991; and 100% of the average weekly wage, estimated at \$511, effective Jan. 1, 1992.

Future benefit increases would be automatically tied to increases in the state average weekly wage, though benefit hikes would be capped at 5% annually.

- Reducing the minimum weekly benefit for temporary and permanent total disability to \$98 from \$112 for injuries occurring on and after Jan. 1, 1990; to \$84 effective Jan. 1, 1991; and to the lesser of \$126 or the employee's average weekly earnings beginning Jan. 1, 1992. Cuts in the minimum weekly benefit are proposed because of employer concern about some low-income workers receiving more in disability payments than in wages.

- Increasing death benefits for workplace incidents occurring on and after Jan. 1, 1990. The benefit for one surviving dependent would increase to \$95,000 from the current \$70,000 maximum; the death

benefit for two or more surviving dependents would rise to \$115,000 from \$95,000 currently.

In addition, death benefits will continue to be paid at the same rate as weekly temporary disability benefits until the worker's youngest minor child reaches the age of 18, even if the total death benefit paid exceeds the statutory maximum.

- Increasing burial allowances for private sector and state employees to \$5,000 from the current \$2,000 effective Jan. 1, 1990. Burial allowances for local public employees would rise to \$4,500 from \$2,000 effective Jan. 1, 1990.

- Creating a new state Division of Workers' Compensation, which would assume all non-judicial duties and powers now exercised by the Workers' Compensation Appeals Board.

The new division would consist of an Office of Benefit Assistance and Enforcement to mediate claims disputes and assess civil penalties for improper claims practices; an Office of Benefit Determination to take over current duties of the Rehabilitation Board and the Disability Evaluation Board; and an Office of Claims Adjudication for determination of disputes not resolved by the Office of Benefit Assistance and Enforcement.

- Reorganizing the current Medical and Chiropractic Advisory Committee to select physicians qualified to evaluate the existence and extent of disabilities.

Medical determinations would be made by designated "impartial medical evaluators," rather than physicians chosen by the injured workers. Employers would pay the cost of the initial evaluation, but subsequent evaluations would be

paid by the requesting party.

- Limiting the types of stress claims that are compensable.

The proposal would require that stress claims be "based on actual events and objective medical standards;" make disability indemnity payments proportional to work-related cause of the injury; and exclude compensation for psychiatric injuries resulting from lawful personnel actions by the employer.

- Requiring first payment of temporary and permanent disability indemnity benefits within 14 days of the employer's knowledge of the injury, with subsequent payments to be made every two weeks thereafter. A late penalty of 10% payable directly to the employee would be assessed if indemnity payments are delayed after a claim is filed.

- Specifying that an employer can withhold maintenance allowance payments—payments for the employee's living expenses during rehabilitation—if an eligible employee "unreasonably fails to cooperate" with a vocational rehabilitation program. The employer must notify the employee of its intent to withhold payment and, if the employee objects, continue payment pending review by the state Department of Benefit Determination.

- Allowing employers, in some cases, to credit one-half of vocational rehab maintenance payments against permanent partial disability benefits.

- Giving employers incentives to encourage modified or alternative work programs. A workers compensation premium rebate would be paid to the employer if an employee completes one year of modified or alternative work.

California comp report shows need for reform

By GLENN HUNTLEY

SACRAMENTO, Calif.—A report on California's workers compensation system prepared by the state auditor general's office reinforces arguments for changing the system, observers say.

However, conclusions drawn from the auditor general's report vary widely, from a state legislator's claim that it indicates excessive insurer profits to an insurer trade group's contention that it reveals inefficiencies in the work comp system.

The 138-page report, released last month by acting Auditor General Kurt R. Sjoberg, found that California workers compensation premiums increased 33% to \$5.2 billion in 1986 from \$3.9 billion in 1984. Meanwhile, benefits paid and reserved increased only 26.9% to \$3.3 billion in 1986 from \$2.6 billion in 1984.

The auditor general's report also offered several suggested "alternatives" to improve the state's workers comp system.

"We are in general agreement with the report but feel the recommendations contained in it don't go far enough to cure the ills of this sick system," said Thomas F. Conneely, president of the Sacramento-based Assn. of California Insurance Companies.

Assemblyman Bruce Bronzan, D-Fresno, charged that the report shows workers comp insurers are reaping huge profits as the costs of the system soar.

Using figures from the report, he and other legislators claim that workers comp insurers' profits increased nearly five-fold to \$1.4 billion in 1987 from \$240 million in 1983.

However, the ACIC contends that the leg-

islators misinterpreted the information.

The legislators compared premium increases to paid claims and reserves for 1983-87, but failed to include incurred-but-not-reported losses, the ACIC's Mr. Conneely said.

If they had taken IBNR losses into account, even using their incorrect methodology, they would have seen that "premiums increased 85% while paid losses and reserves for losses increased 88%," he said.

Assemblyman Bronzan conceded last week that the auditor's report was "not conclusive" about insurer profits, but said it still indicates that workers comp insurance is "a highly profitable business."

State lawmakers will require more detailed information about workers comp costs and profits before acting on any workers compensation reform legislation, Assemblyman Bronzan said.

Employer, insurer and labor groups have negotiated a workers compensation reform package that they hope will soon move through the California Legislature (see story, page 3).

The report's recommendations for improving the workers comp system include:

- Increasing the maximum weekly indemnity benefit to equal two-thirds of California's average weekly wage and make annual adjustments for new claims. Using the 1987 average weekly wage of \$444, the benefit payment would rise to \$296 from the current \$224.

- Offsetting temporary disability payments against settlement amounts when an employee chooses a lump-sum settlement.

- Holding the Department of Industrial

Relations responsible for temporary disability payments if it does not hold conferences to determine whether benefits are to be terminated within the 30-day limit set by law.

- Making compromises, release agreements and stipulations binding on the parties without requiring a judge's approval.

The report documents "some distressing failings in the system that insurers and the employer community have been attempting to change for years," Mr. Conneely said.

The auditor general found that most employees hire attorneys to present their claims for workers compensation benefits. The average fee for an employee's attorney was \$1,662 for claims closed in 1985.

"This is an indictment of the system because it should be totally unnecessary for workers to hire attorneys to receive these benefits," Mr. Conneely said.

Also, duplicative medical reports used to make disability determinations are "documented, but not highlighted" in the study, he said.

In cases submitted to the Workers Compensation Appeals Board in 1985, the parties submitted an average of 2.5 medical reports for each claim, the report states. A random sample of claims filed with the State Compensation Insurance Fund, the state's largest work comp insurer, found the average cost was \$577 for an insurer-requested medical report and \$651 for an employee-requested report in 1987.

The auditor general also found:

- Most work comp claims were resolved without litigation. Nearly 1.2 million claims were filed with the State Compensation Insurance Fund and self-insured employers in

1985, while the number of litigated claims filed with the Workers Compensation Appeals Board totaled only 175,000 in 1985.

