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Update

Rhode Island work comp reform expected to save $160 million

PROVIDENCE, R.I.—Rhode Island Gov. Bruce Sundlun signed a sweeping workers compensation insurance reform bill last week that is expected to save the workers comp system $160 million annually.

Under the law, the weekly benefit for all injured workers will be changed to 75% of net wages from 66.67% of gross wages, exclusive of overtime and bonuses. This benefit now will be reduced by the amount of Social Security and

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Veterans' bill targets employers

Legislation would hike pension, health care costs

By JERRY GEISEL

WASHINGTON—Legislation headed for a Senate floor vote intended to protect the employment rights and employee benefits of employees who join the military could put employers in an impossible situation.

If employers comply with the bill's pension provisions, their plans would violate various Internal Revenue Code rules and run the risk of being disqualified by the Internal Revenue Service.

And, if employers ignore the bill's requirements, they would face numerous penalties. For example, if an employer is found to have willfully violated the law, it could be forced to pay double the amount it owed a returning veteran.

Aside from technical problems, the bill also would significantly increase the cost of pension and health care benefits for employers with a large number of employees who enlist in the military or are called to active duty.

In addition, benefit experts fear that some returning veterans could abuse their rights under the law to collect benefits from their former employer and then resign.

Under the proposal, an employer would have to retroactively provide to employees returning to their jobs after military service the same defined contribution plan payments, like profit-sharing benefits, provided to other workers while the returning workers were in the armed forces.

While at first glance it would appear that a returning veteran would be entitled to no plan contributions if he or she received no compensation from the employer while serving in the military, benefit consultants inter-

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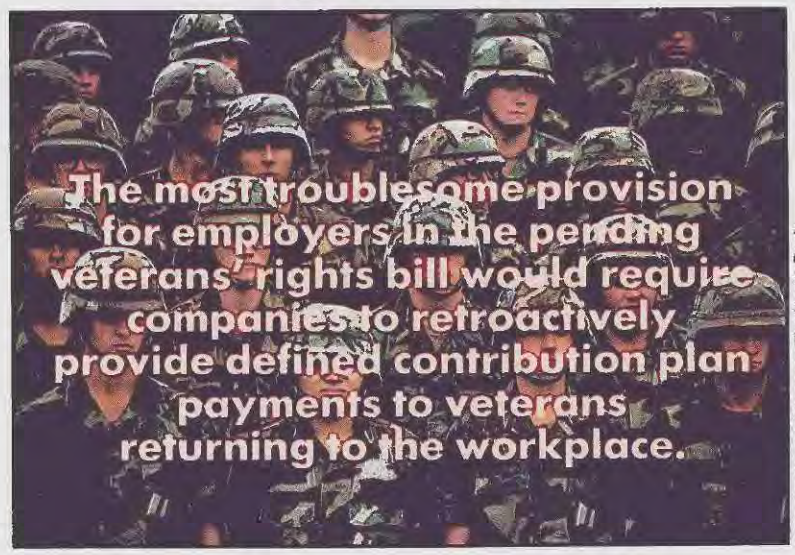


Photo by Gary S. Chapman/The Image Bank

O&Y downfall hits hard

Real estate developer's bankruptcy could cause insurers to incur portfolio, financial guarantee losses,

By DOUGLAS McLEOD

NEW YORK—Several insurers are facing investment or insurance losses on commercial property controlled by troubled real estate giant Olympia & York Developments Ltd.

The risk of investment loss varies widely from property to property, and the extent of potential losses remains unclear.

Many insurers say investment losses, if they develop, will be small in relation to the insurers' overall investment portfolios.

Meanwhile, at least one insurer is facing underwriting losses on O&Y property: Aetna Casualty & Surety Co. backed the financing on a New York office building with a financial guarantee on which it stands to lose $46 million.

Toronto-based O&Y, one of the world's largest real estate developers, sought protection from creditors earlier this month under the Canadian equivalent of a bankruptcy filing. Simultaneously, it filed for protection under the U.S. Bankruptcy Code in New York.

The real estate giant, controlled by Toronto's Reichmann family, has extensive real estate and corporate holdings in Canada and the United States, and is the developer of the $4 billion Canary Wharf complex in London's Docklands, the world's largest private development project.

The bankruptcy filings involve only the parent company, its Canadian real estate holdings and its Canadian and U.S. corporate holdings. Among the latter are majority interests in Gulf Canada Resources Ltd., an oil and gas producer; Abitibi-Price Inc., a newsprint manufacturer; and a stake in Santa Fe Pacific Corp.

Not included in the filing are the Canary Wharf project and the company's interests in 22 office buildings in nine U.S. cities, among them a dozen buildings in New York City.

In its U.S. bankruptcy filings, O&Y describes a "confluence of circumstances" that led to the filing, including rising commercial vacancy rates, falling rents, falling property values and the impact of the recession on O&Y's non-real estate businesses.

The resulting cash flow problems were com-

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Appeals court offers firms some relief from cleanup liability

By STACY GORDON

PHILADELPHIA—Companies named as potentially responsible parties for pollution cleanup costs have a new defense as a result of a recent federal appellate court ruling.

The Superfund law—formally known as the Comprehensive Environmental Response, Compensation & Liability Act—provides that companies responsible for pollution can be held jointly and severally liable for cleanup costs. This means that any one company can be forced to pay the full amount of the cleanup costs.

However, the 3rd U.S. Circuit Court of Appeals on May 14 said that before a PRP can be held fully liable for cleanup costs, it has the right to attempt to prove that cleanup costs can be properly apportioned based on fault.

If a company can show that the harm is divisible and that it sent less harmful materials to the site than other PRPs, it will only be held liable for its share of cleanup costs, the court said.

If the harm cannot be apportioned, joint liability would still apply.

Attorneys note that the 3rd Circuit is not the first court to recognize the right of PRPs to apportion liability based on fault, but add that its decision is the most far-reaching to date.

"Prior circuit court cases on divisibility have tended to take a

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Health cost hikes slowed

Midwest sees cost containment success: Study

By CHRISTINE WOOLSEY

CHICAGO—Group health care cost increases appear to be moderating for Midwest employers, according to a new survey.

Per-employee costs for group health care benefits are still rising, but at a somewhat slower rate, the Midwest Business Group on Health reports.

"Health care costs on average increased 13.1% in 1991, compared to 16.4% in 1990," explained Phil Rosenberg, director of market research for Intracorp. The survey was financed by a grant from the Berwyn, Pa.-based medical cost management unit of CIGNA Corp.

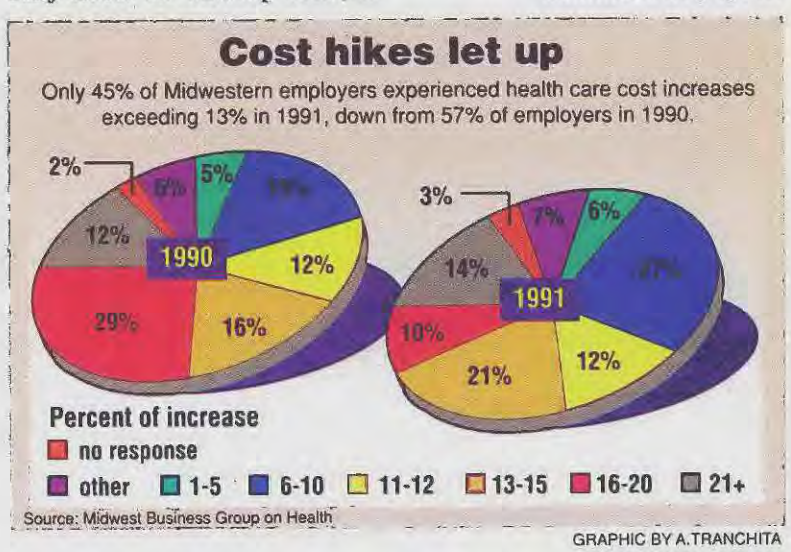
The MBGH, a coalition of public and private employers in 11 Midwestern states, gives much of the credit to increased use of cost containment programs like direct contracts with providers, group purchasing and managed care.

And, for the first time since the MBGH began surveying its members in 1987, fewer respondents expect the rate of health care inflation to keep growing over the next two years.

Employers do, however, expect health care cost management to become more difficult in the years ahead, the survey found.

"This moderation data presents a complex picture," said MBGH President James Mor-

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GRAPHIC BY A.TRANCHITA

Update

States pass work comp reforms

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any pension benefits claimants receive. Medical protocols—including utilization review, peer review and caps on doctors' fees—also will be implemented and monitored by a new advisory board.

The law, which passed unanimously in the House and Senate, is the result of negotiations among labor, legislators, employers and insurers. Reforms should be in place by July 1, said Director of Policy Sheldon Whitehouse.

Separately, Tennessee Gov. Ned McWherter signed a workers comp reform bill May 8 that requires "hazardous employers" to establish safety committees. It also allows employers to expand managed care programs to include utilization review.

Suit against Lloyd's progresses

DENVER—The 10th U.S. Circuit Court of Appeals has issued an injunction prohibiting Lloyd's of London from drawing on a member's 350,000 pound ($637,000) letter of credit.

The member, Ronald Riley, had filed a lawsuit to block a drawdown, but the suit was dismissed last August by U.S. District Court Judge Jim Corrigan, who ruled that he did not have jurisdiction over the case (*BI*, Sept. 9, 1991). Oral arguments on the appeal are scheduled for June 24, but the injunction means the judges "found the appeal has the likelihood of success," said Richard Sander, a partner with Popham, Haik, Schnobrich & Kaufman in Denver, who represents Mr. Riley.

The lawsuit alleges that Lloyd's breached U.S. securities laws by not registering under the Securities Exchange Act.

Efforts by British members to block Lloyd's from drawing down on their deposits failed (*BI*, April 20).

Municipal Superfund liability

WASHINGTON—The U.S. Environmental Protection Agency is redrafting at the White House's request a proposed agency guideline that would limit municipal responsibility for the cost of cleaning up Superfund hazardous waste sites.

The guideline would have limited local governments' liability under the Comprehensive Environmental Response Compensation and Liability Act if the governments neither owned nor operated the sites where they dumped common household and office trash. Such waste generally contains very little hazardous material.

The draft guideline would have required local governments to pay about 4% of the cleanup costs in return for immunity from suits from other dumpers that wanted the municipalities to pay more.

The draft was leaked to business groups, which complained to various agencies and Bush administration officials that it was unfair to force them to foot so much of the cleanup bills. The groups noted that common garbage, though generally non-hazardous, makes up a large volume of the waste at Superfund sites.

An EPA spokeswoman said the draft has been sent "back to the drawing board."

Lincoln National HMO sale

FORT WAYNE, Ind.—Lincoln National Corp. completed the sale of its health maintenance organizations to TakeCare Inc., an HMO based in Concord, Calif., earlier this month.

The acquisition, valued at $140 million, will add about 290,000 members to TakeCare's network. But TakeCare plans to sell several of the smaller Lincoln National HMOs.

Meanwhile, Great-West Life & Annuity Insurance Co. of Englewood, Colo., will assume only part of Lincoln National's group life and health business, including 335,000 members of Lincoln National's PPOs. Great-West declined to acquire 250 large group indemnity accounts, worth approximately $100 million in annual premiums, that were part of an earlier agreement (*BI*, Jan 13). Hartford Life Insurance Co. of Simsbury, Conn., agreed in February to acquire those accounts for an undisclosed amount.

Lincoln National reported strong first-quarter results for all of its business segments: $101.3 million of net income, up 158% from $39.3 million in the first quarter of 1991. The insurer is withdrawing from the group life and health business, except for its small Employers Health Insurance Co. unit.

New FASB draft on benefits

NORWALK, Conn.—The Financial Accounting Standards Board has issued an exposure draft on how employers should account for so-called post-employment benefits—like extended health care coverage under COBRA and disability benefits—to non-retirees.

But, benefits consultants say the proposal would not cause near the stir caused by FAS 106, the rule on recognizing retiree health care obligations in financial statements.

"It'll be very minor," said Dave Benovitz of Kwasha Lipton.

The draft, which would be effective in 1994 if adopted, applies to post-employment benefits that were excluded from FASB statements 5 and 43. Statement 5 guides employers in accounting for "contingencies," or unexpected expenses and liabilities. Statement 43 provides guidelines on accounting for "compensated absences."

Under the new exposure draft submitted for public comment, employers would be required to account for the value of post-employment benefits during an employee's active service if:

- A benefit is linked to employee service already rendered.
- Employees' rights to those benefits accumulate or vest.
- Payment of benefits is probable.
- The amount of benefits can be reasonably estimated.

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Auditors fear liability

Price Waterhouse hit by $338 million award

By MICHAEL BRADFORD

PHOENIX—Accounting firms are nervously watching the growing trend of large negligence awards after a state court jury assessed $338 million in damages against Price Waterhouse late last month.

Accountants warn that if their liability continues to increase unabated, it could limit the business they accept.

The state court jury in Phoenix awarded $338 million—all in compensatory damages—to British bank Standard Chartered P.L.C. The bank sued Price Waterhouse in 1988, charging negligence and breach of fiduciary duty related to audits of United Bank of Arizona in 1985 and 1986. Standard Chartered, which bought the Phoenix-based bank in 1987, alleged that Price Waterhouse had failed to look at losses on two of the bank's biggest loans, which later produced an aftertax charge of about $17 million.

Price Waterhouse will attempt to have the verdict set aside and, failing that, will file an appeal, said Erica Baird, a special assistant to Price Waterhouse Chairman Shaun O'Malley. "The verdict is absurd and has no relationship to reality or the evidence."

If the award is upheld, Price Waterhouse has professional lia-

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Agents, banks draft accord on insurance sales

By LORI BLOCK

WASHINGTON—After months of wrangling, representatives of insurance agencies and the nation's largest regional banks have reached a compromise that would enable interstate banks to sell insurance—with some limitations and consumer protections.

However, the agreement—forged between the Independent Insurance Agents of America, on behalf of several agency groups, and six regional banks—is only a first step. The agreement next must be incorporated into a banking bill and approved by Congress.

The banking bill, which is expected to be introduced by Rep. Frank Annunzio, D-Ill., would contain provisions concerning both banks' insurance activities and interstate branch banking.

The agreement, which is not finalized, came out of a meeting earlier this month. The bill could be introduced in a few weeks.

According to a summary provided by Mark Leggett, director of government relations for NationsBank Corp. of Charlotte, N.C., and Robert A. Rusbuldt, the IIAA's vp of federal affairs in

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House panel to consider broad reforms to safety law

By MARK A. HOFMANN

WASHINGTON—A House committee could approve sweeping revisions of federal workplace safety laws as early as Thursday.

The House Education and Labor Committee was scheduled to vote last week on H.R. 3160, the Comprehensive Occupational Safety and Health Reform Act, which the Bush administration and employers oppose.

But the vote was postponed after committee Chairman William D. Ford, D-Mich., announced that he would offer a substitute bill to his original measure.

The substitute bill, which was not available in final form last week, makes only minor changes to the 71-page bill, according to the Washington-based Workplace Health & Safety Council, a trade association comprising businesses and trade groups, which opposes H.R. 3160.

For example, the substitute bill would

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Coverage litigation limits

Agreement to cut discovery expense for ARCO, insurers

By STACY GORDON

NEW YORK—The hallmark of pollution coverage litigation is that it is extraordinarily expensive, but Atlantic Richfield Co. is embarking on a novel course to limit that expense.

Los Angeles-based ARCO is currently negotiating with its general liability insurers to establish what will and will not be subject to pretrial discovery in a pending massive coverage dispute.

"ARCO has been negotiating for six months with its insurers about discovery matters," said ARCO attorney Stephen Goldberg. "This is the first mega-coverage case in which this is being done."