- Compromises and the use of release agreements were the most frequently used means to settle WCAB cases. Of the 175,000 claims contested to the WCAB in 1985, 77% had been settled by Dec. 1, 1988.

- Most claims filed with the WCAB are filed by employees. Only 8% of the contested cases were filed by employers or insurers from 1985 through 1987.

- The average number of days to resolve litigated cases did not change significantly from 1985 through 1987.

A random sample of resolved 1985 claims took an average of 525 days to close.

And, cases that were filed with compromise and release agreements or stipulations already in hand took only an average of 47 days each to resolve.

- The number of new vocational rehabilitation cases rose steadily, adding to the overall costs.

The number of cases grew to 36,269 in 1986, a 37% increase over 26,490 in 1984.

- The most effective method of vocational rehabilitation—modified or alternative jobs with the same employer—is the least used.

A sample of 226 employees in rehab programs found only 20 in modified or alternative jobs.

All 20 workers were still employed at the end of their rehabilitation.

The least effective rehabilitation method was schooling programs, which were chosen by 149 of the 226 sample employees.

Only 92, or 61.7%, of these employees were working at the end of the rehabilitation.

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Berkshire Hathaway

Continued from previous page

shire's business, Mr. Buffett also autographed more than two dozen annual reports at the request of admiring shareholders.

Mr. Munger, who says very little in these shareholder meetings, deferring to Mr. Buffett, also signed several annual reports.

While advising shareholders that the property/casualty insurance business would be volatile, Mr. Buffett nonetheless assured the shareholders, "it's OK to be in" the insurance business.

Berkshire's insurers are reporting "excellent" underwriting results, Mr. Buffett said in the annual report, citing the insurers' combined ratio on a statutory basis, excluding structured settlements and financial reinsurance transactions, of 104%.

Mr. Buffett has been extremely successful in managing the insurance companies' investment portfolios. And investing their portfolios, he stressed, is his role in the operation of the insurance companies.

As with all of Berkshire's operations, the individual managements run their businesses, while Mr. Buffett and Mr. Munger take responsibility for "allocating capital," Mr. Buffett said several times during the meeting.

To emphasize the importance of the individual operations' managements, Mr. Buffett introduced the various managers to shareholders, including Michael A. Goldberg, Berkshire's vp in charge of insurance operations.

Mr. Goldberg, in turn, introduced Ajit Jain, president of the reinsurance treaty division and the professional liability and specialty risk division; Dinos Iordanous, president of the commercial casualty division; Rod Eldred and Brad Kinstler, co-managers of three Berkshire Midwest standard lines companies; and Don Wurster, manager of Berkshire's commercial automobile and general liability division.

While Berkshire's insurance operating profits are generated by investment income, Mr. Buffett points out that in selecting marketable securities for the companies' investments, his "criteria have nothing to do with maximizing immediately reportable earnings; our goal, rather, is to maximize eventual net worth."

Among the insurance companies' largest com-

mon stock investments are Capital Cities/ABC Inc., The Coca-Cola Co., Federal Home Loan Mortgage Corp. preferred stock (which Mr. Buffett notes is financially equivalent to a common stock), GEICO Corp. and The Washington Post Co.

Capital Cities/ABC, GEICO and The Washington Post are "permanent holdings," while the Coca-Cola and Freddie Mac holdings are intended to be held "for a long time."

Proof of Mr. Buffett's investment success is in the increased value of the permanent investments: 3 million shares of Cap Cities/ABC acquired at a cost of \$517.5 million have a market value of \$1.1 billion; 6.85 million shares of GEICO acquired at a cost of \$45.7 million have a market value of \$849 million; and 1.7 million shares of the Washington Post acquired at a cost of \$9.7 million have a market value of \$364.1 million.

The insurance subsidiaries also sometimes engage in arbitrage, which in 1988 was especially profitable, creating a pretax gain of about \$78 million, Mr. Buffett said in the annual report.

Berkshire only engages in a few, very large arbitrage transactions each year, and only those involving stocks when a corporate event has

been publicly announced, Mr. Buffett said in the annual report. It does not trade on rumors or try to guess takeover candidates, he said.

In the coming year, however, Mr. Buffett has told shareholders that he expects Berkshire "to be on the sidelines" of arbitrage activities, partly because the company has increased its investment in stocks it expects to hold for a very long time and because, "Some extraordinary excesses have developed in the takeover field."

"As Dorothy says: 'Toto, I have a feeling we're not in Kansas any more,'" he wrote in his letter, referring to Dorothy's observation upon landing in "Oz" in the movie "The Wizard of Oz."

Mr. Buffett's selections of investments for Berkshire's insurance subsidiaries as disclosed to the Nebraska Insurance Department have been so closely watched—and imitated—by other investors that the company last year started to take advantage of a provision of Nebraska's insurance code that permits the Insurance Department to keep confidential certain investment information filed by Berkshire's insurers.

While most of the insurers' investments are publicly disclosed, the Nebraska department has

Continued on next page

Shareholders check out retail operations

OMAHA, Neb.—Berkshire Hathaway Inc. shareholders, feeling flush and enthusiastic after the company's annual meeting, were transported in school buses to two retail Berkshire operations in Omaha: a furniture mart and a jewelry store.

Noting that Berkshire shareholders do not have to be convinced of the value of investment, Berkshire Chairman Warren E. Buffett said the buses were there to give them a push "toward consumption."

The Nebraska Furniture Mart is the largest home furnishings store in the country, offering a wide selection of furniture, carpeting and home accessories across all price ranges—at a discount.

The mart is still managed by its founder, 95-year-old Rose Blumkin, affectionately known as "Mrs. B," and her family.

Noting that Berkshire acquired an 80% interest in the highly successful furniture mart in 1983, Mr. Buffett wrote in his annual report to shareholders: "Your Chairman blundered then by neglecting to ask Mrs. B a question any schoolboy would have thought of: 'Are there any more at home like you?' Last month I corrected the error: We are now 80% partners with another branch of the family."

The other branch of the family is the Friedmans, who owned Borsheim's, a highly successful jewelry store in Omaha.

"The cornerstone for both enterprises is Mrs. B's creed: 'Sell cheap and tell the truth,'" Mr. Buffett wrote in his report.

Shareholders flocked to both retail operations and were not disappointed.

—By Kathryn J. McIntyre

Benefits Plan Design & Administration



On May 22 Business Insurance will publish a spotlight report on Benefits Plan Design & Administration. Editors will review the latest trends in employee benefits information systems as well as review new info systems available in the marketplace. They'll analyze info systems — how they impact benefits plan structure and implementation.

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Continued from previous page

agreed that it should keep confidential the holdings of several investment trusts.

As a result, the purchase or sale of a particular investment by these trusts can't be imitated by others now, averting potential disruption to markets and at least denying other investors free market tips.

Noting that Berkshire's insurers have "tons of surplus compared with others, so there is no security question," Mr. Buffett said there is no reason for policyholders to want to view these trusts' investments.