If ARCO is successful in its negotiations with its insurers, the agreements could create a model for others to follow.

Mr. Goldberg, with Heller, Ehrman, White & McAuliffe in San Francisco, outlined ARCO's landmark attempt to reduce litigation costs by negotiating with its insurers during "Environmental Insurance Coverage Claims and Litigation: 1992 and Beyond," sponsored by the Practising Law Institute in New York earlier this month. The PLI is a non-profit legal education organization.

ARCO is suing more than 70 insurers in state court in Califor-

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Inside

- The intent is good, but the content of a proposed bill to protect the employment rights of those returning from military service could damage benefit programs, this week's editorial says. **PAGE 8**
- The market for non-profit directors and officers liability insurance remains competitive, a consulting firm's recent survey says. **PAGE 28**
- Some lawsuits filed by Lloyd's of London members over mounting losses may succeed, while others should never have been brought, an attorney says. **PAGE 29**
- 'Vast structural improvements' are needed in the workers compensation system, but there is no obvious solution, a consultant's report says. **PAGE 33**
- The property/casualty insurance industry is a 'sick business' and the pricing situation is 'lunacy,' a leading analyst told the Casualty Actuarial Society. **PAGE 36**

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Agent regulation reform plan fails

By MICHAEL BRADFORD

ATLANTA—An association-sponsored plan to centralize the licensing of agents and brokers nationwide has fallen through because of a lack of interest from state regulators.

However, brokers and some regulators remain frustrated with the current state-by-state system of agent/broker regulation and believe there should be some uniformity in the process.

Intermediaries and state regulators have long complained about an overburdened regulatory system that leads to licensing delays, cumbersome requirements for maintaining licenses and an inability to adequately track unscrupulous agents and brokers (*BI*, Dec. 9, 1991).

Despite those grumblings, state regulators have not supported the State Insurance Licensing Network proposed by Centralized Insurance Services Inc. The firm is a unit of the Life Office Management Assn.

The proposed system would have allowed regulators to use personal computers to tap into a mainframe system in Atlanta. Its supporters say the system could have: saved regulators much time in licensing agents and brokers; provided regulators with a way to keep tabs on intermediaries who breached professional conduct or lost their credentials; and given regulators a streamlined method of keeping up with continuing education credits.

Among other things, the proposed system was designed to:

- Receive, verify and enter license applications, issue licenses and collect fees.
- Bill for annual license renewals and collect renewal fees.
- Record continuing education requirements completed by intermediaries.
- Electronically deliver all license fees to state departments each night.
- Reproduce accounting reports, audits and other reports agents and brokers are required to file.
- Provide annual listings of current agents and new agent appointments.
- Compile information on regulatory violations by agents and brokers.
- Issue license revocations and cancellations.

"Regulators were not interested," said Lynn G. Merritt, president of Atlanta-based LOMA. "We thought it was so

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L.A. lawyers ready for massive wave of suits spawned by riot disputes

By JOANNE WOJCIK

LOS ANGELES—Attorneys are mobilizing for the barrage of lawsuits expected to follow last month's rioting in Los Angeles.

Two riot-related lawsuits already have been filed: one seeking emergency food stamp assistance and one by a reporter seeking damages from Los Angeles officials for injuries he suffered while covering the riots.

In addition, many attorneys are anticipating litigation over insurance coverage as business owners begin seeking payment from insurers for fire, looting and business interruption losses.

A key issue now bandied about Los Angeles law offices is whether business owners can seek coverage for business interruption losses incurred during the rioting even though they did not sustain actual property damage.

That question "has come up a lot," said Geoff Thomas of Paul, Hastings, Janofsky & Walker in Los Angeles. "It's second only to whether or not you can sue the city."

"Conventional thinking is that business interruption (coverage) is only triggered when there's property damage," he said. "But coverage is subject to policy interpretation."

The same issue has been raised in connection with business interruption losses caused by the Chicago "flood" last month (*BI*, May 4; April 20).

Since most commercial insurance policies that cover business interruption losses allow recovery for lost profits resulting from a shutdown of operations, revenues lost due to the city-imposed curfew may be covered, said David Greenberg, a partner in Los Angeles-based Greenberg & Simon.

Mr. Greenberg's firm has

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Aviation rates aloft

July 1 reinsurance renewals may hike light aircraft rates

By STACY SHAPIRO

SCOTTSDALE, Ariz.—Aviation rates should be gaining altitude by year-end for nearly all types of aircraft, from hot-air balloons to Boeing 747s.

AIA CONFERENCE

Airlines' hull and liability rates already are rising, with increases this year continuing the trend of major rate hikes begun last year.

And, if reinsurers—as expected—crack down on the July 1 renewals of U.S. general aviation insurance underwriters, light aircraft rates could start to climb for the first time since the mid-1980s.

The general aviation segment of the aviation market to date has remained very competitive, with premium levels flattening in the first half of this year.

General aviation includes all kinds of commuter and light aircraft, hot-air and helium-filled balloons and helicopters, for both personal and commercial use.

Rates also are continuing to increase slightly for aviation manufacturers' product liability insurance.

But underwriters say rates are not yet high enough.

The rate increases that are taking hold, particularly for airlines, are still not enough to make aviation insurance profitable, said Martin Belcher, chief underwriter for Transglobe Underwriting Management (Guernsey) Ltd., a Guernsey captive management company that manages Polygon Insurance Co. Ltd., a captive owned by three airlines.

Enough aviation capacity still exists worldwide to place any airline's hull and liability insurance program 2½ to three times over, he said. "Direct (insurance) rates will not go up to a profitable level while this is the case."

Mr. Belcher was the opening speaker for the 16th annual Aviation Insurance Assn. conference, held May 3-5 in Scottsdale, Ariz.

The annual forum for continuing education sessions, workshops and entertainment, which drew a record 416 people this year, attracts mainly general aviation insurers, managing general agents and brokers from around the United States.

In addition, loss adjusters, aviation lawyers and overseas members of the aviation insurance industry descend on the three-day conference to have private meetings outside the conference hall and occasionally listen to a speaker.

During the most well-attended session at the conference, Mr. Belcher noted that for the

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Photo by Stacy Shapiro

Hot-air balloon coverage was discussed at the Aviation Insurance Assn. meeting. See page 14.

Investment perils vs. rewards

Communicating risks of GICs

By JUDY GREENWALD

ORLANDO, Fla.—Pension plan sponsors should tell plan participants that guaranteed investment contracts are relatively safe investments, but are not absolutely risk free, a consultant says.

GIC

Plan sponsors should also be careful to educate 401(k) plan participants about the investment options available without crossing the line to actually providing investment advice, says David C. Veeneman, president of Louisville, Ky.-based benefit consultant Veeneman Associates.

Mr. Veeneman was among the speakers at a session on employee communication strategies at "GICs '92," a seminar sponsored in Orlando last month by the New York-based Institute for International Research.

Also speaking were two plan sponsors: Donald J. Butt, manager of defined contribution plan trusts for Denver-based US West Inc.; and Joseph M. Reott, manager of qualified plans for the Houston-based M.W. Kellogg Co., an engineering firm.

Pension plan sponsors face three key issues in communicating their GIC plans, said Mr. Veeneman: Should they communicate? What should they communicate? How should they communicate?

"The critical issue to look at is to whom we are communicating," he said. And the "fundamental fact of life" to consider is that the conservative plan participants who invest in GICs are more concerned about the return "of" their GIC investments than the return "on" their investments, he said.

"Keep in mind their No. 1 goal

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Managed care innovation

Employers detail health plan evolution since Cadillac days

By CHRISTINE WOOLSEY

MINNEAPOLIS—Innovation in managed health care will continue at a fast pace into the next decade, employee benefit managers predict.

NAEHCA

And over the next few years an increasing number of employers will adopt managed care as their primary health care delivery system, they say.

Meanwhile, employers that already have managed health care programs in place will continue efforts to hone and improve their plans.

Employers are learning what works and what doesn't within managed health care, said Robert F. Leonard Jr., director of benefits planning for NYNEX Corp. in White Plains, N.Y.

Mr. Leonard detailed the evolution of NYNEX's managed care program during a session at the National Assn. of Employers on Health Care Action held April 29-May 1.

NYNEX, formerly part of the Bell telephone monopoly, used to have a so-called Cadillac benefit plan, offering rich benefits and first-dollar coverage with no deductibles or copayments, he explained. After divesting from the Bell system, the company saw its health care costs soar.

So, NYNEX implemented a series of cost containment strategies. "We proceeded to put in foxhole-type solutions," explained Mr. Leonard, including pre-certification, concurrent review and large-case management.

But NYNEX made those moves "in a vacuum because we didn't have a strategic plan," Mr. Leonard said. Eventually, the company decided to re-focus its cost control efforts on preventive care and preferred provider arrangements.

Among the factors influencing NYNEX's health plan is its heavy concentration of union employees and retirees, Mr. Leonard said. The company covers 83,000 workers, 52,000 of

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OSHA bill

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mandate, among other things that all firms with 11 or more full-time workers establish labor-management safety committees and draft workplace safety plans. The original bill did not specify that the 11 workers had to be full-timers.

The safety plans would have to contain eight mandatory elements, including methods for: investigating work-related illnesses, injuries and deaths; identifying safety and health hazards; and monitoring employee participation in safety and health programs. The original bill contained 10 mandates.

Like the earlier version, the new bill would extend Occupational Safety and Health Administration regulation to public-sector workplaces, which currently do not have to comply with OSHA regulations.

The new bill, like the earlier version, also would impose harsh criminal penalties for "willful" OSHA violations that result in serious bodily injury. H.R. 3160 would impose a maximum prison term of five years for first-time violations of the serious bodily injury standard and 10 years in prison for subsequent convictions. Current OSHA regulations do not call for criminal penalties in such cases.

The substitute bill also still provides for the creation of a "Federal Workers Compensation Commission." The commission would study state workers comp systems and recommend reforms within two years of the bill's enactment.

The commission would be charged with examining whether pre-empting state workers comp systems with a national system is feasible.

H.R. 3160 seems almost certain to win approval by the House committee. Among its nearly 100 cosponsors are 21 of the 23 Democratic members serving on the committee. Thirteen Republicans serve on the committee.

The Senate Labor and Human Resources Committee has held hearings on a companion bill, S. 1622. The Senate bill does not contain the provision calling for a workers comp commission. No committee vote has been scheduled for the Senate bill, whose chief sponsor is Labor Committee Chairman Edward M. Kennedy, D-Mass.

The Bush administration opposes H.R. 3160. Emphasizing the increased cost of monitoring public as well as private workplaces, OSHA Acting Administrator Dorothy Strunk told the House Education and Labor Committee last month that OSHA's budget would have to double to carry out the bill's mandates. She also said the bill was inflexible and could hamper OSHA's effectiveness.

Business groups also oppose it.

The changes in the bill amount to only "tinkering around the edges," said Win Froehlich, general counsel for the Workplace Health & Safety Council.

Groups opposing H.R. 3160 stress that they do not oppose workplace safety programs or even changes to the current OSHA structure, provided that the changes are warranted.

"There's no program that's ever been created that's perfect, that can't be improved," said F.M. Lunnie Jr., director-employee relations for the Washington-based National Assn. of Manufacturers. NAM opposes H.R. 3160 because it does not think a case has been made for making sweeping changes to OSHA.

The Schaumburg, Ill.-based Alliance of American Insurers also opposes the measure.

"Yes, you have to have penalties and you have to have regulations," said Tom O'Day, associate vp in the Alliance's Washington office. But H.R. 3160 represents a "one-size-fits-all, a mandated way" to promote safety.

Mr. O'Day questioned whether H.R. 3160 was truly a safety bill. For example, he asked what safety purpose was met by tacking a call for a national workers comp commission onto an OSHA bill. "We see it very much as a labor-management bill, not a safety bill."

The vast majority of employers are concerned about providing a safe workplace, he said. But instead of encouraging employers to provide such a workplace, H.R. 3160 "stresses the adversarial part of the relationship between OSHA and the marketplace."

"This bill would change OSHA into a criminal punitive statute," said NAM's Mr. Lunnie.

The Workplace Health & Safety Council's Mr. Froelich agreed. He noted that OSHA definition of "willful" violation encompasses what most people would regard as indifference to OSHA rules rather than an active violation of the law.

But, organized labor supports the bill because "far too many workers are still getting killed, injured and sick from job hazards," said a statement from the AFL-CIO. The AFL-CIO particularly supports the mandatory worker representation on workplace safety and health committees and in extending OSHA jurisdiction to public entities. ■



Peter Hughes, Principal at Foster Higgins, the Johnson & Higgins benefit consulting subsidiary, on workers comp medical costs:

More than 50 percent of your benefit plan cost is for health care.

Like many companies you probably are exploring ways to control your expenses through managed care arrangements.

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Benefits study sponsorships still available

Only a limited number of sponsorships are still available for the "Employee Benefit/Human Resource Managers' Viewpoint" study to be conducted by Yankelovich Clancy Shulman and *Business Insurance*.

YCS researchers will conduct personal, one-hour, face-to-face interviews with key decision makers on employee benefit issues at 300 corporations around the country to determine the key issues affecting how corporations buy employee benefit products and services.

"This research will help providers of employee benefit products and services to better serve existing clients and reach new markets," said Kathryn J. McIntyre, publisher and editorial director of *Business Insurance*.

"Interviews will begin in June," said Noah Waldman, the YCS vp who is directing the project.

Sponsors of the study, who will receive the survey results, include leading benefit consultants, insurance companies and managed care networks, he said.

"The response to this research effort throughout the industry has been excellent," Mr. Waldman said, leaving only "a limited amount of sponsor space still available."

Sponsors have the option of receiving the general study or a company-specific study, which adds an in-depth evaluation of a company's strengths and weaknesses in its communication programs, personnel and service.

For more information, contact Mr. Waldman at YCS, 3390 Peachtree Road N.E., Atlanta, Ga. 30326; 404-364-6569. ■

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MCA extends benefits to same-sex partners

By MICHAEL SCHACHNER

MCA Inc. will soon become the first entertainment company to extend health benefits to the partners of gay and lesbian employees.

A gay and AIDS-sufferers advocacy group hopes that MCA's move paves the way for other entertainment conglomerates to provide coverage to the partners of employees who are gay or lesbian.

Beginning July 1, same-sex partners of MCA employees will be eligible for group health insurance just like spouses of married MCA employees.

Under the MCA plan, the gay and lesbian partners who meet specific spousal equivalent criteria may obtain family coverage through the company's partially self-insured health plan.

Opposite-sex domestic partners are not eligible for coverage from the the Matsushita Electric Industrial Co. unit, which is also the parent company of Universal Studios.

MCA would not provide details on its health plan.

But, Richard Jennings, executive director of Hollywood Supports, a gay and AIDS-sufferers advocacy group in the entertainment industry, called the company's health care program a "hybrid" of self-insured and insured plans.

Mr. Jennings commended MCA and its president, Sidney Sheinberg, for deciding to provide health benefits to gay and lesbian workers' partners.

"MCA's action sends a powerful message of support and caring for all of its employees, regardless of sexual orientation," he said, adding, "I think MCA chose to offer it only to the gay workforce because it has been the gay community that has voiced the most concern."

Hollywood Supports is urging all entertainment companies to extend family coverage to any couple of consenting age that resides together and intends to do so indefinitely. The couple must be mutually responsible for basic living expenses, and neither partner may be married to someone else.

The advocacy group has drafted model criteria that employers can use to determine which domestic partners should be eligible as spousal equivalents for purposes of receiving health care coverage. These criteria could apply to opposite-sex partners as well.

Several major television and movie studios, including Fox Inc., are considering extending health insurance to the partners of gay and lesbian workers, according to Hollywood Supports.