Assessing overall market conditions in the property/casualty insurance business, Mr. Buffett said last week that he expects the combined ratio to continue to deteriorate about 3 points annually to a high of about 120% before insurers raise their rates to improve their underwriting results. A national catastrophe creating an equally high or higher combined ratio one year also would result in higher insurance prices, he said.

But, Mr. Buffett does not expect the industry's combined ratio to "peter out at 110% to 112%" and then come down due to rate hikes.

The property/casualty insurance industry's combined ratio was 105.4% in 1988.

Property/casualty insurers will end their price war "only when people are afraid to do business," Mr. Buffett explained. "As long as they are not terrified to do business," insurers won't raise their rates, he said.

"Literally, you have to have people in the bigger lines say, 'I don't want to write it no matter what the price,'" Mr. Buffett said.

He recalled that during the liability insurance crisis "people who sold a policy at 2X didn't want to sell it at 10X" because they "became paralyzed."

Noting that "every month our exposure goes up" relative to the premium written due to rate decreases, Mr. Buffett said: "Somebody has to quit and they never gradually quit. It doesn't work that way."

Instead, in the insurance industry "many managements underestimate their costs for very long periods of time," he said.

"It's not good to compete against people who underestimate their costs," Mr. Buffett said.

Until prices rise in the commercial insurance market, Berkshire's insurers "will retain our talented professionals, protect our capital and try not to make major mistakes," Mr. Buffett said in his annual report.

Berkshire's 12 insurance company subsidiaries, led by National Indemnity Co. in Omaha, write primarily commercial liability insurance, including commercial automobile insurance, and specialize in large or unusual risks. They also underwrite financial insurance and reinsurance contracts.

In addition, insurance subsidiaries in Colorado, Kansas and Nebraska write standard multiline property/casualty insurance in their home states while California-domiciled Cypress Insurance Co. writes workers compensation in that state.

Primary or direct insurance underwriting generated \$218.8 million in 1988 premiums, a big drop from

\$412.7 million in 1987 and \$594.6 million in 1986.

Explaining the drop, the annual report says: "Group members are expected by management to practice disciplined underwriting, a consequence of which is a decrease in accepted risks occurring in periods of decreased pricing."

Conventional treaty reinsurance assumed, a large portion of which is generated by a quota-share reinsurance contract with Fireman's Fund Insurance Cos., decreased to \$203.3 million in premiums written from \$328 million in 1987.

The declines are primarily a result of treaties that were not renewed at expiration, noted Mr. Goldberg in an interview last week.

The four-year quota share reinsurance contract with Fireman's Fund, under which Fireman's Fund cedes 7% of its property/casualty insurance business to National Indemnity, is scheduled to terminate in September.

Berkshire insurers also wrote \$62.6 million in premiums related to financial insurance and reinsurance products.

In response to questions from shareholders at the meeting, Mr. Buffett also commented on other developments in the property/casualty insurance business.

Regarding the Tax Reform Act of 1986, Mr. Buffett said: "It has resulted in taxes being front-ended in the insurance business. The change in the tax law negatively impacts insurers," he said, because "it reduces the amount of float we temporarily hold."

The float is the sum of unpaid losses, unpaid loss adjustment expenses and unearned premiums, less agents' balances receivable, amounts recoverable as reinsurance on paid losses and deferred policy acquisition costs.

Berkshire's float at year-end 1988 of \$1.54 billion was about \$50 million less under the new tax law than it otherwise would have been, Mr. Buffett said.

The new tax law "means the same underwriting result will produce less profit or a greater loss," Mr. Buffett explained.

Nonetheless, the change in the tax law "has not had a beneficial effect on pricing" in the property/casualty insurance industry, Mr. Buffett said.

Regarding Proposition 103, Mr. Buffett said "people are very unhappy about what they pay for insurance" and believe that they have wasted their premium dollars if they don't receive a claim payment.

When people become unhappy about the cost of a necessity, such as personal auto insurance, "they may decide to socialize it," he said. "It is not inconceivable that will happen with auto insurance," Mr. Buffett said.

In his annual report, he said: "If voters insist that auto insurance be priced below cost, it eventually must be sold by government. Stockholders can subsidize policyholders for a short period, but only taxpayers can subsidize them over the long-term."

The prospect of the government forcing insurers to leave the auto insurance business would not directly hurt Berkshire insurers, but GEICO, the specialty auto insurer that is 44%

owned by Berkshire, "has a huge amount of economic good will at risk," Mr. Buffett pointed out in the annual report. "In turn, so do we."

While "you can argue that the distribution costs of auto insurance are expensive" in the overall market, Mr. Buffett said last week, it is not certain that a socialized auto insurance program "would be administered well."

Questioned on how the insurance industry could improve its public relations, Mr. Buffett said it would be "very difficult."

"Explaining the logic of something is not tantamount to gaining acceptance," he said.

"Insurance is expensive," he continued, citing distribution costs, the litigious nature of American society and the contingency fee system for compensating plaintiffs' attorneys.

Even if the economics of the insurance system were "magnificently explained by someone terribly believable, I'm not sure how many votes that would change," Mr. Buffett said.

"It's not necessarily the case that people do not want a free ride if it's offered to them," Mr. Buffett quipped.

Mr. Munger predicted that "a good part of Proposition 103 will be declared unconstitutional" by the California Supreme Court, but added that he still expects to see more insurance regulation.

Proposition 103 mandates, among other things, a one-time reduction of most property/casualty insurance "charges" to 20% below November 1987 levels (BI, Nov. 14, 1988).

While Mr. Buffett is not optimistic about prices rising soon in the commercial insurance market, he told shareholders that Berkshire "will stay in the insurance business."

Indeed, the company intends to expand its insurance operations, deciding last month to develop a facultative reinsurance underwriting operation, Mr. Goldberg said in an interview last week.

The company will begin a search for the right person to start the operation, Mr. Goldberg said.

The small salaries that Mr. Buffett and Mr. Munger are paid are legendary among investors and corporate executives.

Asked at the meeting if Mr. Buffett and Mr. Munger weren't underpaid, Mr. Munger said: "You could argue that we were overpaid," citing Cornelius Vanderbilt, who only took his share of dividends from his various companies.

Mr. Munger's cash compensation last year was \$104,471, while Mr. Buffett's cash compensation was \$100,549.

And Berkshire, under Mr. Buffett's leadership, has not declared a dividend since 1967.

Mr. Buffett and his wife owned 516,242 shares of Berkshire stock, or 45% of the company, as of February 1989. At Monday's closing price of \$5.925—a \$50 gain on annual meeting day—that stock is valued at \$3.1 billion.

Mr. Munger owned 22,382 shares as of February 1989, valued at Monday's stock price at \$132.6 million.

"Mr. Vanderbilt did all right and so are we," Mr. Munger said, drawing chuckles from the audience. ■

Update

Banks sue Lloyd's syndicates

Continued from page 2

The banks had guaranteed repayment of loans made to the Republic of Palau, an island in Micronesia, by various other lending institutions for the construction of a power plant. The banks then purchased insurance guaranteeing repayment of the loans.

But, underwriters refused to pay claims after Palau defaulted, contending that the banks had not disclosed all pertinent information.

Suit seeks Constellation sale

NEW YORK—Great American Insurance Co. is suing New York insurance regulators in an effort to acquire the assets and liabilities of defunct Constellation Reinsurance Co.

Great American, which has proposed its own liquidation plan for the failed reinsurer, is seeking a court order to force the New York Insurance Department Liquidation Bureau to solicit additional proposals from insurers for Constellation's liquidation.

In a suit filed last month in New York Supreme Court, Great American—an American Financial Corp. unit and Constellation's largest creditor and retrocessionaire—also seeks a judgment that the department's behavior has been "arbitrary, capricious, unreasonable and an abuse of discretion."

The Liquidation Bureau proposed a commutation plan that it projects would pay Constellation creditors 84 cents on the dollar (BI, Feb. 6). Great American, however, claims its plan could yield a payment of 100 cents on the dollar (BI, Feb. 20).

In a memorandum replying to the suit, the department says there are "serious flaws" in Constellation's proposal, which if accepted, could result in a "serious conflict of interest" because Great American is also Constellation's largest debtor.

A hearing is set for May 18 in New York Supreme Court.

Judge freezes NYIE funds

NEW YORK—A state judge has frozen nearly \$3 million in unallocated New York Insurance Exchange premium funds while the New York Insurance Department determines how much of the money is owed to four NYIE syndicates in liquidation.

The exchange, which closed its doors in late 1987 (BI, Nov. 30, 1987), now holds about \$6 million in a premium account for syndicate members, according to court papers filed by the exchange. Of this, about \$3 million has been allocated to individual member syndicates, including \$600,000 to the four syndicates in liquidation. The account's remaining \$3 million cannot be allocated to specific syndicates.

In an April 13 petition, the Insurance Department sought an injunction freezing all allocated and unallocated premiums and other assets the exchange held. But, state Supreme Court Judge Michael J. Dontzin denied the request and instead issued a 90-day injunction that applies only to the unallocated funds.

Under the judge's order, the department will have 90 days to examine exchange records and determine how much of the unallocated premiums are owed to the four syndicates in liquidation.

Judge Dontzin also ordered the exchange to pay the \$600,000 already allocated to the four syndicates to their liquidator. The four syndicates are Heartland Group Inc., Realex Group N.V., U.S. Risk Inc. and Pine Top Syndicate Inc.

In a letter to exchange members, NYIE President Joseph Fahys pointed out that the 90-day injunction has no practical effect on members, because the exchange would not have distributed the unallocated funds during the next three months in any case.

The department filed its petition when it discovered the exchange was considering abandoning efforts to allocate the remaining \$3 million in premiums, court papers say. The cost of reconciling the funds would equal the \$3 million to be allocated, papers indicate.

Because of objections from the department and other syndicates, the exchange will not terminate reconciliation efforts.

Insurer groups will not merge

CHICAGO—The Alliance of American Insurers and the National Assn. of Independent Insurers have decided not to merge after completing a joint two-month feasibility study.

"The feasibility study was just that—a feasibility study," said Alliance President Franklin W. Nutter. Both he and NAII President Lowell R. Beck stressed the study was not commissioned to back any preconceived notion, but rather was undertaken to explore whether the groups would benefit from pooling their resources (BI, Feb. 20). However, both presidents said their groups saw no overwhelming reason to merge.

The two insurer trade associations, though, will "continue to work closely together from separate membership bases," Mr. Nutter said.

Both association presidents also stressed that the decision to forgo a merger now does not rule out such a move in the future.

Briefly noted

William M. McCormick will resign by year-end as chairman, president and chief executive officer of Fireman's Fund Insurance Cos. Jack Byrne, chairman of Fireman's Fund Corp., the holding company, will assume Mr. McCormick's duties. Mr. McCormick will continue to serve on the corporate board of directors. Mr. McCormick did not announce his future plans. . . . Chicago-based **UNR Industries Inc.**, which is in Chapter 11 reorganization, has settled its insurance dispute with Bituminous Casualty Corp. and Allstate Insurance Co. (BI, Dec. 5, 1988; April 25, 1989). Under the settlement, UNR will receive \$8.5 million from Allstate over three years and \$2.1 million from Bituminous for the costs of asbestos bodily injury claims. . . . **Armstrong World Industries Inc.** of Lancaster, Pa., has settled its insurance dispute with Travelers Insurance Co. of Hartford, Conn. The settlement contains provisions for the coverage of asbestos injury and property damage claims. No other details were released. . . . Former Texas Budget Director Paul Wrotenbery has been selected by Gov. Bill Clements as chairman of the embattled **Texas State Board of Insurance**.

Pollution coverage ruling

Continued from page 1

The appellate court's decision stems from a dispute between Aerojet General Corp. and 55 of its general liability insurers over tens of millions of dollars in potential coverage for cleanup costs (BI, April 24; Feb. 20; June 13, 1988).

The California 1st District Appellate Court, overturning a trial court, ruled April 19 that a policyholder ordered under the federal Superfund Act to pay for pollution cleanup costs "may reasonably expect that its (general liability) insurance for property damage will cover those costs."

At the heart of the coverage controversy was standard CGL policy language that states that insurers will "pay on behalf of the insured all sums which the insured shall become legally obligated to pay as damages because of injury or loss, destruction or loss of use of property."

San Mateo County Superior Court Judge John J. Bible last year interpreted this language to include only legal

damages awarded by a court of law and not government-mandated cleanup costs.

However, the appellate court said cleanup costs are damages within this policy language.

"It is not unreasonable to argue that while a technical meaning of 'damages' may refer to award in an action at law, the ordinary plain meaning of damages is broader and covers environmental response costs," the appellate court said.

"The fact that the damages do not take the form of a traditional damage award in an action at law is not determinative of the insured's reasonable expectations of coverage," the court added.

The appellate ruling stemmed from a suit filed by Aerojet against 55 of its liability insurers from 1956 to 1984 seeking to recoup tens of millions of dollars in cleanup costs.

Trichloroethylene, or TCE, which was used by Aerojet

Continued on next page

LUI

Continued from page 1

LUI's stock price dropped 14 pence on April 26 to between 102 pence per share to sell and 105 pence per share to buy.

Following LUI's announcement that it would not pay a dividend for 1988, LUI's stock dropped to 70 pence to sell and 80 pence to buy at the close of April 27, when 930,000 LUI shares traded. The company has about 58 million shares outstanding, according to stock analyst Philip Olsen of Kitcat & Aitkin & Co. in London.

LUI stock closed at 67 pence to sell and 72 pence to buy on April 28.

The April 27 fall in LUI's stock price was due to the early announcement of LUI's results and that no dividend would be paid, said Mr. Olsen.

"I would say that, unsettled by press reports, the company (LUI) made an early announcement of its results (that said) its dividend would be passed as a result of the need for reserve strengthening, which caused the share price to drop significantly,"

he said.