Only a handful of other private companies currently offer health care benefits to the partners of gay and lesbian employees. Among those are Ben & Jerry's Homemade Inc., Levi Strauss & Co., Lotus Development Corp. and Montefiore Medical Center.

A few West Coast cities—Seattle, San Francisco and Berkeley, Calif.—also offer the benefits.

Some of those employers also extend benefits to opposite-sex domestic partners.

Backup child care

Putnam Cos. is offering all of its 1,800 Boston-area employees a heavily subsidized emergency child care program.

Benefit beat

In conjunction with four other downtown Boston employers, the financial management firm recently opened a facility that can provide emergency child care for up to 20 children between the ages of 1 month and 12 years.

The facility, run by Workplace Connections Management Group Inc. of Waltham, Mass., provides basic care to children when regular child care arrangements fall through and on certain holidays when school is closed but parents still must work.

Employees pay $15 daily for the program and can place more than one child in the center on any given day. Putnam covers the undisclosed remainder of the costs.

"We subsidize the majority of the cost," said Donna Baughman, senior vp and director of employee relations staffing.

"We pay the portion attributable to administration. Because we got in at the start, our costs are very reasonable," she said.

The March opening of the downtown facility, which Putnam shares with ITT-Sheraton Corp. and three local law firms, came six months after Putnam began offering a backup child care facility at its suburban Quincy, Mass., office.

"It's all part of our overall work and family focus. We're trying to cut back on sick days and lost vacation days and improve productivity," Ms. Baughman explained.

The new "Children's Place at 60 State Street," which occupies space owned by the law firm of Hales & Dorr, allows Putnam employees to place their children in a supervised setting when regular child care is unavailable or a child is mildly sick or injured.

The center, which accepts a total of 20 children from the five participating employers, takes no more than seven infants. It is open every working day as well as Martin Luther King Day; Presidents Day; Patriots Day, a legal holiday in April in Massachusetts and Maine; Columbus Day, Veteran's Day and the day after Thanksgiving.

Parents can place their children in the center for only five consecutive days. Enrollment is limited to 20 days annually per child, after which a child becomes second priority to other children whose eligibility has not expired.

Ms. Baughman said utilization is running extremely high since the center opened nearly three months ago.

She said the company initially expected that 10% to 15% of all employees would use the center. "But we're way above that," Ms. Baughman said. "At first, we thought executives would never use it. That has not been the case, as all levels of employees are using it." ■

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Community Wellness Program Coordinator
Coors Brewing Co.
Golden, Colo.

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Harriett Bartell
Assistant Vp-Benefits
The Franklin Life Insurance Co.
Springfield, Ill.

Our program involves employees, retirees and spouses. We offer seminars in nutrition, stress management and AIDS awareness. Our in-house clinic provides CPR training, newborn care classes and even free flu shots. Our cafeteria offers low-fat and reduced-calorie meals. We also subsidize fitness club memberships.



Susan A. Blair
Wellness Promotion Manager
Pacific Bell
San Francisco, Calif.

We have many programs for employees that emphasize nutrition, weight management, fitness and stress reduction. Special interests such as prenatal care, health consumerism and ergonomics are also addressed. We also provide videos for employees and their dependents to view at home.



Mary A. Butler
Employee Benefit Manager
Blount Inc.
Montgomery, Ala.

We send a health promotion newsletter to all employees. It goes to their homes so that the whole family can read it. Other programs, which vary by location, include exercise classes and facilities, health workshops, health screenings and health fairs.

Compiled by Karen Armaganian

Still no coverage in alleged gold theft

By STACY GORDON

BOSTON—A precious metals dealer lost its appeal of a federal jury verdict denying its claim for coverage for an alleged theft of $2 million in gold.

The 1st U.S. Circuit Court of Appeals upheld the portion of the jury's verdict barring coverage because the dealer failed to disclose material facts about a prior loss at the time it applied for coverage.

"Here, the deception was adequately proven," wrote Judge Bruce M. Selya in a 53-page opinion.

Furthermore, he said, "the jury heard testimony that (the underwriter) believed the incidents to be critical to a reasoned consideration of the underwriting risk."

That alone is reason enough to bar coverage, said the 1st Circuit.

So the court said it did not need to decide whether coverage also could be barred because there was insufficient evidence of a loss during the policy period, or a portion of the loss was caused by an agent of the policyholder and therefore was barred by an exclusion.

Putnam Resources of Greenwich, Conn., sought coverage under an $8 million marine policy written by Lloyd's of London underwriter R.M. Pateman of R.M. Pateman Underwriting Agencies Ltd.

Putnam's lawsuit also named as defendants a dozen other London underwriters that followed on the policy.

On. Oct. 12, 1987, Mr. Pateman advanced Putnam $2 million to cover the claim for the stolen gold.

However, after further investigation, Mr. Pateman denied coverage and sought to recoup the earlier payment (*BI*, April 2, 1990).

As part of the effort to recoup the $2 million payment, Mr. Pateman also sued Putnam's broker, New York-based Frenkel & Co.

The underwriter alleged that during negotiations, Frenkel purposely failed to disclose facts material to the risk.

The 1st Circuit in its Feb. 20 ruling remanded the jury verdict against Frenkel.

Following the verdict, Putnam returned the $2 million advanced by Mr. Pateman, said James Campise of Marcigliano & Campise in New York, who represented Mr. Pateman in the litigation.

As a result, Mr. Pateman has no reason to pursue his claim against Frenkel, said Mr. Campise.

"However, this case does alert brokers that they are potentially liable to underwriters for misstatements made in connection with the placement of coverage," said Mr. Campise.

•

Putnam Resources vs. Ronald M. Pateman, U.S. Court of Appeals for the First Circuit; No. 91-1307, No. 91-1308.

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Opinions

Veterans bill goes too far

"BAD" LEGISLATION can be separated into two types. Legislation sometimes is deemed "bad" because it goes against the interests of a certain group. And, legislation can be "bad" because—while its goals are worthy—it is poorly drafted.

The Uniformed Services Employment and Reemployment Rights Act of 1991, now awaiting a vote by the full Senate, is a great example of both types.

It is hard to oppose the bill's intent: protecting the employment rights of employees returning to the private workforce after service in the armed forces. However, the damage to benefit programs that could result from the bill in its current form would be enormous. And, the bill is poorly written to boot.

Take a basic requirement in the legislation: requiring employers with defined contribution plans, like profit-sharing plans, to make retroactive contributions when veterans return to work to cover the period when they were in the military.

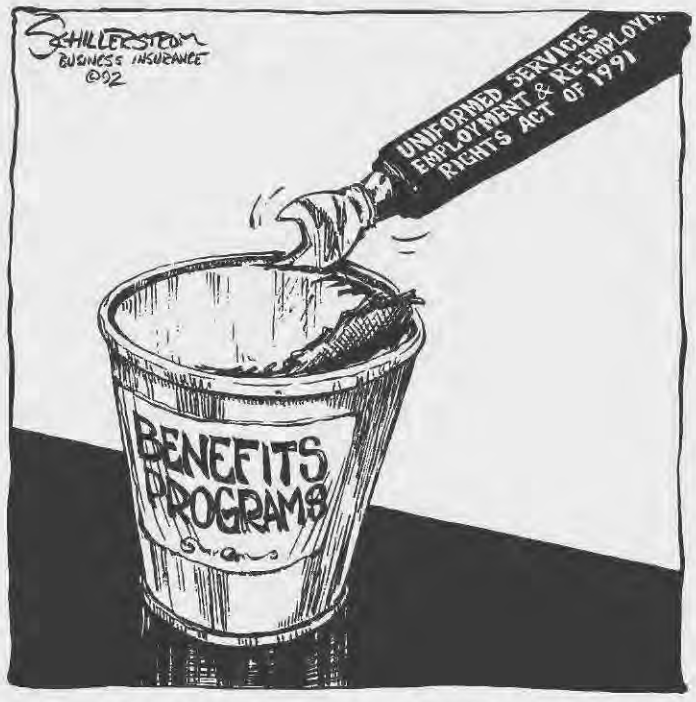
Aside from philosophical issues, the requirement poses massive technical problems. Consider a profit-sharing plan in which an employer contributes an average of 10% of employee compensation during the years an employee was in the service.

Since the employee probably did not earn any compensation from the company during this period, what exactly would be the basis of the employer's retroactive contribution? It is impossible to tell from reading the legislation.

If compensation was considered zero, which it seems it would be, any contribution would seem to violate Internal Revenue Service rules that link an employer's plan contributions to an employee's compensation.

But our objections go beyond technical flaws, which presumably can be ironed out.

Should an employer be required to make profit-sharing contributions on behalf of employees in the armed forces? While we do not think the answer is a blanket no—employees called up from the reserves for short periods because of a national emergency may merit special treatment—we also do not believe the answer is a blanket yes.



Why should an employee, who voluntarily joins the military and then later returns to his or her old job, receive benefits when he or she did not have a direct involvement in the company's profits? While many would argue that military service benefits employers, it would be better to increase military pay to reward those serving their country than to force employers to provide benefits that were never earned.

Many of the problems in the legislation could have been avoided if legislative staffers only had taken the time to talk with benefit experts. Fortunately, that dialogue finally has begun, and we hope the result is a law that protects veterans without making needless demands on employers' benefit programs.

Letters

'A recipe for inaction, delay and confusion'

To the editor: As former directors of governmental affairs for the Risk & Insurance Management Society Inc., we read with astonishment the May 18 article, "RIMS Chapter Opposes Federal Regulation." We do not wish to debate RIMS' position on federal solvency regulation; rather, it is the criticism of RIMS' policy-making process that we feel compelled to comment on.

The Wisconsin chapter's letter to RIMS President Suzanne Crager argues that "a RIMS policy statement of such proportion should always be reviewed and concurrence obtained at the chapter level prior to any release to the public." We can think of no surer way to destroy RIMS' effectiveness than to follow that advice. It is a recipe for inaction, delay and confusion.

RIMS is not, and should not be, run like a Vermont town meeting. Instead, it is rightly a republic. The members elect the board of directors, which elects an executive council to run the society. The executive council, in turn, appoints committee chairs, who choose committee members from among the general membership. These committees are filled with volunteers who respond to RIMS' yearly request for applications. This is how truly interested members can have an impact, as these committees make recommendations to the executive council on RIMS policy.

Asking the full membership, even by chapter, to ratify public-policy positions is kind of like asking the American people to vote on a tax code. RIMS members are busy professionals who lack the time to study and evaluate legislative issues in depth.

That's why they elect an executive council and have an established committee structure: to perform these functions on their behalf. If the membership disagrees with executive council decisions, they have recourse through the board of directors, which meets twice a year.

When RIMS took a position in favor of retaining McCarran-Ferguson in the late 1980s (a position since reversed), the chapters were not asked to ratify it. Nor were they asked to do so for RIMS' positions on changes to the commercial general liability policy or the Risk Retention Act amendments of 1986. And, contrary to a statement reported in the *Business Insurance* article, the meetings between RIMS staff and certain chapters on the National Assn. of Insurance Commissioners' model anti-fronting bill proposal were not held to formulate a position. They were aimed at initiating a course of action in support of a position that had already been established by the executive council.

In fact, the fronting issue provides a good example of why requiring ratification by the membership is a bad idea. When the draft model bill was first released, a quick and powerful response by risk managers was crucial before the NAIC's next quarterly meeting. There was barely enough time but, with some fast work, RIMS and its members mustered a large and timely letter-writing drive. Had the issue been submitted to the chapters for their review, the letter campaign could never have been pulled off in time. Without those hundreds of letters, the dynamics of the NAIC debate might have developed less favorably for risk managers.

The process by which positions were reached on all these issues—and each would certainly be considered a "policy statement of such proportion"—was never, to our knowledge criticized. RIMS followed its representative process, which permitted it to take quick, bold and decisive action. The result is a less-restrictive CGL policy, enactment of the Risk Retention Act amendments and what will likely be a far more reasonable model bill on fronting activities.

Howard W. Greene
Vp
GRE Insurance Group
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Jon Harkavy
Vp/General Counsel
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Managed care

Continued from page 3

them union members, and 67,000 to 68,000 retirees.

"We are fast approaching a situation of one active employee to one retiree. We must be very well aware of this" when designing benefit programs, he explained.

Additionally, medical costs in the Northeast are 30% higher than elsewhere in the country, Mr. Leonard said. Employers should be aware of geographical differences like that, he commented.

As the company continues to refine its managed care plans, it intends to focus on value, which Mr. Leonard defined as "not overpaying for quality." Using that definition, NYNEX has cut back on the number of health maintenance organizations it offers. "At one point we had 60 HMOs. We've weeded that back to 47, and we will continue weeding out HMOs."

NYNEX also has established preferred provider arrangements for substance abuse, prescription drug and mental health benefits, he said. And, the company may eventually develop PPO networks for laboratory, X-ray, obstetrics and transplant services, among other procedures.

NYNEX also will invest more heavily in health education, fitness and prevention programs, Mr. Leonard noted.

Getting employees in unions to buy into the managed care concept helped NYNEX and has proved valuable for other unionized employers, as well.

Even though half its 8,000 employees belong to unions, Northern State Power Co. successfully implemented a managed care plan.

Education about the factors behind rising health care costs was a major focus of the project, said Steve Wetzell, formerly a benefits manager at Northern State and now vp of benefits and payroll at First Bank System Inc. in Minneapolis.

"There is a lack of consumer education and accountability. Until we get employees and insureds to understand the magnitude of the problem, it won't get solved," Mr. Wetzell said.

Northern State Power held focus groups to help educate its employees about the health care crisis. "Especially with organized labor, we had to educate them about the problem and let them know we weren't just out to cost shift." In addition, Mr. Wetzell made sure employees understood that the managed care plans would continue to evolve.

"Focus groups are a great investment. I highly recommend that you use them to help employees adjust and understand change," he said.

Northern State Power was, to say the least, not used to change. Its benefit plan had not been altered since 1959, and Mr. Wetzell initially encountered anger.

"With union employees, you just have to be honest. At Northern State Power we were successful in negotiating managed care because we spent five days talking about health care before we even began to negotiate," Mr. Wetzell said.

Robert A. Cooley, manager of the department of employee relations for the State of Minnesota in St. Paul, agreed that working with—not against—unions is important. Ninety percent of the state's 55,000 employees belong to one of 10 different unions.

"Our success in making changes in our health care delivery systems over the last four to five years has come about because we have a joint labor/management committee on health plans," Mr. Cooley said. Health care "issues need to be talked about 12 months of the year."

Positive communication between labor and management helped the state negotiate seven exclusive provider arrangements for its employees in unions. Since the plans' inception two years ago, participation has risen steadily.

And, the state's health care cost increases have dropped significantly, Mr. Cooley pointed out. Before the EPOs, annual increases averaged about 33%. With them, increases have been about 5.5%. "From a cost standpoint, it's been an unequivocal success," Mr. Cooley said. ■

EAP, managed health can be integrated

By CHRISTINE WOOLSEY

MINNEAPOLIS—Employee assistance programs can be successfully integrated with managed mental health plans if employers understand each program's different goals, says a corporate EAP director.

And effectively combining those programs will reduce mental health care claims costs, he adds.

"I don't have all the answers about managed care, EAPs and how to make them blend together," admitted Ronald A. Finch, corporate director of employee assistance programs at BellSouth Corp. in Atlanta. "But I do have the responsibility for it in my corporation."

BellSouth integrated its EAP and managed mental health plans, but not without problems, said Mr. Finch, who spoke at a National Assn. of Employers on Health Care Action conference held April 29-May 1.

"The difficulty we've had deals with the different goals of each program," he explained.

"An EAP is a comprehensive program designed to assist in the identification and resolution of productivity problems associated with employees who are impaired or likely to be impaired by personal problems," Mr. Finch said. "An EAP is a management system, not a cost containment system."