LUI will release its full 1988 results this week.

In an April 28 letter to London brokers, Mr. Wilson said: "The recent article in the 24th April edition of *Business Insurance* has caused the unbalanced comments made by Alexander & Alexander to their account executives to be grossly exaggerated.

"I am sure you have reviewed the A&A letter which appears to be an amazing document in so far as most of the statements made are factual and consist of either information or figures quoted from our Department of Trade returns, yet each page of the letter contains a statement 'while this information was obtained from sources believed to be reliable, its accuracy is not guaranteed,'" said Mr. Wilson in his letter to brokers.

"The conclusions that A&A reach is that they are unable to understand insurance regulations and accounting practices in the United Kingdom and, in particular, Department of Trade returns," said Mr. Wilson.

He adds that comments A&A made about the Department of Trade and

Industry financial returns of Weavers' companies apply to "all United Kingdom Department of Trade-approved insurance companies."

Mr. Wilson noted that he was referring to A&A's discussion of differences in accounting practices of property/casualty insurers in the United States and the United Kingdom, namely multiyear accounting and discounting of loss reserves in the United Kingdom.

"We have been conscious for some time that those responsible for analyzing insurance companies' accounts have difficulty in assessing the adequacy of claims reserves, which is not surprising as they do not have the wealth of information available to insurance companies' in-house executives and their auditors," Mr. Wilson continued.

"In order to dispel such concerns we engaged Tillinghast at the beginning of the year to review Walbrook's reserves and, although their work is not yet finalized, we are confident Tillinghast will be able to endorse the level of reserves adopted by Walbrook," he said.

A spokesman for Tillinghast in London confirmed that the actuarial consultant has endorsed this statement by Weavers.

LUI hired Tillinghast in early 1989 to review the insurance reserves as of Dec. 31, 1988, of its principal under-

writing subsidiary Walbrook and Walbrook's underwriting subsidiaries, LUI said.

Tillinghast has the reputation of being one of the most conservative actuarial firms in its analysis of insurance company loss reserves. Tillinghast actuaries are known as "high reserve valuers," according to one of its principals (BI, April 10).

Walbrook in 1987 had increased its loss reserves by a special provision of 8.5 million pounds (\$16.1 million at the year-end exchange rate), related primarily to claims for asbestos property damage, Mr. Wilson said previously.

These claims had not been expected by underwriters, he said.

The LUI statement to the stock exchange said "Walbrook will be strengthening its reserves by a similar exceptional provision related primarily to U.S. professional indemnity treaty business underwritten in the year 1981/1984."

Because of the 1987 special provision, Walbrook reported an aftertax loss of 2.4 million pounds in 1987 (\$4.5 million at year-end 1987 exchange rates).

LUI reported an aftertax profit of 5.06 million pounds in 1987 (\$9.51 million), down from 9.1 million pounds in 1986 (\$13.47 million at year-end 1986 exchange rates).

The 1987 dividend totaled more

than 4.6 million pounds (\$8.65 million), and the 1986 dividend was 3.9 million pounds (\$5.78 million).

The LUI statement also says that "in accordance with the requirements of the Department of Trade and Industry, and in line with prudent accounting procedures, no profit is taken in 1988 in respect of that year's underwriting, and the liabilities carried forward in relation to that year are not discounted."

A&A pointed out in its letters that Walbrook in the past has discounted its loss reserves to take into account future investment income.

LUI expects Walbrook to eventually report profits for business written in 1988, the LUI statement said.

"Based on the preliminary discussions with Tillinghast, it appears likely that significant profit is likely to arise in respect of the 1988 business, and it would be the expectation that this could be recognized in 1989 and later years," the LUI statement said.

"This experience reflects the substantially better underwriting conditions which have prevailed since 1986," the statement said. LUI also commented that "notwithstanding the severe competition being experienced, levels of business are being maintained at favorable premium rates."

Insurance services guide

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Pollution coverage ruling

Continued from previous page

as a solvent to clean rocket parts, leached into the groundwater under its 8,000-acre facility near Sacramento, Calif., and is suspected of having leached into the American River.

As a result, both the state of California and the federal government have sued Aerojet and its subsidiary, Cordova Corp., for the costs of cleaning up the contaminated area. The federal government's suit was filed under the Superfund Act, while the state sued for violation of state Regional Water Board regulations.

As of November 1988, Aerojet had spent \$55 million to investigate and clean up the polluted site, according to Scott P. DeVries, an attorney with Lasky, Haas, Cohler & Munter in San Francisco who represented La Jolla, Calif.-based Aerojet in the appeal. The total cleanup could exceed \$100 million, he said.

Insurer attorney Richard L. Seabolt says he will ask the appellate court to reconsider its ruling. If he does not obtain a favorable result, Mr. Seabolt says he will appeal the case to the California Supreme Court.

The appellate court made several factual errors in its decision, according to Mr. Seabolt, who represents Lloyd's of London syndicates known as Cheshire & Cos. in the litigation.

Specifically, Mr. Seabolt faulted the court for failing to look at documents that show:

- The insurance manager for Aerojet testified that cleanup costs are an ordinary business expense and not insurable.
- London market insurers have previously denied coverage on similar pollution claims.
- Aerojet itself has failed to seek coverage for similar, but smaller, pollution incidents.

"It is highly likely the California Supreme Court will agree to review the case," said Mr. Seabolt, who is with Hancock, Rother & Bunshoft in San Francisco.

Insurer attorney Stephen Cohen predicted that because the California Supreme Court is now more conservative than in recent years, it could rule in favor of the insurers.

"The Supreme Court (of California) has specifically noted that the reasonable expectations (of the parties to an insurance contract) can either restrict or broaden coverage, but the appellate court only tried to broaden coverage," said Mr. Cohen, who will join the law firm of McElroy, Deutsch & Mulvaney in Morristown, N.J., on May 15.

Insurer attorney Roger Warin of Steptoe & Johnson in Washington, D.C., agreed: "A more conservative (state) Supreme Court would be more inclined to rule that there is no distinction between the plain, ordinary meaning and the legal meaning of the word 'damages.'"

However, if the California Supreme Court upholds the appellate court decision, Aerojet still must litigate a host of other coverage-related issues—such as the pollution exclusion—with its insurers in California trial court.

The pollution exclusion in comprehensive general liability policies bars coverage for pollution incidents unless the pollution is "sudden and accidental."

Eventually, the case could be put before a jury, which would determine whether Aerojet expected or intended the pollution, and thus whether it had coverage.

This trial would be similar to a recent trial between Houston-based Shell Oil Co. and its liability insurers. In that case, a jury found that Shell was aware it was polluting the environment and therefore was not covered by its CGL insurance (BI, Dec. 26, 1988).

Because the appellate court ruling in the Aerojet case marks the first time any California appellate court has ruled on coverage for cleanup costs, the decision is ex-

pected to have widespread impact on policyholders embroiled in similar coverage disputes.