On the other hand, managed care "is a system of controlling costs through a continuum of care which provides clinically appropriate and necessary care in the least intrusive setting," Mr. Finch explained.

There can be conflicts between the two programs, Mr. Finch said.

For example, short-term savings are the primary goal of managed behavioral care, he noted. But an EAP "is concerned with the long-term results of employee performance and human resource management and is not as concerned with controlling costs."

In addition, managed behavioral care is a function of managing the health care system, whereas an EAP is part of managing employee performance, Mr. Finch said.

Another conflict may arise because a managed mental health care program often defines the resources an EAP will use, including hospitals and physicians, he said. The EAP does not always have a say about which providers are selected.

At BellSouth it does, according to Mr. Finch.

"(We) listen to our EAP and use its input to select providers," including preferred provider organizations composed of physicians, psychiatrists, psychologists and facilities like inpatient and outpatient centers and home care providers, Mr. Finch said. "Who better to help us select our providers in different cities than the EAPs in those cities?"

Mr. Finch acknowledged that BellSouth's mental health care plan historically has reimbursed more for inpatient treatment than outpatient care. "Our benefits have not been designed to give incentives to people to seek care on an outpatient level. We are trying to remedy that—(encouraging) people in our PPO to seek outpatient care and to seek preventive care so they can avoid inpatient treatment," he said.

Again, the local EAP proves invaluable in meeting these goals, Mr. Finch noted. "Who better to monitor the network than the local EAP—they are the eyes and ears of what we are attempting to do with our PPO network."

BellSouth also is attempting to use its EAPs as joint gatekeepers in its managed mental health care plan, Mr. Finch said. "The EAP can join with our utilization review team to be sure the UR team gets the information it needs that will get the employee the treatment he (or she) needs."

EAP professionals must be adequately trained, though, to do this, Mr. Finch said. "We require all of them to be credentialled and licensed as mental health practitioners—that makes them credible to the community we are offering the EAP to," he said. A successful EAP also must be adequately staffed, he said, noting that BellSouth has 17 EAP staffers.

Integrating the EAP and managed mental health plan has helped BellSouth control costs, even though utilization has increased, Mr. Finch said. "From 1988 to the present, we've seen a 25% reduction in our mental health costs. At the same time, we had a 12.5% increase in the number of hospital admissions."

Before BellSouth implemented the managed mental health plan, its mental health costs were rising 25% per year, Mr. Finch said. Increases have now leveled off at about 17%.

Mental health benefits now account for about 10% of the company's overall health care costs. "We want to bring that down to 7% to 8%," he said.

One of the key factors driving up mental health care costs is the extreme variation among providers and treatments, said Brad McDonald, corporate director of U.S. group insurance and health systems at Honeywell Inc. in Minneapolis, who also spoke during the session.

"We cannot afford the variation in health care providers, so we want to define who our providers are," he said, noting that Honeywell has carved out mental health coverage from most of its health plans.

"It's important to focus on quality in the mental health care business," Mr. McDonald stressed. "Quality means you are trying to reduce variation. If you are a manufacturer, you want every part on the assembly line to come out the same. With patients, we want a treatment that will result in people coming out well."

Unfortunately, "in the mental health system, there is a ton of variation," Mr. McDonald said. For example, there is a lot of discretion in how people are diagnosed and by whom they are diagnosed—whether that person is a psychiatrist, psychologist, social worker or medical doctor, he explained.

Improving mental health care may hinge on developing treatment guidelines and standards, Mr. McDonald said. "We want standards—but not standards that are so restrictive that they say, 'All depressed people will be treated like this.' We want providers to have a method of treatment, though, focusing on how to treat a condition medically, through counseling and so on."

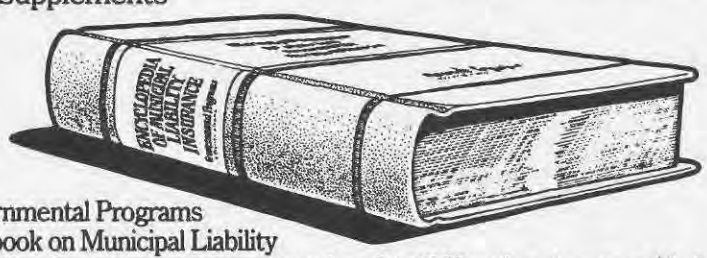
Mental health care providers are now attempting to work with employers to reach some of these goals, said C. Henry Engleka, deputy director of the American Psychological Assn. in Washington. "We buried our heads in the sand when we saw managed care coming," he said. "But now we are ready to assume a leadership role and talk about this with corporations, insurers, legislators, institutions and managed care companies."

Moderating the session was Jacob Spies, a partner at The Furst Group, a Dallas-based executive search firm specializing in health care and insurance. ■

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Firms measuring quality delivered by managed care

By CHRISTINE WOOLSEY

MINNEAPOLIS—Employers are more closely measuring quality in managed health care programs, say corporate health care experts.

"The continuum of managed care requires that we constantly monitor quality and costs," said Joyce Johnston, manager of health care programs for Allied-Signal Aerospace Co. in Torrance, Calif.

"We put in managed care to save money, but also to create predictability," she said during a session at the National Assn. of Employers on Health Care Action conference held April 29-May 1 in Minneapolis.

Allied-Signal is in the fourth year of a point-of-service managed care plan administered by CIGNA Corp. "Our focus is on total quality management, and it's not just a buzzword in our company. Our 100,000 employees are receiving TQM training and so is CIGNA and the other companies they contract with," Ms. Johnston said.

"We are sure that involving employees in managed care will enhance overall health care for our employees and drive health care costs down," she said.

To ensure that involvement, the company has set up focus groups around the country to identify ways it can improve health care, the gatekeeper concept within its managed care plans and employee satisfaction with those plans, said Ms. Johnston. "We've asked CIGNA to become a partner with us and work with our focus groups," she added.

Through those projects, Allied-Signal identified the need to educate its employees on how managed care works. "Communication is important," she said.

The company is letting its employees help it evaluate the quality of its managed care plans. "To measure performance, we look at customer satisfaction, cost-effectiveness, claims payment and accuracy and how the plans monitor the quality of their providers."

Allied-Signal defined some of the quality indicators it wants its managed care network to use. For example, "we have networks look at outcome studies for high-risk, high-volume diagnoses," Ms. Johnston explained.

In addition, the company has put its own measures of quality in place. Among other things, Allied-Signal has established performance standards with CIGNA regarding claims turnaround time; it has monitored physician turnover within its managed care plans, trying to find out why doctors are leaving; and it is requiring its managed care plan to provide meaningful and timely data on health care usage and costs.

Acquiring meaningful data "takes patience and initiative," Ms. Johnston pointed out. Employers often encounter difficulty in getting providers to give them the reports and information they want, she noted. But, providers themselves often have problems turning over employer-specific data, because they have never been asked for it before and they may not collect and store it in a way that is useful to employers.

"Be persistent but not adver-

Continued on next page

NAEHCA conference draws 160 to Minneapolis

MINNEAPOLIS—Nearly 160 corporate benefit managers, consultants and managed care professionals attended the National Assn. of Employers on Health Care Action's 20th anniversary meeting here April 29-May 1.

The meeting, "Managed Health Care in the '90s: Solutions for 1992 and Beyond," included sessions on managed care benefit design and implementation strategies. Speakers discussed how they are handling cost containment within their companies and communities, how to measure quality within a managed care plan and how employers can help shape the future of health care reform.

In addition, the conference featured an exhibition of 18 companies that provide services to employee benefits managers.

NAEHCA is a non-profit organization of employers that gathers information on managed health care plans. Its members include corporations, brokers and consultants as well as health care organizations.

The 1993 conference is scheduled for May in Dallas. For more information, contact the National Assn. of Employers on Health Care Action, P.O. Box 220, 240 Crandon Blvd., Suite 110, Key Biscayne, Fla. 33149; 305-361-2810.

—By Christine Woolsey

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Measuring quality

Continued from previous page
sarial," she advised.

Southern California Edison Co. also is working on quality improvement within its managed care plans, said Dr. Mark Granoff, senior physician adviser to the utility's health care department.

"Quality assurance implies an obligation to assure quality to employees," he said. "When an employer directs patients into a network for financial reasons, there is an implied responsibility assumed with that."

In 1989, the company, which is based in Rosemead, Calif., established an internal managed health care plan that covers 55,000 employees. The health plan includes a preferred provider network with 7,500 providers and 75 hospitals.

"When we put in the network, we decided to do all the managed care in-house in our medical department. We do claims payment, utilization review, case management, preventive health and quality assurance," Dr. Granoff explained.

Southern California Edison also runs seven occupational and primary health care clinics.

To help it measure quality, the company felt it had to try to define it. One definition the company has used is: achieving optimal outcomes using appropriate processes of care delivered by providers.

Among other things, employers need to know what their managed care organization does to credential physicians and how often that credentialling is updated, he suggested. "We update and credential every two years to make sure physicians retain the skills they need." Southern California Edison also requires its physicians to be board-certified for their specialty and to have medical malpractice coverage.

"If action is taken by the California Medical Board against one of our providers, we go ahead and remove him (or her) from our network," he said.

Southern California Edison also established a two-pronged quality assurance program for its preferred provider organization and clinics.

"First, we attempt to identify undesirable outcomes. We have an incident reporting system that allows employees, relatives and coworkers to call us toll-free with complaints." Those complaints are documented by nurse specialists who investigate the incidents and evaluate the providers involved, Dr. Granoff explained.

In addition, Southern California Edison has built into its utilization management system a series of generic quality screenings, he said. "For any service we review—like hospital admissions or durable medical equipment—at the time data is collected, the computer generates a list of quality screenings. If the service fails the screenings, a report is issued to a quality assurance nurse who collects further information."

After the nurse collects more data, the incident is given a severity level based on how adverse an outcome was because of a quality problem, he said. "If it appears to be a significant quality care issue, the patient's medical records are reviewed and the information is sent to another provider for peer review."

Next, the information is passed along to a managed care committee, which functions as a peer review committee and includes doctors of various specialties. The committee reviews and discusses the case to reach a decision about its severity and what action should be taken with the provider.

"All of this doesn't mean a thing unless we intervene," Dr. Granoff said. "The minimum intervention is simply to collect the information, put it in the computer and keep track of it. Then, when we look at re-credentialling that physician, we look at it," he explained.

If there is a significant problem, though, focus studies are started. "We pull all the claims filed for patients of that doctor and collect more information from patients about the quality of care they received from that doctor. Then we look for trends," he said.

If the quality problem is particularly severe, "we notify the California Board of Medicine about it and we get the doctor out of our network," Dr. Granoff said.

"We have to get rid of some providers" as a result of this process, Dr. Granoff acknowledged. "But we have improved the quality of our network."

Managed health care companies like United HealthCare Corp. of Minnetonka, Minn., and Health Risk Management Inc. of Minneapolis also can help employers measure the quality of their managed care programs.

Sheila Leatherman, vp of research and development at United HealthCare, discussed the company's computerized system of clinical practice guidelines during the session.

And, Gary McIlroy, chairman and chief executive officer of HRM, discussed his company's computer system, which uses algorithms based on clinical practice to indicate the optimal care for various illnesses.

Ms. Johnston of Allied-Signal moderated the session. ■

Aviation market

Continued from page 3
world's airlines, both claims and premiums rose in 1991. Premiums increased to about $700 million last year from about $300 million in 1990, while major claims rose to about $720 million from about $500 million during the same period, according to Mr. Belcher's statistics. This does not include attritional losses, however, of another $400 million, he said. Attritional losses stem from routine personal injury or property claims, like lost baggage or minor passenger injuries.

Commuter airlines had a bad 1991 in terms of losses, while commercial airlines had a fairly stable level of accidents, he said. In 1991, there were 0.3 deaths per 100,000 departures for commuters, and 0.05 deaths per 100,000 departures for commercial airlines, he said.

"I am sure all of you have heard that airline rates have gone up dramatically," said Mr. Belcher. Percentage-wise, the rate increases during the last quarter of 1991, which is when 70% of the world's airlines renew their hull and liability programs, look dramatic, according to his statistics.

Hull rates quoted last October were 160% higher than 1990 rates, although by the end of 1991, the rate increases had moderated to about 120% of 1990 rates, according to Mr. Belcher.

"It looks a healthy picture," he said.

However, this doesn't take into account the massive rate reductions that have been common since 1986, Mr. Belcher said. "The only problem is that if you start from a 10-cent rate and give a 50% reduction to 5 cents and then the next year give another 50% reduction to 2½ cents, you need a 300% increase to get back to 10 cents again. So comparison of percentage changes presents a totally unrealistic picture."

Using an average of rate movements for about 200 airlines, Mr. Belcher said that by 1990, aviation underwriters were only charging 10% of 1984 hull insurance prices and 25% of 1984 liability prices. In 1991, underwriters were charging about 20% of 1984 hull rates and about 45% of liability rates.

In the meantime, "a lot of companies and syndicates have lost a lot of money," he said. "To say that (the 1989 underwriting year results just being closed) are catastrophic is certainly not an understatement."

Some direct aviation underwriters' results are "not too bad," mainly because they have been relying heavily on reinsurance, noted Mr. Belcher. But in 1992, these reinsurers "are either absent or demanding the price for the job; i.e., something that resembles the correct rate based on the historic (losses)."

Of 60 Lloyd's of London syndicates that have merged or closed this year, eight were aviation syndicates, said Mr. Belcher, quoting statistics from syndicate analysts Chatset Ltd. This kind of contraction also is happening among London insurance companies writing aviation coverage, he said.

"The direct aviation market has, over the past three years, effectively bled the surplus out of the reinsurance market," he said. "Now it is the turn of the direct market to have its surplus capacity burned off. The phrase 'only the fit will survive' could not be truer."

As reinsurance capacity evaporates, insurers will be forced to retain more risk, which eventually will push up direct aviation rates.

But, until direct insurers start feeling the pinch and paying retained losses, airline premiums are not likely to go up as dramatically as is necessary to achieve profits, Mr. Belcher said. "No one's seen the losses coming through yet" this year, he said. "Management will only make up its mind when the losses come through."

In the meantime, increases this year in airline hull and liability insurance rates show a slow, upward movement, Mr. Belcher said in an interview following his speech. Airline hull rates from Jan. 1 to May 1 saw 35% average increases on top of last year's hikes, while liability rates increased an average of 30% from last year's levels, he said.

However, most of the world's major airlines will not renew their insurance programs until the last quarter of this year, he said. By then, "we will get higher increases than we are seeing at the moment, but not necessarily as high as last year," he predicted.

General aviation insurance rates also might start to rise in the latter half of this year as aviation insurers place their reinsurance programs and find that they will be retaining more risk for a higher price, AIA conference members say.

Once some of the major U.S. general aviation insurers renew their reinsurance programs on July 1, "I think (the general aviation market) will retract very quickly," said Mr. Belcher. "If that happens, rates will go up July 1."

The general aviation market "is fairly flat" at the moment, added Ed McDonough, executive vp of American Eagle Group in Dallas, formerly known as AOA Corp. "But it's looking to harden later this year, or by the end of this year. A lot of people are hurting. It's been a difficult four or five years for the (aviation) insurance industry," he said.

For years, AOA wrote aviation insurance through the Aviation Office of America Inc., a managing agent that AOA Corp. acquired along with six insurers from Crum & Forster Inc. in 1986. Earlier this year, however, AOA decided to reorganize the group, Mr. McDonough said.

First, the group decided to drop the AOA name, adopting instead American Eagle, the name of its lead insurer, American Eagle Insurance Co. of Dallas. The group felt that its B+ rating by A.M. Best Co. was due to its practice of acting as an MGA rather than a risk-taking insurance company.