"This is a very important ruling for policyholders," said policyholder attorney John Heintz of Popham, Haik, Schnobrich & Kaufman in Washington, D.C. "It is a major development."

Mr. Heintz said the decision could influence courts nationwide that are reviewing the insurability of cleanup costs to rule in favor of policyholders.

"This case should have an effect on all jurisdictions around the country that follow the same approach to construing insurance policies as California does," agreed Aerojet attorney Mr. DeVries.

Mr. DeVries explained that California courts construe insurance policies as the average layperson would. They do not make different interpretations when the policyholder is a large, sophisticated company.

However, Lloyd's of London attorney Mr. Seabolt criticized the appellate court for not considering the fact that Aerojet is a sophisticated insurance buyer.

He said the court should have ruled that Aerojet could understand complex language in its insurance policies because the company has in-house legal counsel, a full-time risk manager and had the assistance of the world's largest broker, Marsh & McLennan Cos. Inc.

"The court completely ignored Aerojet's sophistication," said Mr. Seabolt.

The Aerojet ruling will have an especially great impact on hazardous waste cases now being tried in California trial courts, attorneys pointed out.

Policyholder attorney Mr. Anderson predicted that the Aerojet decision "is going to have an impact in California that almost ends this controversy."

"This decision will be cited in every case in the state of California where this question arises," said Mr. DeVries.

"As a practical matter, trial courts (in California) will follow this court of appeal decision," he said.

For example, the trial court hearing litigation between Chicago-based FMC Corp. and 174 of its primary and excess liability insurers will look at the Aerojet decision, according to attorneys.

FMC, whose coverage dispute currently is pending in Santa Clara County Superior Court, is attempting to recoup the costs to clean up 46 hazardous waste sites nationwide (BI, April 4, 1988; Feb. 1, 1988).

"FMC and at least half a dozen other corporations now litigating in California will be influenced by this decision," said policyholder attorney Mr. Heintz.

In addition, the 9th U.S. Circuit Court of Appeals, which is now reviewing a dispute over coverage for cleanup costs, could be influenced by the Aerojet decision since the court is being asked to interpret California law, according to attorneys.

The 9th Circuit is reviewing a dispute between Hartford Accident & Indemnity Co. of Hartford, Conn., and Intel Corp. of Santa Clara, Calif.

Hartford appealed a U.S. District Court ruling that it must indemnify Intel for the costs to clean up pollution at Intel's Mountainview, Calif., plant (BI, June 27, 1988).

In addition, litigation between Boston-based Commercial Union Insurance Co. and the trustees of the now-bankrupt Superior Plating Works Inc. of San Diego is now pending before the 9th Circuit.

Commercial Union appealed a U.S. District Court ruling that it must pay about \$3 million in cleanup costs linked to a polluted waste site in San Diego (BI, Sept. 26, 1988).

As a result, the Aerojet decision "has to be of very substantial importance to the 9th Circuit," said Mr. Anderson.

Brokerage stocks presage shifts in insurance market

By LEONARD M. WILSON

Special to Business Insurance

COMPETITION in commercial property/casualty lines still crowds out all other issues for observers of insurance brokerages. Yet, insurance brokerage stocks reached a price peak late in 1986. Share prices have traced a desultory course for almost three ensuing years. Could it be that insurance brokerage stocks have already discounted the soft market and its consequence—slowed earnings momentum?

Quite frankly, we are unsure of the answer. Nor can we be certain as to when premium rates will firm, but we believe that before there is definitive evidence of a turn in rates, insurance brokerage stocks will have begun a new cycle of capital appreciation.

This tendency for stock prices to discount events before they can generally be discerned was most recently evident in 1986. Expert consensus held that with a cresting in premium rates, competition would be temperate coming down the other side of the cycle.

Too many factors argued against more than gentle rate adjustment. Commonly cited were disarray in reinsurance, including the drying up of the retrocessional market, reinsurance uncollectibles, newly enacted tax legislation, better insurance company information systems and the need to rebuild underwriter reserves. Insurance company management, chastened by the industry's worst performance in memory, were supposedly not only sadder, but much wiser and therefore not likely to countenance another round of destructive price cutting.

Nonetheless, in the face of well-reasoned viewpoints on the probability of mild competition, brokerage and underwriting insurance

We have little doubt that the brokerage stocks will prove to be a leading indicator of any shift in the climate of insurance markets.

stocks performed badly early on and effectively called the soft insurance market with far greater perspicacity than the industry pundits, as it turned out.

Recently, brokerage shares appear to have shown somewhat greater resiliency. This price movement set us to thinking. As a consequence, we decided to compare current price-to-earnings ratios for the publicly owned insurance brokers with those prevailing around the middle of 1984, well before signs of a subsequent firming in property/casualty markets was evident.

Bear in mind that this was a period of despair over commercial markets. Gloom was almost palpable. Yet, in that doleful context insurance brokerage stocks were selling at a P/E ratio of about 13. The Standard & Poor's 500 Index, as the benchmark of comparative valuation, carried a P/E ratio of 10.

Insurance brokerage stocks at a time of general pessimism and poor earnings comparisons were valued at a 30% premium to the general market. This premium falls within a normal range of relative valuation for the brokers, based on almost 20 years of valuation analysis.

We then calculated P/E ratios, using current earnings estimates for 1989—estimates that incorporate a measure of restraint in the face of the none too rosy outlook for premium rates over the balance of this year.

Our figures indicate that brokerage P/E ratios last month averaged about 14. The P/E ratio for the S&P 500 is now running at a shade under 12.

Thus, insurance brokerage stocks, as a group, seem to be selling at a 20% premium to the stock market. This premium is somewhat smaller than that of 1984, but again is well

within the band of normal valuation for the brokers.

In our view, this capsule analysis of value cannot help us discern whether brokerage stocks are soon to anticipate a turn in the commercial insurance market. But it is interesting that relative valuations have not deteriorated materially despite a generally lackluster operating environment.

We are willing to venture a few conclusions from our brief valuation exercise. Brokerage stocks clearly are not discounting major structural changes with adverse long-term implications.

If anything, the stocks suggest that growth expectations are intact. We have expressed in earlier columns our opinion that insurance brokers can sustain their historical gains in the range of 12%-15% over a full insurance cycle in the years ahead.

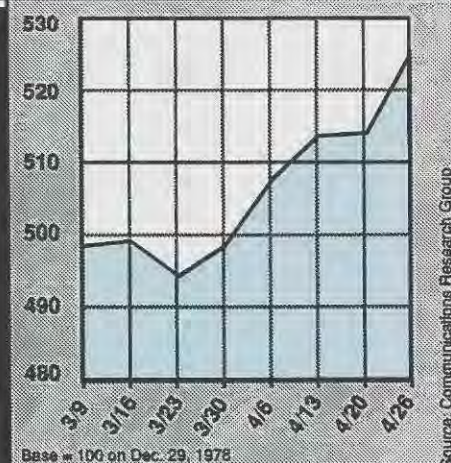
The current premium valuation lends support to our viewpoint.