By making several other changes, American Eagle hopes to obtain an A rating from Best this year. This includes increasing its capital to $50 million by the end of this year from its current $31 million, noted Mr. McDonough. The group currently is talking to investors about increasing the company's capital, he said.

American Eagle also from now on will focus exclusively on general aviation business. In the past, it has occasionally written coverage for major airlines, although those risks accounted for less than 5% of its overall premium volume, said Mr. McDonough.

"We will begin to concentrate on general aviation, (though) that doesn't mean we will never write an airline again," he said.

Also, as part of this plan, American Eagle will retain more risk when it renews its reinsurance program on July 1, he said.

The group also will try to begin placing more of its reinsurance coverage in the United States this year than in London and continental Europe, although he acknowledged that "in the past, we have heavily relied on London." American Eagle has no plans to "cut out old friends" in London and will continue to place some of its reinsurance coverage in the London market, he said.

Meanwhile, Boeing Co. on May 1 renewed $1.5 billion in aviation products liability insurance and paid a premium increase in the range of 20% to 30%, AIA sources say.

The Boeing coverage was placed in three layers: $350 million led in London at Lloyd's, $950 million excess of $350 million and $200 million excess of $1.3 billion. The program was placed by Johnson & Higgins in the United States and Willis Corroon P.L.C. in London.

AIA members said that J&H wanted each insurer on the coverage to write no more than 10% of its surplus, but found that the program could not be completed within that guideline and had to relax it a little.

Chris White, assistant vp of J&H Aviation in New York, would not comment last week on Boeing's renewal except to say that, in general, aviation manufacturers' product liability rates are increasing.

"On average, the aviation product insurance market is charging about 15% more than last year, while airlines' insurance rate increases vary between 20% and 250%," Mr. White said.

"General aviation is seeing 10% to 20% increases since Jan. 1."

In the meantime, Mr. Belcher took exception to comments made earlier this year at the 7th annual International Airline Insurance Conference in London sponsored by DYP Insurance & Reinsurance Research Group Ltd.

Lloyd's aviation underwriter Brian Beagley at that meeting predicted that soon there would only be two major aviation insurance groups and only three or four Lloyd's aviation syndicates left in London. There also will be only two major groups in Paris, two in the United States, a few large insurers in Europe and reinsurance support from Japan, he predicted (*BI*, March 23).

Mr. Belcher took exception to this scenario, pointing out that his company, Transglobe, should be on that list.

"We cannot all be right, but one thing is obvious: There will be a substantially reduced market in the near future which will produce underwriting profits. The companies and syndicates that survive and form part of this new market will not only have to have a strong capital base, good underwriting and reserving policies and perceptive management, but will also actually have to add value and have a distinct role in the market," he said. ■

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Aviation industry leads way in environmental disputes

By STACY SHAPIRO

SCOTTSDALE, Ariz.—The aviation industry is in the forefront of litigation for coverage of environmental liability costs, an attorney says.

AIA CONFERENCE

Since the early 1980s, when policyholders lodged the first major claims for environmental pollution against the insurance industry, the aviation and aerospace manufacturing industries have been leading the way, said Richard F. Allen, a partner in Lane Powell Spears Lubersky, a Seattle law firm.

"One of the first substantial claims made (for cleanup coverage) was by Boeing Aircraft Co.," said Mr. Allen at the annual Aviation Insurance Assn. conference, held earlier this month. "Look down the list of coverage litigation going forward today where industries are seeking to cover the cost of environmental cleanup from insurers and you'll see the names of all the major aviation and aerospace manufacturers."

For example, one case expected to go to trial later this year is Hughes Aircraft Co.'s suit against its insurers for coverage of cleanup costs and more than $85 million in bodily injury claims stemming from a contaminated site near Tucson International Airport, said David M. Schoeggl, also a partner in Lane Powell Spears Lubersky, which represents Hughes' insurers.

The plaintiffs suing Hughes also are suing the Tucson airport, which was brought into the Hughes litigation as a third-party defendant (*BI*, Sept. 3, 1990).

In addition, Aerojet-General Corp. is still involved in litigation over a polluted facility near Sacramento, Calif. In litigation between Aerojet and 55 of its general liability insurers, the California Supreme Court in 1989 declined to review an appellate ruling that cleanup costs are covered "damages" in comprehensive general liability policies (*BI*, April 24, 1989).

An increasingly broad spectrum of pollution-related lawsuits is making it necessary for the aviation industry to battle its insurers in court.

In another current case, Mr. Schoeggl said neighboring landowners are suing a Southern California aviation manufacturing facility for the devaluation of their land from the time pollution contamination was found to the time it was cleaned up.

"Perhaps the most frightening type of liability is something that is really just emerging and that relates to bodily injury claims," said Mr. Schoeggl. "It is becoming more common that people living in the vicinity of these various toxic waste sites are getting together and filing lawsuits in large groups."

One such case involves an entire town that is suing aviation manufacturers that the residents believe polluted the groundwater, he said. The residents are finding experts who concur that the cancers and other diseases they have contracted have been from ingesting their tainted tap water. And even if they are not ill, they are claiming injury from the undue stress that this situation has caused, said Mr. Schoeggl.

In fact, Mr. Allen said, eight individuals were awarded $200,000 each for "reasonable fear" of a life-threatening disease for ingesting a known carcinogen in water that had been contaminated by a Firestone Tire & Rubber Co. facility in Southern California (*BI*, Jan. 11, 1988). The award was recently upheld by an appellate court.

"But it's not just major manufacturers who are subject to this type of claim," said Mr. Allen. "We see the entire range of the aviation industry has been (pursued for) claims for cleanup, bodily injury and property damage. Cases against airport authorities are becoming more and more common. All the participants in maintenance around the airport are becoming the focus of environmental claims."

As a result, all sorts of aviation-related insurance policies are becoming involved in coverage litigation, said the lawyers. These include general liability policies, hangar-keepers liability policies and airport liability policies.

Much of the litigation stems from the pollution exclusion clause found in comprehensive general liability and other policies, which says coverage only applies "if such discharge is sudden and accidental."

Lawyers have spent more time on those words "sudden and accidental" than any others, said Mr. Schoeggl. During one case, he said, a lawyer tracked down the man who wrote those words and thanked him, saying that those three words had put his six children through college.

Insurers argue that the "sudden and accidental" language bars coverage for all pollution that does not occur abruptly. Policyholders, on the other hand, argue that the exclusion only bars coverage for intentional pollution.

Courts in more than 30 states have ruled on the meaning of the pollution exclusion clause and, so far, insurers are winning by a 2-to-1 margin, said Mr. Schoeggl.

Meanwhile, the Hughes litigation involving a contaminated site at Tucson International Airport highlights a huge range of coverage issues that are being fought in court, the lawyers said.

A videotape presented at the conference showed an in-depth television report stating that Tucson residents depend solely on underground reservoirs for their drinking water. More than 1,000 of the residents of the city's "South Side" allege that their water was poisoned. The source of the contamination, they allege, is two miles from their neighborhood at a U.S. Air Force site leased by the government to Hughes.

As far back as the mid-1950s, toxic waste from the plant that was dumped into open unlined wells seeped into the desert ground and poisoned the water, the residents allege.

About 10 years ago, Linda and Rick Gonzalez, who went to school in the area in the mid-1960s, started to notice that many of their friends were developing cancerous tumors. They concluded that there

Continued on next page

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Pollution suits

Continued from previous page
might be something unusual about the neighborhood, they said in the report.

In 1981, Ms. Gonzalez said, she read that the toxic wells at Hughes were being closed and realized "this has to be it."

As a result, Mr. Gonzalez, who is an attorney, filed a lawsuit on behalf of his friends and other residents. Hughes and later the U.S. Air Force were named.

It turns out that the wells contained high levels of trichloroethylene, which the Environmental Protection Agency in 1985 said was a probable cause of cancer.

Originally there were 18 plaintiffs in the lawsuit against Hughes, Mr. Allen said at the AIA meeting. By the time Hughes paid just less than $85 million to settle the charges, nearly 2,200 residents had joined the action, he said.

In the meantime, Mr. Allen said, Hughes has filed claims against its aviation product liability insurers from 1953 to the mid-1980s, claiming that all the policies should respond to the Tucson claims because the pollution occurred throughout those years, he said.

There is now a second wave of litigation against Hughes by residents who were not part of the first action, said Mr. Allen. This includes a class-action in Tucson by all the residents of the city's "South End," he said.

"With this factual background, we recommended that aviation insurers take the defensive and file a declaratory action with respect to coverage of these claims in Tucson," he said.

In the Hughes coverage litigation, there's now been several years of discovery involving at least 137 depositions all over the country and 20 depositions in London, said Mr. Schoeggl.

A trial expected to last eight to 10 weeks is expected to begin later this year. ■

Scottsdale draws AIA attendees

SCOTTSDALE, Ariz.—The Aviation Insurance Assn. annual conference draws attendees from around the world for its mix of continuing education sessions, industry seminars and entertainment.

At the 1992 conference, held May 3-5 in Scottsdale, aviation insurance experts heard about rising aviation insurance rates, expanded liability of aircraft manufacturers and owners and the aviation industry's exposure to environmental litigation, among other topics. They also gained some first-hand exposure to general aviation risks with balloon rides in the desert and a peek at a new helicopter developed by McDonnell Douglas Helicopters Co.

One of the meeting's most well-received sessions was a speech by Bill Gallagher, an author, lecturer and psychologist, who spoke to a spellbound audience on learning to get along with other people. Only when individuals learn the art of being fair, caring about people and sharing with others will they truly succeed, he told AIA members.

The conference also featured a number of continuing education sessions, ranging from aviation-related education options to the impact of the Executive Life Insurance Co. rehabilitation on structured settlements paid to aviation accident victims.

Next year's conference will be held May 1-4, 1993, in San Antonio, Texas. For more information, contact Bob Cannon, Forbes Westar Aviation, 3001 112th Ave. N.E., P.O. Box 245, Bellevue, Wash. 98009; 206-822-8176.

AIA attendees get a lift in hot-air balloon trip

By STACY SHAPIRO

SCOTTSDALE, Ariz.—There's nothing like first-hand experience when underwriting insurance for not-so-traditional aircraft.

Exposure to alternative aircraft like hot-air balloons, gliders and helicopters was an integral part of the fun and work at the Aviation Insurance Assn. annual conference, held earlier this month.

At dawn on May 4, a group of AIA members boarded a van and headed out beyond Scottsdale's borders into the desert. They were dropped off at a site where a local ballooning company, "A Balloon Experience," was inflating four hot-air balloons for a morning flight.

In the air were more than two dozen balloons floating gently in the cool early morning wind across the desert to sites about 12 miles away.

Hot-air balloons only fly at dawn in Scottsdale in the spring and summer, since temperatures rise above 100 degrees by midday and air currents become too unpredictable. Generally, hot-air balloons only fly at dawn and dusk because they need stable air currents to take off and land safely. In addition, the heated air within the balloon must be warmer than the surrounding air for optimum lift.

Hot-air balloon operators typically buy liability insurance with limits of $1 million per occurrence, with a sublimit of $100,000 per passenger.

The average premium is about $800 for $1 million of coverage, according to Pat Costello, president and owner of underwriting agency Costello Insurance Associates Inc. in Tempe, Ariz. Coverage is available through Dallas-based American Eagle Group, which earlier this year changed its named from AOA Corp. (see story, page 3).

The premium, however, is more expensive if the balloon is being used for flight instruction, lower if it is privately owned and used for pleasure, and somewhere in-between if it is commercially chartered, he said.

There is at least one company that writes hot-air balloon coverage exceeding $1.7 million in limits: Italy's Assicurazioni Generali S.p.A. insures a program offered by Aviation Insurance Managers Inc. in Cleveland.

While some AIA members gained ballooning experience, others tried their hand at soaring.

Soaring is the term for flying aircraft without engines, also called gliders. Most gliders are single-seat aircraft, although instruction gliders have two seats.

Soaring is not just for rich people, said Mr. Costello, whose underwriting agency has been writing glider insurance since 1985. Glider risks are placed with The Home Insurance Co.

"From a financial point of view, everybody's doing it," he said. Even pilots who have lost their full pilot's license because they couldn't pass their medical requirements are turning to soaring because there are no medical requirements, said Mr. Costello.

Gliders can cost anywhere from about $3,000 to $200,000, though most are in the $20,000 range, he said. "They are affordable to anybody who wants to get into aviation and doesn't want to buy gas."

The number of gliders flown is growing, he added. There are 5,000 gliders in the United States and an increasing number of those are manufactured in Europe. New gliders are being built mainly overseas unlike other light aircraft, he said. The aircraft are built out of metal, wood, fabric and, increasingly, of fiberglass.

Hull, liability and medical insurance coverages for passengers, pilots and gliders are similar to those of light aircraft with engines, said Mr. Costello.

There also is coverage for damage to trailers used to cart the glider to the airstrip.

A glider's insurance coverage depends on how it is used: for pleasure; as part of a club in which several members fly the same craft; for commercial use; or in competition.

Mr. Costello said other underwriting considerations include whether:

- The glider is single-seated, since passenger liability may need to be insured if the aircraft has two seats.
- Racing is excluded by the policy. If this coverage is needed, such as for a club that races its glider, the exclusion should be deleted, he said.
- The policy covers damage incurred during launching of the glider.



Photo courtesy McDonnell Douglas Helicopter Company

Attendees viewed McDonnell Douglas' new helicopter, the NOTAR. As a safety feature, the model has one main rotor and no tail rotor.

As far as losses are concerned, "there is a great deal of frequency in this category compared to other categories of general aviation aircraft," said Mr. Costello. It's a seasonal sport taking place five or six months out of the year, and most of the accidents seem to take place in the first month of the season because pilots have not flown in the past several months, he said.

Generally, though, losses are not severe, added Mr. Costello. And almost 97% of glider claims are for hull losses, not personal injuries or third-party damage, he added.

Most gliders in trouble hit land at only 3 mph to 5 mph, he noted.

Many claims arise because gliders frequently land in farmland or other rough terrain away from an airfield, Mr. Costello said. Claims also occur when the gliders are being carried from one spot to another, he said.

There are unusual losses, too, like the pilot who filed a claim for the three gunshot holes in the side of his glider and "who said he had no enemies," said Mr. Costello. Then there was the claim for a damaged glider that was partially eaten by cattle in the field where it had landed, he said.

Claims can be especially expensive, though, for fiberglass aircraft, because there are only 20 qualified repair stations in the country and it's expensive to transport a glider to one of those locations, Mr. Costello said. One glider had to be sent 1,500 miles for repairs, he said.

Meanwhile, some AIA members stayed on the ground to get a look at a new helicopter that is the first to have a single main rotor but no tail rotor.

The new McDonnell Douglas MD 520N helicopter, known as the "NOTAR," was parked in the parking lot during part of the AIA conference.

The NOTAR is "the dawn of a new era," said Alan Neugebauer, manager of MD 500 business development at McDonnell Douglas Helicopters Co.'s headquarters in Mesa, Ariz.

The NOTAR also is the first new helicopter in more than a decade to receive certification from the Federal Aviation Administration, which it did last September.

Though originally conceived in 1975, the first seven NOTAR helicopters were only produced and delivered to the Arizona police department late last year. So far, 16 NOTARs have been produced, said Mr. Neugebauer.

The new helicopter is safer without a tail rotor, he maintained. The U.S. Army in 1985 found that 20.6% of all helicopter fatalities were due to malfunctioning tail rotors, he said.

Among its other qualities, McDonnell Douglas claims that NOTAR is 50% quieter than other helicopters.

Each aircraft costs about $665,000.