Yields also have to be taken into account. Brokers, on average, provide a somewhat greater dividend yield than the broad stock market indices. This attribute owes to their typically generous free cash flow, a notable characteristic of insurance brokerage, that in turn leads to generous dividend payouts. Higher yields contribute to higher valuations. Excess cash has also engendered share repurchases, which contribute to better valuations.

The present wave of corporate acquisitions has not recently engulfed any publicly held insurance broker, but it is quite possible that valuations reflect, at the margin, the effects of prevailing takeover sentiment for equities in general.

We remain uncertain about the course of the property/casualty cycle, both as to duration and depth beyond 1989. We have little doubt, though, that the brokerage stocks will prove to be a leading indicator of any shift in the climate of insurance markets. We believe that the present valuations for brokerage shares should be taken as a constructive sign for the longer term, although we remain hesitant to read into those valuations any forecasting significance with respect to the immediate course of commercial pricing.

BI Insurance Index



Insurance industry stocks jumped last week, as the *Business Insurance Index* rose 10.8 points to 525.5 on April 27, from 514.7 on April 20. Advancing issues were led by HMO America Inc., up 25%; Nobel Insurance Ltd., up 23.5%; and Safeguard Health Enterprises, up 18.2%. Decliners followed Western Health Plans Inc., down 6%; Washington National Corp., down 4.2%; and Zenith National Insurance Corp., down 3.9%. The most active issue was Sears, Roebuck & Co. (Allstate), 5 million shares traded. The *BI Index* gained 2.1% for the period; the Dow Jones 30 Industrials, up 1.7%; the Standard & Poor's 500, up 1.4%; and the New York Stock Exchange Composite, up 1.0%.

British Issues

April 28	Price	P/E	Div.	Yield	High—Low
Companies	pence	pence	%	pence	pence
Comml Union	382	13.2	25.3	6.6	383—373
Genl Accident	939	8.7	58.7	6.2	943—935
Gdn Royal Exch	205	10.6	13.3	6.5	205—202
Royal	407	12.7	30.0	7.4	409—406
Sun Alliance	1140	8.9	54.7	4.8	1143—1118

Brokers

Brokers	Price	P/E	Div.	Yield	High—Low
Bredstock	223	12.6	9.0	4.0	225—223
CE Health	460	14.6	34.5	7.5	460—458
Hogg Robinson	146	12.9	8.7	5.9	147—145
Lloyd Thompson	228	17.5	8.0	3.5	230—228
PWS Holdings	63	17.0	4.6	7.4	63—63
Sedgwick Grp	245	20.2	16.0	6.5	246—235
Steel Brl Jones	221	18.9	13.3	6.0	221—221
Willis Faber	222	16.4	15.3	6.9	224—223

Source: Philip Olsen/Alan Clifton, Insurance Industry Specialists Kitcat & Aitken Stockbrokers, London

BI Industry Stock Report

APRIL 27, 1988

4/21/89 THRU 4/27/89

BROKERS

		Weekly Price	% change	Year to Date % change	Annual High	Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
Alexander & Alexander Svcs	NYSE	25.00	-3.4	6.4	26.50	22.63	102	1.00	4.0	15.9	3.71	6.74
Corroon & Black Corp	NYSE	33.75	-1.8	8.4	35.00	30.75	68	1.24	3.7	5.0	12.40	2.72
Gallagher Arthur J. & Co.	NYSE	19.88	1.9	18.7	19.88	16.13	7	0.52	2.6	14.1	5.45	3.64
Hall Frank B. & Co.	NYSE	3.75	0.0	30.2	4.63	2.50	40	0.00	0.0	-2.2	0.00	N/A
Hilt, Rogal & Hamilton	OTC	14.75	0.0	-3.3	15.75	13.75	44	0.00	0.0	13.3	4.60	3.21
Marsh & McLennan Cos. Inc.	NYSE	60.75	-2.6	8.0	64.50	55.13	560	2.50	4.1	15.0	6.48	9.38
Poe & Assoc. Inc.	OTC	8.75	0.0	6.1	8.75	8.25	11	0.40	4.6	9.5	0.27	32.41
BROKERS	AVERAGE		-0.8	10.6					2.7	10.0		

CONGLOMERATES & HOLDING COMPANIES

		Weekly Price	% change	Year to Date % change	Annual High	Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
Berkley W.R. Corp	OTC	33.50	3.9	13.6	33.25	29.25	123	0.40	1.2	7.2	20.24	1.66
Berkshire Hathaway Inc. DEL	NYSE	6350.00	7.6	35.1	6175.00	4275.00	198	0.00	0.0	23.2	2492.68	2.55
ITT (Hartford Group)	NYSE	58.38	2.6	16.5	58.50	49.75	1601	1.48	2.5	10.0	52.23	1.12
Sears Roebuck & Co. (Allstate)	NYSE	45.75	0.8	11.9	46.88	40.13	4953	2.00	4.4	17.1	34.74	1.32
CONGLOMERATES	AVERAGE		3.7	19.3					2.0	14.3		