A special factory-sponsored insurance program is available for NOTAR owners through McDonnell Douglas Helicopter, according to Rosie Stout, assistant vp of The Daniel & Henry Co. in St. Louis, which arranged coverage for the program.

The coverage is underwritten by Southern Marine & Aviation Underwriters Inc. and is administered by Daniel & Henry.

Ms. Stout said the NOTAR program includes:

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Aircraft firms in tailspin

Defense lawyer sees a solution: liability reforms

By STACY SHAPIRO

SCOTTSDALE, Ariz.—"General aviation is sick."

AIA CONFERENCE

That assessment comes from George S. Petkoff, a defense lawyer who argues that product liability lawsuits and soaring insurance premiums have debilitated the light aircraft manufacturing industry.

He urges other defense lawyers, aviation product liability underwriters, brokers and manufacturers to back new legislation in Congress designed to reduce the number of product liability claims against light aircraft manufacturers.

Mr. Petkoff of Petkoff & Lancaster in Memphis, Tenn., spoke at the annual Aviation Insurance Assn. conference, held earlier this month.

"Cessna Aircraft Co. once employed 16,000 to 20,000 people," he said. But in 1986, it had 3,600 employees "and it faced $20 million per year in claims, defense costs and liability premiums." This expense related to claims stemming from airplanes that Cessna no longer was producing, Mr. Petkoff said.

Piper Aircraft Corp. had 1,600 employees in 1990; it now has 400, he said.

Beech Aircraft Corp. was sued 203 times from 1983 to 1986, according to Mr. Petkoff. "Beech won most of these cases, but it spent approximately $530,000 defending each case," he said.

U.S. General Aviation Aircraft Corp.'s deliveries "have literally dropped off the charts," said Mr. Petkoff. From 18,000 units in 1979, deliveries fell to 1,440 in 1990 and to 1,021 last year.

The largest single expense to light aircraft manufacturers is product liability coverage.

That is true even though 85% of accidents are found to be due to pilot error and 10% to other causes, Mr. Petkoff said. "Only 5% (of losses) were caused by an equipment failure or product failure of some kind."

"If manufacturers do not build the airplanes, underwriters can't write the policies," said Mr. Petkoff. "Agents and brokers can't place risks. Adjusters can go play golf and good defense attorneys will have to handle divorce cases.

"I hate handling divorce cases, so I ask you to please do something about this and support your local defense attorneys. If you don't want to support your local defense attorneys, then support yourselves and support your industry, and get behind your Congresspersons and support" the General Aviation Accident Liability Standards Act of 1991 and Product Liability Fairness Act.

The aviation liability bill is sponsored in the Senate by Sen. Nancy Kassebaum, R-Kan., and has a companion measure in the House of Representatives, H.R. 2815. The legislation would provide uniform standards of liability for harm arising out of general aviation accidents.

First proposed by Sen. Robert Kasten, R-Wis., in 1981, the product liability measure, S. 640, has been reintroduced in each successive session. Its latest setback in the Senate came earlier this month (*BI*, May 18).

The legislation is not a cure-all but it can make a difference, said Mr. Petkoff.

For years aviation manufacturers have lobbied for similar measures. Product liability proposals have been introduced "as far back as I can recall"—including some from a task force set up by President Carter—but to no avail, said the attorney. Strong opposition has come from plaintiffs' lawyers.

"This is an election year and your support could make a difference," Mr. Petkoff said at the AIA conference. "Don't sit back and look to others to change things."

Meanwhile, Mr. Petkoff gave an update on aviation-related litigation over the past few years, some of it important and some just unique. Among the cases are:

• *Eastern Airlines Inc. vs. Floyd, et al.*

Last year the U.S. Supreme Court held that airline passengers aboard an international flight cannot sue for mental anguish caused by a near ditching unless they also suffered physical injuries (*BI*, April 22, 1991).

"The justices unanimously ruled that Eastern Airlines could not be forced to pay passengers aboard an Eastern flight for mental anguish alone (in the absence of physical injuries) after all three of the jet engines failed on the airliner en route to the Bahamas," said Mr. Petkoff.

This decision "will save numerous insurers a lot of money in the future," he said. It means that in international flights where the Warsaw Convention applies, plaintiffs cannot seek damages for mental distress *alone*, he said.

• *Buonocore vs. Trans World Airlines Inc.*

In this 1990 ruling, the 2nd U.S. Circuit Court of Appeals found that TWA was not liable under the Warsaw Convention for the death of a passenger. The passenger, John Buonocore III, was murdered during a terrorist attack at Da Vinci Airport in Rome, said Mr. Petkoff. He was scheduled to depart at 11 a.m. and arrived at Da Vinci sometime before 9 a.m., as TWA had instructed.

He checked his luggage, received a seat assignment, boarding pass and baggage claims ticket at the TWA departure counter. As he was walking away from the departure counter, he was gunned down by terrorists wielding machine guns.

In a wrongful death action, Mr. Buonocore's parents alleged that TWA was liable under Article 17 of the Warsaw Convention, which imposes liability on airlines for injuries that occur in "the course of any of the operations of embarking or disembarking," said Mr. Petkoff.

TWA claimed that Mr. Buonocore was neither embarking nor disembarking at the time of the attack. A U.S. District Court agreed, saying that he was murdered while waiting in a public area. The 2nd Circuit upheld the decision.

Continued on next page

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Aviation liability

Continued from previous page

• Several lawsuits against helicopter manufacturers, including a 1990 product liability ruling in U.S. District Court in Honolulu against Bell Helicopter Textron Inc.

The suit was brought in 1988 by the pilot of a helicopter who was injured when it lost power shortly after takeoff and plunged to the ground.

"The plaintiff alleged that the helicopter, which was 13 years old at the time of the crash and had been resold at least seven times, was defectively designed and manufactured," said Mr. Petkoff. The injured pilot also alleged that the pilot's seat and seatbelt were designed defectively, exacerbating the injuries, he said.

His claim was dismissed, at least in part because the four-year statute of limitations had already run on any claims for breach of warranty, expressed or implied. The helicopter was first delivered in 1973.

• A suit in Florida state court by Princess Zsa Zsa Von Anhalt, better known as Zsa Zsa Gabor, against Delta Airlines.

This dispute, said Mr. Petkoff, began with Ms. Gabor refusing to allow a flight attendant to stow her carry-on bag. After an exchange of words, she was involuntarily removed from Delta Flight 462. She was escorted off the aircraft at an intermediate stop in Atlanta and denied permission to reboard.

In her lawsuit, Ms. Gabor sought compensatory and punitive damages in excess of $10 million for her alleged wrongful ejection, according to Mr. Petkoff.

Agreeing with Delta, a Florida court in 1990, dismissed the action on the grounds that it lacked jurisdiction under the Federal Aviation Act.

However, the court noted that the plaintiff could reassert her claim against Delta under a federal law that would "challenge the reasonableness of Delta's action," Mr. Petkoff commented. ■

Communicating GICs

Continued from page 3

is minimization of risk," he advised.

Until a year ago, the conventional wisdom about GIC communications was "the less said the better," but changes in the legal and investment environment have signaled the need for a new approach, he said.

On the legal front, Mr. Veeneman said, a draft of proposed Section 404(c) regulations by the Labor Department requires plan sponsors provide sufficient information to plan participants so they can make informed investment decisions (see story, page 18).

Furthermore, most people a year ago assumed GIC investments were risk-free. However, in light of the Mutual Benefit Life Insurance Co. and Executive Life Insurance Co. failures, many now know "they are not entirely without risk," he said.

At the same time, fixed-income rates have declined, which caused a general decline in GIC rates. As a result, many people now conclude that "GICs are no longer the simple choice that they were once thought to be," he said.

Mr. Veeneman said factors that should be communicated to plan participants include:

• Characteristics of GICs.

Plan sponsors should tell plan participants that GICs are carried at book value, which is the value of the guaranteed principal and interest of the GIC contract at its termination. They should also stress that these contracts are not guaranteed by the federal government nor the plan sponsor and describe in "plain English" what these risks might be, he said. "If you do nothing else, please avoid using the name 'guaranteed.' "

• Investment objectives of the GIC fund, including the general types of contracts being purchased, the average maturity of the contracts and the portfolio structure.

• Issuer selection standards, including the types of GIC issuers in the portfolio, the minimum quality standards for issuers, the number of issuers in the portfolio and the percentage of issues held by each issuer in the portfolio.

• Interest earned by the fund.

"Avoid rate forecasts," advised Mr. Veeneman, but discuss the recent history and current rate.

• Events influencing the value of GICs.

"It would certainly be advisable" to look at contracts and see what events could affect what plan participants receive, said Mr. Veeneman. These events would include early withdrawal of funds due to layoffs or early retirement programs, he said.

• The sale of an operating division, which could lead to cash payouts of account balances in the plan.

These are generally paid out at either book value or the current market value, whichever is lower.

• GIC issuer default.

Plan participants should be told who bears the risk in the event of issuer default and what action should be taken.

US West's Mr. Butt said his firm changed its communications strategy in response to plan participants' desire for more information. He noted US West has a $2 billion defined contribution plan, including $300 million invested in GICs and bank investment contracts.

US West is a $28 billion international telecommunications company with 66,000 employees, 62,000 of whom participate in the defined contribution plan.

In addition to its defined contribution plan, it also has an $8 billion defined benefit plan, although the defined contribution plan's assets are expected to exceed those in the defined benefit plan within 10 years.

US West's communications strategy is in the process of changing, said Mr. Butt. Previously, the company provided quarterly statements and occasional articles to participants that "used real small print" and referred questions to the benefits office. But, he frankly admitted, "We hoped to hell participants wouldn't ask questions in the first place."

The company learned, though, that participants want more information, as well as help with their financial planning, Mr. Butt said. With respect to their GIC funds, participants are interested in safety, honesty and timely information, he said.

US West's strategy today is to provide "full and complete disclosure" so that participants can make informed decisions, he said.

Mr. Butt said he recently conducted 18 focus groups with plan participants and found it to be a "real eye opener."

"They are hungry for information," he said. They "want to know how to plan for the future."

Complete disclosure involves giving plan participants information on the issuers, the risks involved and credit quality. Communication vehicles used by US West include quarterly newsletters, as well as an annual report that includes additional information such as data on rating agencies.

The company also has prepared two booklets on its defined contribution plan and will shortly release two more. US West's communication program also includes monthly articles, employee meetings and retirement planning information. In addition, US West now has an toll-free number that plan participants can call for more information, which by the end of the year will provide full-service, "one-stop shopping," enabling them to make any desired change in their plans.

Mr. Butt said US West plans a video presentation as well as a "town hall" presentation that will be presented simultaneously to various US West sites and enable plan participants to call in questions. It also is planning to introduce interactive personal computer programs and financial planning services.

"A lot of us will be doing more of that in the future," Mr. Butt said, referring to financial planning services.

The rewards of US West's revamped communication approach, said Mr. Butt, include improved participation, better preparation for participants' retirement and reduced litigation risk.

Kellogg's Mr. Reott said 2,500 of his company's 3,500 employees participate in a 401(k) plan. The plan contributes 75 cents for every dollar that plan participants contribute, up to 6% of salary, though employees are permitted to contribute up to 16% of their gross pay.

Kellogg offers three investment funds: a fixed-income fund that is invested strictly in GICs, a Standard & Poor's 500 fund and a balanced mutual fund.

The company follows four basic communications strategies, he said. These are:

• An electronic bulletin board, which uses monitors located on every floor near the elevator to provide periodic information on the plan.

• The company's personal computer network, which is accessible by approximately 95% of its employees.

• Its in-house newsletter, Houston Headlines.

• Quarterly statements.

Mr. Reott said with about 60% of employees' funds in the fixed-income fund, Kellogg is trying to educate its employees about GICs. "They need to think about diversification," he said.

While conventional wisdom dictates that only young people should invest in equities and older employees should invest in more conservative, albeit lower-yielding funds, this is not necessarily true, said Mr. Reott. A participant who is 65 years old could still live another 20 years and should also consider whether staying with a fixed-income fund is advantageous, he said.

"We want to get the word out to employees there are other alternatives to GICs," said Mr. Reott. But the firm still plans to continue to offer GICs, he said. "We're happy with the GIC fund. We're not running for cover at this point," he said.

The session was moderated by Marc Katz, principal of MK Financial Management, based in Fresh Meadows, N.Y. ■

Educate industry on advantages of buying GICs, executive urges

By JUDY GREENWALD

ORLANDO, Fla.—The insurance industry is failing in its duty to educate pension plan sponsors about the benefits of guaranteed investment contracts, says an insurer executive.

GIC

Judith Markland, vp at Boston-based John Hancock Financial Services, a major GIC issuer, urged insurers to put forth an education effort in her address during "GICs '92," a symposium sponsored last month by the New York-based Institute for International Research.

In response to the Executive Life Insurance Co. and Mutual Benefit Life Insurance Co. failures, plan sponsors have been anxiously seeking a variety of alternatives to traditional guaranteed investment contracts in order to avoid over-concentration in the insurance industry (*BI*, Nov. 18, 1991).

These alternatives include synthetic GICs, which are products whose assets are generally U.S. Treasury, government agency or high-quality corporate bonds. Assets are generally owned directly by the plan.

The synthetics have a "wrapper" provided by a financial institution that guarantees book value of the assets. Book value accounting permits employers to report to employees that their contracts are valued at the interest and principal due at maturity.

Some plan sponsors also have introduced funds, including U.S. Treasury note or bond funds, that are reported at market value and do not have the benefit of book value offered by guaranteed investment contracts.

Some industry observers estimate that in the turmoil created by the Executive Life and Mutual Benefit debacles, investments in traditional GICs may be down by as much as one-third as pension plan sponsors revise their portfolios.

But there are risks in these alternative plans that sponsors are not recognizing, and it is the insurance industry's job to point these out, said Ms. Markland, who gave the concluding speech at the conference.

Ms. Markland commented that a lot has happened in the past year, much of which is evolutionary, much of which is regressive "and much of it in fact is destructive."

She said she questioned whether the industry has fulfilled its collective responsibility to help people understand the emerging new marketplace.

She told an anecdote about a friend whose company abandoned the GIC marketplace for a bond fund at the urging of a consultant when in fact its high-quality GIC portfolio was performing well.

"I think it's a failure on our part" that the adviser could not be convinced of the value of the basic GIC fund, Ms. Markland commented. Comparable incidents have occurred elsewhere, she added.

"Maybe the industry has been trying so hard to catch up and come up with new products and management styles in keeping with the new marketplace that we've lost our bearings a little bit," said Ms. Markland. Maybe "it's time to take stock."

GICs offer a number of advantages, she said. Insurers assume financial risk and have the capital structure needed to do so, she explained. And if plan sponsors diversify away from insurers, they either must find collateral for their fund assets, accept lower U.S. Treasury yields or assume more risk.

Assuming risks is fine, but only if the risks assumed are understood, said Ms. Markland, adding that the insurance industry has failed to communicate this. "How many of us are taking the time and trouble to put that out to people and remind them of that?

'There's enormous potential for abuse' among alternative products, says Ms. Markland.

"We have an obligation to explain that this is a nice instrument," she said of insurer-issued GICs. If the industry cannot do that, it should not be surprised if it loses market share, she said.

Furthermore, despite Executive Life and Mutual Benefit, the risk of GIC default is small.

"But have we managed to explain that to anybody?" she asked rhetorically.

While insurers have explained this to their individual customers, "I think no one has done it in the marketplace at large," she said.

Ms. Markland said she is not against alternative products per se. They demonstrate progress and can offer flexibility and an attractive yield. "But many times, that yield comes in a package with a lot of extra risk," and it is not always in participants' best interests to diversify away from the insurance industry.

"There's enormous potential for abuse here," she said.

While diversity of risk is important, it is also important that decisions be made appropriately, said Ms. Markland.