INSURERS/REINSURERS

		Weekly Price	% change	Year to Date % change	Annual High	Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
Aetna Life & Cas Co	NYSE	52.38	-2.3	10.9	54.88	46.75	750	2.76	5.3	9.0	54.73	0.96
American General Corp	NYSE	34.75	-1.4	16.3	35.75	29.50	540	1.50	4.3	10.1	28.04	1.24
Amer Heritage Life Inv	NYSE	26.25	0.0	1.9	27.88	25.00	1	1.08	4.1	10.9	22.47	1.17
Amer Indly Fin'l Corp	OTC	11.25	11.1	7.1	11.25	9.50	7	0.56	5.0	7.2	17.06	0.66
American Int'l Group	NYSE	81.75	0.0	20.7	84.25	66.25	840	0.40	0.5	11.4	33.55	2.44
Aon Corp	NYSE	32.13	-0.8	14.8	33.38	27.00	131	1.40	4.4	10.1	15.13	2.12
Argonaut Group	OTC	53.75	0.5	22.9	56.00	43.50	172	0.00	0.0	7.4	34.94	1.54
AVEMCO Corp	NYSE	23.13	-2.1	-10.6	26.13	23.13	26	0.40	1.7	12.2	9.20	2.51
Baldwin & Lyons Inc.	OTC	16.25	0.7	9.2	16.50	14.50	18	0.20	1.2	6.5	17.57	0.92
Belvedere Corp	AMEX	5.63	-2.1	25.1	6.50	4.50	1	0.04	0.7	8.2	8.43	0.67
Chandler Insurance	OTC	12.25	11.4	32.4	12.50	8.75	288	0.00	0.0	5.9	6.65	1.84
Chubb Corp	NYSE	67.50	-1.3	16.4	69.00	57.63	345	2.32	3.4	7.8	46.13	1.46
CIGNA Corp	NYSE	54.00	-1.6	14.6	56.13	45.88	331	2.96	5.5	9.7	51.37	1.05
CNA Fin'l Corp	NYSE	65.00	0.2	7.4	65.50	57.63	122	0.00	0.0	10.3	46.40	1.40
Continental Corp.	NYSE	33.88	-0.4	4.6	36.00	31.50	436	2.60	7.7	16.2	42.10	0.80
Durham Corp	OTC	32.50	-0.8	-1.5	33.75	30.00	5	0.92	2.8	19.2	26.23	1.24
Fireman's Fund Corp	NYSE	34.63	6.1	18.4	34.88	29.00	268	0.60	1.7	8.6	30.91	1.12
Forum Re (Bermuda)	OTC	1.25	10.6	-23.3	1.75	1.13	0	0.00	0.0	3.5	2.58	0.48
Freemont Gen Corp.	OTC	17.00	0.7	27.1	18.25	12.13	170	0.60	3.5	10.8	16.06	1.06
Frontier Insurance Group	OTC	15.25	-2.4	22.0	16.75	12.25	26	0.00	0.0	7.5	7.53	2.03
General Re Corp	NYSE	67.88	1.5	22.3	68.25	54.38	561	1.36	2.0	13.5	27.10	2.50
Home Group Inc.	NYSE	13.00	0.0	18.2	14.50	11.00	228	0.20	1.5	5.5	18.66	0.70
Hanover Ins Co.	OTC	29.00	-0.9	8.4	30.25	26.00	50	0.44	1.5	5.4	31.47	0.92
Harleysville Group Inc.	OTC	21.75	6.1	20.8	21.50	17.75	59	0.48	2.2	7.6	18.24	1.19
Hartford Steam Boiler	OTC	42.00	-0.6	14.3	42.50	34.75	150	1.40	3.3	11.6	13.04	3.22
Kans City Life Ins	OTC	34.50	3.0	0.0	35.00	32.75	3	0.00	0.0	12.3	39.22	0.88
Kemper Corp.	OTC	34.75	3.7	44.8	34.75	22.75	355	0.84	2.4	9.9	28.91	1.20

		Price	Weekly % change	Year to Date % change	Annual		Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
					High	Low						
Lawrence Ins. Group	AMEX	6.88	0.0	-12.7	8.50	6.88	1	0.24	3.5	15.0	2.90	2.37
Liberty Corp. S.C	NYSE	36.50	2.8	1.4	38.00	34.63	11	0.80	2.2	12.9	20.76	1.76
Lincoln Nat'l Corp.	NYSE	49.75	-0.3	13.1	50.63	42.75	79	2.48	5.0	12.1	37.11	1.34
NAC Re Corp	OTC	38.25	0.0	20.5	38.75	31.00	51	0.00	0.0	15.2	22.06	1.73
Navigato's Group	OTC	22.75	3.4	13.8	22.75	20.50	1	0.00	0.0	10.3	14.79	1.54
Nobel Ins. Ltd.	OTC	2.63	23.5	-44.6	2.75	2.00	50	0.42	6.0	-10.1	7.76	0.34
Northwestern Nat'l Life	OTC	32.88	-3.3	5.6	34.25	26.88	239	1.20	3.6	10.9	35.05	0.94
Ohio Cas. Corp.	OTC	43.50	5.5	21.7	45.25	35.50	293	2.08	4.8	6.7	33.30	1.31
Old Rep. nt'l Corp.	OTC	25.00	2.5	4.2	28.88	23.75	475	0.74	3.0	12.5	26.50	0.94
Orion Cap. Corp.	NYSE	22.00	6.0	-43.0	22.25	15.38	102	0.76	3.5	7.4	12.93	1.70
Phoenix Re Corp.	OTC	9.25	0.0	-2.6	11.00	9.00	14	0.00	0.0	4.8	12.49	0.74
Protective Life Corp.	OTC	14.00	1.8	5.7	14.50	12.88	93	0.70	5.0	155.6	17.25	0.81
Re Capital Corp.	AMEX	10.75	7.5	17.7	10.88	9.13	4	0.00	0.0	23.9	11.93	0.90
RLI Corp	NYSE	8.38	-1.4	9.8	9.25	7.50	9	0.36	4.3	6.9	10.71	0.78
Provident Life & Acc. Ins. Co.	OTC	23.38	-3.6	21.5	24.75	19.13	532	0.68	2.9	9.9	21.96	1.06
St. Paul Cos. Inc.	OTC	50.50	0.0	16.1	51.00	43.00	439	2.20	4.4	7.0	43.47	1.16
SAFECO Corp.	OTC	28.63	0.0	21.2	29.13	23.13	409	1.08	3.8	8.0	24.87	1.15
SCOR US Corp.	NYSE	8.75	-2.8	-4.2	9.50	7.50	18	0.20	2.3	6.4	10.35	0.85
Seibels Bruce Group Inc	OTC	12.00	0.0	5.4	13.00	11.25	50	0.80	6.7	7.6	13.42	0.89
Selective Ins. Group Inc.	OTC	24.00	0.0	4.3	24.50	21.75	65	1.24	5.2	5.3	22.33	1.07
Statesman Group Inc.	OTC	2.81	2.2	-10.2	4.00	2.75	36	0.05	1.8	70.3	3.48	0.81
Tokio Marine & Fire Ins	OTC	75.00	0.7	-17.9	95.50	74.50	0	0.22	0.3	45.5	0.00	N/A
Torchmark Corp.	NYSE	35.88	7.5	17.6	34.88	30.00	672	1.20	3.3	11.0	12.24	2.93
Transamerica Corp.	NYSE	34.75	-1.4	2.6	36.00	32.75	666	1.88	5.4	7.8	27.36	1.27
Travelers Corp.	NYSE	40.00	-1.2	15.1	40.88	34.50	887	2.40	6.0	43.5	45.28	0.88
Trenwick Group Inc.	OTC	17.75	9.2	22.4	17.00	13.75	44	0.24	1.4	10.0	16.91	1.05
United Fire & Cas. Co.	OTC	30.00	2.6	-1.6	30.75	29.00	10	1.08	3.6	5.3	22.56	1.33
United States Fid. & Gty	NYSE	31.75	0.4	11.4	32.88	28.50	1555	2.80	8.8	11.9	22.15	1.43
UNUM Corp.	NYSE	31.88	0.8	18.1	32.88	26.83	253	0.60	1.9	11.1	30.64	1.04
USLI Life Corp.	NYSE	41.75	-0.9	19.7	44.88	34.13	341	1.36	3.3	10.2	46.77	0.89
Washington Nat'l Corp.	NYSE	25.50	-4.2	-5.6	27.63	25.25	33	1.08	4.2	-18.2	32.33	0.79
Zenith Nat'l Ins. Corp.	NYSE	18.38	-3.9	5.0	19.50	16.75	40	0.80	4.4	8.7	13.61	1.35
INSURERS/REINSURERS		AVERAGE	1.6	10.2					3.1	13.6		

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