People also should be educated that value may or may not be synonymous with the highest yield, she said.

And people must be reminded that "there's no free lunch," said Ms. Markland.

The only risk-free investment is U.S. Treasury notes. Otherwise, some risk is always present, she said. ■

Monitoring a company's GIC portfolio

By JUDY GREENWALD

ORLANDO, Fla.—The work does not stop once a guaranteed investment contract issuer is selected.

GIC

"There's much to be done after a placement," said Marjorie E. Zwick, principal with William M. Mercer Inc. in New York. Ms. Zwick spoke last month at "GICs '92," a seminar sponsored by the New York-based Institute for International Research.

Portfolio monitoring, including monitoring for creditworthiness, is one responsibility sponsors must handle. She recommended reviewing a portfolio issue by issue.

A regular review of contract restrictions should be conducted, as well as a review of the administrative side of the relationship.

An issuer can be evaluated on a variety of standards, said Ms. Zwick, including: rating information, asset quality, liquidity, its ability to raise capital, how well its business is doing, its diversification and its relationships with affiliates.

Plan sponsors also should take into account what is going on in their own organizations, like divestitures and demographic changes, said Ms. Zwick.

Other issues to be considered include the percentage of the portfolio issuers hold and maturities. "Use common sense," said Ms. Zwick, and consider any portfolio problems along with plan participants' needs.

Steve Schaeffer, portfolio manager of ICMA Retirement Corp., a Washington, D.C., firm that invests in GICs on behalf of local governments, noted, however, that if a Triple-A rated issuer is downgraded, a concerned plan sponsor's options are limited.

The plan sponsor could buy additional insurance or credit enhancements on the existing contract. Such coverage is relatively expensive. But because the rates are generally calculated on the assumption that there will be a 100% loss, if a plan sponsor can figure out what that actual loss will be, the cost might be lower.

Another option is to work with the issuer, said Mr. Schaeffer. Do not "sit back with your hands folded." Keep on top of the news and monitor participant calls. "Clearly, you have to deal with the uncertainty that's going to happen," he said.

Yet another option is to renegotiate your contract, although companies with problems are unlikely to agree to this, said Mr. Schaeffer.

Plan sponsors also can discontinue contracts. Among the problems associated with this, however, is that the sponsor will lose credibility with other issuers.

Mr. Schaeffer cautioned sponsors about cutting GIC options altogether for plan participants. "It seems a real need for people," and terminating the option "can cause a significant amount of ill will," he said.

It is also the most popular 401(k) option, in part because participants do not want to have money put into a fund where investments are accounted for on the basis of market value.

Mr. Schaeffer also analyzed the consequences both of taking action and of doing nothing when there is concern about an issuer.

If a plan sponsor discontinues a contract, and it turns out that its concerns are justified, it could help cause a run on the bank. The problem "becomes self-perpetuating," he said.

But if the sponsor is wrong, it has jumped the gun and caused unnecessary costs to plan participants. Jumping the gun also will hurt the sponsor's insurance industry reputation, and "that's something you really want to maintain," said Mr. Schaeffer.

If a plan sponsor does not act and nothing happens, "you go on from there." But if the sponsor does nothing and the insurer goes under, the sponsor will "go down with the ship" and "wait for an uncertain resolution, to say the least," said Mr. Schaeffer. Litigation and a "lot of second guessing" could result, he said. And there also is the question of who pays the loss.

Do not 'sit back with your hands folded,' after an issuer is downgraded, says Mr. Schaeffer.

Those who should be kept informed of developments include the plan sponsor's board of trustees and investment committee, as well as plan participants.

Good communication is critical, said Mr. Schaeffer. "I can't emphasize enough the importance of that," he said.

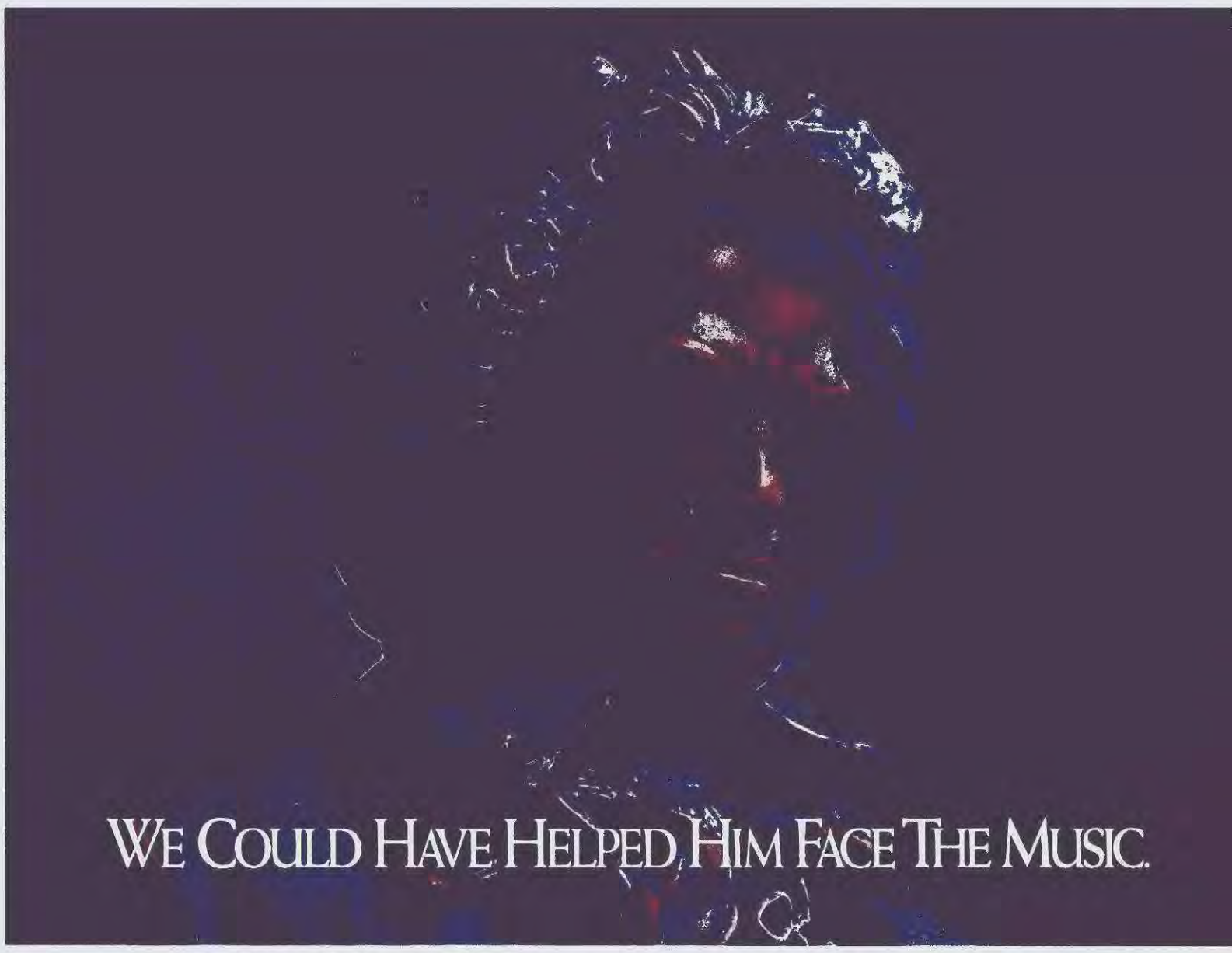
Discussing what can be learned from dealing with a troubled issuer, Mr. Schaeffer said that in an ideal world, all contracts would have termination provisions. As it is, before entering into a contract, plan sponsors should make sure there are market value adjustment features in the event of problems.

Investment guidelines should be established to prevent over- or under-diversification. Having more control over what is going on is also desirable for sponsors, he said.

Assuming that the plan sponsor is still committed to the GIC option, the plan should offer competing options, like money market or U.S. Treasury funds, said Mr. Schaeffer. Renegotiate contracts, he suggested, and consider professional help if you feel overwhelmed.

If the plan sponsor is not committed to the GIC option, it must choose a replacement. Money market funds are one option, but "I think you're going to have a lot of participant dissatisfaction (with the lower yields) if you make that choice," Mr. Schaeffer stressed.

Also speaking at the session, which was moderated by Ms. Zwick, was Thomas F. McCord, a principal with benefit consulting firm J.E. Stone & Associates Inc. of Houston. ■



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Fiduciary duties in flux

Many forces shape what is expected of plan sponsors

By JUDY GREENWALD

ORLANDO, Fla.—Pension plan sponsors face the daunting challenge of fulfilling their fiduciary duties in a time of rapid change, says a consultant.

GIC

Sponsors need to decide how to respond to factors like economic uncertainty and changing benefit philosophies, said Scott J. Macey, executive vp and general counsel of AT&T Actuarial Sciences Associates Inc. in Piscataway, N.J.

He discussed this changing environment, along with proposed Section 404(c) regulations, last month at "GICs '92," sponsored by the Institute for International Research.

Among the factors that are changing the environment for plan sponsors, he said, are:

- Changing benefit philosophies.
- Evolving plan designs.
- Rapidly changing administrative techniques.
- An increasing shift to defined contribution plans and away from defined benefit plans.
- New fixed-income products.
- Reduced paternalism among employers.

"It's more a partnership approach," he said. "Employees are becoming more and more aware and involved" in their benefits.

- Instability of financial institutions.
- Corporate restructurings.

Mr. Macey also discussed proposed Labor Department regulations that would make it easier for employers to avoid fiduciary liability y for investment decisions made by employees enrolled in defined contribution plans (*BI*, Dec. 24, 1990).

A final version of those rules—known as 404(c) rules after the section of the Employee Retirement Income Security Act of 1974—is expected later this year.

The proposed regulations call for participants to exercise control over the investments. Fiduciaries would not be liable if participants are presented with meaningful choices, said Mr. Macey.

So even if a 60-year-old plan participant decides to put all his funds in stocks just before the market falls 30%, the plan fiduciaries would not be liable per se. They would still be responsible, though, for monitoring the investments and selecting proper investment managers.

Under the Labor Department proposal, participants would have to be offered a broad range of at least three investment alternatives along a "risk-return continuum." These investments would have to be diversified, pooled investment vehicles.

Guaranteed investment contracts would fall under this category, he said.

Based on the proposal, even a single GIC would be considered sufficiently diversified, said Mr. Macey, though he added that this is not necessarily true. Plan participants who invested in an Executive Life Insurance Co. GIC, for instance, may question whether that investment was sufficiently diversified.

A pool of GICs from different issuers, however, would be properly diversified.

Similarly, the regulations also prohibit fiduciaries from offering equity funds that focus on a single industry.

In addition, plan participants should be able to give investment instructions at least every three months, said Mr. Macey. "The frequency depends on the volatility of the individual investment."

Participants must also be given sufficient information to make a choice. Mr. Macey said he understands the final regulation will have more definitive guidelines than those released so far.

Plan sponsors would not be required to follow the Labor Department rules. But sponsors who choose not to comply could, nevertheless, have problems with the courts, he warned.

Another issue of concern to sponsors is the scope of communications that the regulations will require. The proposal would require "much more information and much more disclosure," said Mr. Macey.

And pension plan sponsors also will keep an eye on rules regarding employer securities. Under the current proposal, employer stock is not one of the three required investment options. However, Mr. Macey predicted that employers will be able to offer stock under the final regulations, "hopefully, without too many artificial restrictions."

The regulations are still only a proposal and changes are likely, said Mr. Macey. For instance, he said it is expected that the effective date of the regulations, which is now set for six months after they are approved, will be extended.

To fulfill their fiduciary responsibility, Mr. Macey said, sponsors cannot influence participants' choices and must be prudent in selecting both investment alternatives and managers. The sponsor also is responsible for adequate exposure and "complete and timely information."

Mr. Macey also discussed fiduciary concerns in insurer insolvencies. These include protecting the assets of the plan, where options could include freezing the fund and turning to state guaranty funds.

One area of uncertainty in the insolvency area is disclosure. It is not clear under current disclosure rules what a plan sponsor should do if an insolvent insurer accounts for only a small percentage of the plan, he said. Clearly a sponsor would have to disclose such information if the insurer's GICs account for a "material" part of the plan.

Other concerns, said Mr. Macey, include whether the selection of the investment was prudent; what employees were told about the investment, and whether the plan sponsor should become involved in the insolvency proceeding. ■

Synthetic GICs will erode GICs' market share: Expert

ORLANDO, Fla.—Insurance company-issued guaranteed investment contracts are unlikely to repeat their rapid 1980s growth in this decade, an investment manager says.

GIC

Martin H. Ruby, chief executive officer of Analytical Risk Management of Louisville, Ky., discussed the future of insurer-issued GICs at a session on credit enhancement strategies during last month's "GICs '92" conference, sponsored by the Institute for International Research.

Mr. Ruby said one major factor likely to prevent insurer-issued GICs from enjoying the growth rate of the 1980s is the loss of market share to synthetic GICs.

Banks and other institutions are now offering a wide variety of synthetic products—instruments often backed by government agency obligations, U.S. treasury notes, high-quality corporate bonds or similar investments. Assets generally are owned directly by the plan, which is not the case with traditional GICs.

Slowing growth in 401(k) plans, for which GICs are a popular investment option, also is likely to slow the growth of insurer-issued GICs, said Mr. Ruby.

Furthermore, GIC profits, which have never been high, "will probably suffer even more," he said.

Other likely developments that will affect the GIC marketplace include:

- Increased competition from non-insurers, including mutual funds.
- Continuing commercial mortgage problems.
- A continuing "hard line" from rating agencies.

Mr. Ruby said that in the coming decade, highly rated insurance companies will continue to exploit their advantages. "They have a valuable franchise and can do quite well," he said. But insurers beneath that top tier will need credit enhancement, he predicted.

Also speaking at the session was J. Thomas Morrow, executive vp of Morley Capital Management Inc., an investment adviser in Lake Oswego, Ore., who said plan sponsors should be cautious in moving to GIC alternatives.

Some synthetic GICs "really are detrimental to the management of a GIC portfolio," Mr. Morrow said. Many plan sponsors may not realize the "negative baggage" that comes with these alternatives, he said.

What accounting treatment the alternatives should receive, whether their interest rates are guaranteed and other issues should be considered, he said. The risk of default should also be considered, said Mr. Morrow. "What kind of risks do they entail?"

Look at the ownership or access to the underlying assets, which can be a "literal minefield," he suggested.

Plan sponsors also should investigate their own plan investment guidelines before investing in synthetics, said Mr. Morrow. In many plans, the language must be modified before investing in synthetics would be permitted, he warned.

Also speaking at the session was Peggy Garfunkel, manager-new products and new businesses department at MBIA Corp. in Armonk, N.Y., and Victor Gallo, vp and assistant actuary at the Prudential Asset Management Co. Inc. in Newark, N.J.

—By Judy Greenwald

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Setting up guidelines helps ring up returns

By JUDY GREENWALD

ORLANDO, Fla.—Set realistic guidelines for investing in guaranteed investment contracts, says a GIC consultant.

GIC

Otherwise, it becomes "just an ad hoc process," says C. Jason Psome, principal with Brentwood Asset Advisors in Santa Monica, Calif.

Mr. Psome spoke on advanced investment strategies and tactics last month at "GICs '92," a symposium sponsored by the New York-based Institute for International Research.

Among the issues that must be determined in setting guidelines, said Mr. Psome, is whether the GIC is the focal point of the plan, the likely maximum rate of return and a process for embarking on credit assessments.

"Try to establish credit guidelines," he said. It is important that plan sponsors not limit themselves only to Triple-A rated issuers, he said.

Mr. Psome also stressed the importance of the human resources and treasury departments working together to determine the plan sponsor's GIC strategy. "These two departments must have a free flow of information."

Next, at least two months before the bid process, sponsors should prepare bid specifications. Make sure the specifications are accurate and the data consistent. Monthly cash flow information is particularly important, he said.

"Stay in contact with the underwriters. This is extremely critical," he said. By doing this, the plan sponsor becomes aware of any changes in how bids are set up. It also gives the issuer greater familiarity with the plan.

"Highlight the positive aspects of your plan. . .It really doesn't hurt to let them know what the positives are," said Mr. Psome, adding that the "human factor" will strengthen the bid.

Bid sheets themselves should present data in a concise, readable manner, he said. "Graphs are good if they're relevant," he suggested.

Set up regular bidding intervals, "smooth it out" and be flexible, he suggested. Dollar cost averaging, in which funds are invested slowly over a period of time, permits plan sponsors to stay current with interest rates.

But he cautioned plan sponsors against entering into the market with less than $10 million. Those with less probably should be invested in pooled funds, he said.

While bidding should be done at regular intervals, the plan sponsor should not be held hostage to a particular date. "Set up a theoretical bid date around which you want to make your purchase," said Mr. Psome.

By setting up a bid period of two to three days rather than being confined to a single day, "you can avoid placing on a very low day," when interest rates are not doing well. The bid period should be coordinated with the company's treasury department.

Bid dates should be set on Tuesday, Wednesday or Thursday. On Monday, he said, the market is still dealing with overseas trades from the weekend, while on Friday, the options and futures markets close early.

Also, try to avoid December bidding dates, when insurers may already have used up all of their capacity, he said.

Mr. Psome offered one more warning: "You don't want to be in the market the same day as General Motors (Corp.)." A $1.2 billion bid from GM "is going to artificially depress the spreads you might receive," he said. Furthermore, "You might not get the kind of attention you desire."

Credit assessments also are important. Sponsors that follow a practical set of guidelines can at least protect themselves as fiduciaries.

Outside services should be used for credit analyses, but an internal system—even a simple one—will permit plan sponsors to gauge discrepancies among the rating agencies, he advised.

"You should know where the spreads are" over the U.S. Treasury rates, and be more concerned about this than with absolute returns, said Mr. Psome.

And another important factor —the range of maturities— should be defined in plan-sponsor guidelines, he added.

In determining where to place GICs, sponsors should view the contracts not as securities, but as credit-driven instruments, "a form of corporate debt," he said.

"We would like to see a move toward more efficiency in the GIC market," he said. Plan sponsors should put more pressure on lower-rated issuers to offer higher rates, said Mr. Psome. "We need to see a widening of the spreads over the credit values."

'You don't want to be in the market the same day as General Motors. . . .(Its $1.2 billion bid) is going to artificially depress the spreads,' warns consultant C. Jason Psome. Furthermore, 'you might not get the kind of attention you desire.'

Discussing the "art of closing," Mr. Psome said the focus is to squeeze margins. If a plan sponsor is dealing with two Triple-A rated issuers, let them know, he said. "It's not a problem to let the issuers know who their competition is."

Try to find out which issuers are aggressive and which aren't, and focus on them, said Mr. Psome.

"Know where the markets are. It's important that you gauge yourself," he said. A plan sponsor should have the three most recent weeks of GIC data, even if it is just from The Wall Street Journal, to evaluate the market.

If a sponsor receives offers of identical rates from two issuers, see which one you have in your portfolio—then pick the other one, recommended Mr. Psome. "You want to set up a diversified portfolio," and not just for credit reasons, he said. Next year, the issuer you select will have your money already—which means the administrative costs will be lower—and will bid on your business.

Another tactic to use in choosing between issuers is to ask one of them to give a rate that is one or two basis points above the bid and say they have to get back to you within 30 minutes.

If they say they cannot hit the rate, "go to the next carrier and see if that carrier can move," said Mr. Psome. More often then not, this tactic will be successful, he said.

Documentation has become an important issue, said Mr. Psome. Sponsors should prepare process-bid summary reports that include information about which insurers were contacted in the bid, the second and third runners up, why they were not picked, any post-bid changes and the final rate.

"We can't stress enough" that participants "have become more oriented than ever as to what has been going on in the portfolios," said Mr. Psome.

The bid process should be "matter of fact," he said. "We see it as a chance for some healthy competition in the bidding environment." But it should also be an "extremely relaxed situation for you," said Mr Psome. ■

Much ado about failed issuers

GIC

ORLANDO, Fla.—About 260 people attended "GICs '92, the Sixth Annual Symposium," a conference sponsored by the New York-based Institute for International Research and held last month at Walt Disney World's Grand Floridian Beach Resort in Orlando.

Much of the discussion during the 2½-day seminar on guaranteed investment contracts focused on the impact of the rehabilitations of Executive Life Insurance Co. and Mutual Benefit Life Insurance Co., whose troubles have spurred greater interest among plan sponsors in synthetic GICs, as well as in other alternatives to insurer-issued GICs.

Also discussed during the wide-ranging symposium was plan sponsors' recognition of the need to educate plan participants about their GIC investments.

There were also sessions on accounting issues; on an expected Department of Labor regulation that could affect plan sponsors' 401(k) plans; on strategies for investing in GICs; and on GIC portfolio management.

Next year's symposium has been set for April 26-28 in Scottsdale, Ariz.

A separate one-day conference on synthetics and other GIC alternatives is scheduled for Sept. 30 in New York.

For more information, contact Lauren Schulman at the Institute for International Research, 437 Madison Ave., 23rd Floor, New York, N.Y. 10022-7001, 212-826-3340 extension 3071.

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What spooked Kroger?

Supermarket firm stops buying GICs, citing insurer instability

By JUDY GREENWALD

ORLANDO, Fla.—A major supermarket chain is no longer investing in insurance company guaranteed investment contracts because of concerns about the industry's financial stability.

GIC

"We're not buying any new GICs today," says Richard A. Manka, chief investment officer of all retirement plan assets of The Kroger Co. of Cincinnati, which bought some of its GICs from troubled Mutual Benefit Life Insurance Co.

Mr. Manka spoke last month at "GICs '92," a symposium sponsored by the Institute for International Research.

Mr. Manka said Kroger has $1.4 billion in retirement plan assets, equally divided between defined contribution plans and defined benefit plans.

Of the four funds within the defined contribution plan, the most popular is the company stock fund. The second most popular is a stable-value fund with $200 million in assets.

Kroger's investment objectives for its fixed-income fund, said Mr. Manka, have been to preserve invested principal and earned interest; earn a stable, predictable fixed-income yield; and provide liquidity for participant-directed disbursements.

Kroger's previous investment policy had been to diversify among the top insurance companies; invest the most with the very strongest of those companies; and obtain outside research from rating agencies and others, he said.

But Mr. Manka said Kroger developed several concerns about the rating agencies. One issue has been the significant number of downgrades in recent years. For instance, at year-end 1988, 74% of the companies reviewed by Standard & Poor's Corp. had a triple-A rating, while by year-end 1991, this had declined to 33%.

Meanwhile, 25% of the companies rated by Moody's Investors Service Inc. had triple-A ratings at year-end 1988, while this declined to 7% by 1992.

Another concern is the inconsistencies between S&P's and Moody's ratings, he said. Moody's ratings are generally lower and "in some cases, the difference is really extreme."

Yet another concern, he said, has been the slowness with which the rating agencies have lowered their ratings of both Executive Life Insurance Co. and Mutual Benefit Life.

"These are three reasons why we don't have much confidence in S&P and Moody's," he said.

"We believe the insurance industry is basically sound, but we have a number of fears," said Mr. Manka.

These fears include:

- Concern that the full extent of real estate problems is not known and that real estate values have not bottomed out.

Pointing to the well-publicized problems of real estate firm Olympia & York Developments Ltd., which has since filed for bankruptcy protection, Mr. Manka asked, "How will this affect the real estate industry? We don't know."

- Fears over the new accounting disclosure requirements by the National Assn. of Insurance Commissioners or the Securities and Exchange Commission, or auditors.
- Apprehension about the prospects of federal legislation.

"We fear that Congress may attempt to regulate," said Mr. Manka. "We think about Congress, and we remember these are people who couldn't run the House bank."

- Concern about the quality of press coverage and its potential impact, including a "run on the bank caused by the press."
- Fear about the unpredictability of future insolvencies.

"We fear that there will be possible insurance company failures that will be random, unpredictable events," he said.

Those are the concerns that led Kroger to forego new GICs for its fixed fund in favor of investment in synthetic contracts backed by U.S. government or agency securities, with all securities owned directly by Kroger's plan, Mr. Manka said.

A "wrapper" with a major bank provides book value accounting for these assets. "We very much believe our participants still desire book value accounting," said Mr. Manka. Also, he noted, "we select a principal and interest payment schedule to fit our portfolio."

Beginning with 1990's fourth quarter, half of the fixed fund's cash flow was put into these synthetics, with this boosted to all of cash flow invested beginning with 1991's fourth quarter.

Discussing employee reaction to this change, Mr. Manka noted that participants withdrew 7.5% of the assets in the fixed fund.

"We do not believe this transfer is entirely a result of credit issues," Mr. Manka said, adding that he believes these funds have been invested in equities instead.

Mr. Manka also noted that contributions to the fixed-fund option have actually increased slightly. Furthermore, he said, "very few of our employees have contacted anyone in management" about the change.

Mr. Manka said if trouble is anticipated in connection with an issuer with which Kroger still has a GIC in the future, the company "would do anything possible" as a fiduciary. This would include analyzing the cost of discontinuing the contract, considering liquidating it in a secondary market and pricing credit insurance.

Mr. Manka also discussed the steps Kroger has not taken, at least yet. These include:

- Terminating GICs.

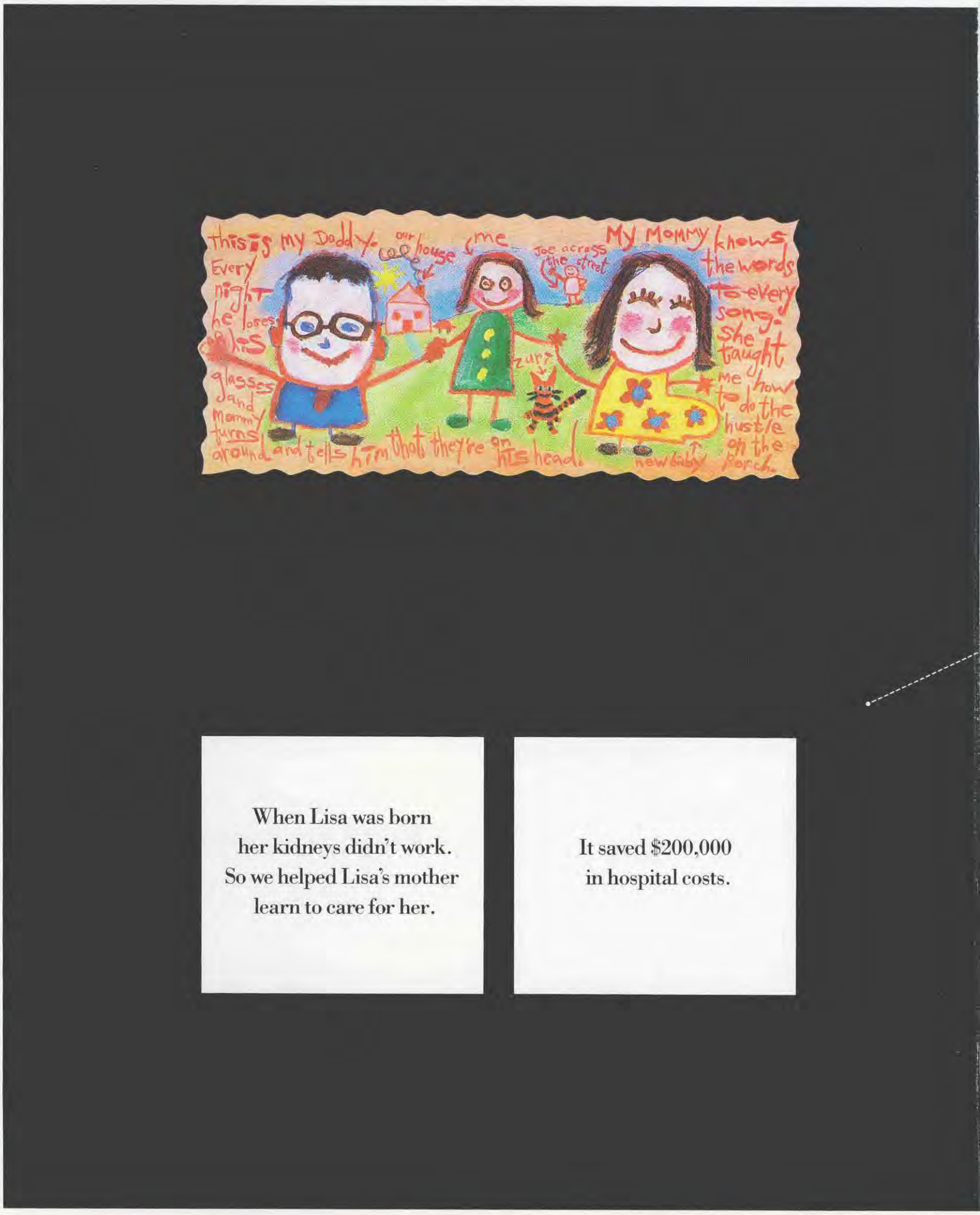
Although Kroger has never liquidated any GICs, "we would do so, if necessary," said Mr. Manka.

- Selling any GICs in the secondary market.
- Investing in insurance company separate-account products. These are GICs whose assets are held in a separate account, with the promise they would be isolated from the insurer's creditors and other policyholders in the event of an insolvency.

Kroger cannot control the cash flow or the structure of these products, and there is also some uncertainty about the status of these separate accounts in the event of an insolvency, said Mr. Manka.

- Investing in any securities that

Continued on next page



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Continued from previous page
require they be reported at fair or market value rather than book value.

Kroger will continue to follow this policy as long as accounting regulations permit it to do so, he said.

- Offering employees any new investment funds, such as a U.S. Treasury bill fund or a bond fund. Kroger's four funds already provide "good diversification," he said.
- Planning for the company to assume losses. Instead, Kroger believes that the most important thing is to use good judgment and to be prudent and selective in its fund management, he said. "That's what's going to protect us" and Kroger employees.

Also speaking at the session was Dan Kohler, who is director of corporate and investment research for the ICMA Retirement Corp. in Washington, which sponsors defined contribution plans on behalf of 3,000 local governments and 15,000 participants. It has a $1.5 billion GIC portfolio.

Mr. Kohler discussed the issue of diversification vs. quality in selecting GICs. While these are two important characteristics, he said, "it's difficult, if not impossible," to have both. The limited number of high-quality GIC issuers is a hindrance to "true diversification among issuers," he said. There is also an administrative argument against holding a large number of small contracts, he said.

ICMA tries to emphasize quality and strives to be as diversified as possible, but "we don't find that's very easy," said Mr. Kohler. He noted that ICMA now has contracts with nine different insurers and is looking closely at synthetics as well.

Mr. Kohler noted the value of internal research, as opposed to relying simply on the rating agencies. It is impossible to rely solely on the rating agencies, he said, "even if you wanted to."

Among the benefits of internal research, he said, is that it helps anticipate "rating events," including downgrades. The purpose of this is not to beat the rating agencies, but to assess issuers' true financial strength, said Mr. Kohler.

By anticipating a rating change, even by a quarter, "you can add significant value to the portfolio." It also allows you time to prepare communications for participants if necessary, he said.

Mr. Kohler also described the three elements of due diligence as a GIC plan sponsor. These are a review process, including a review of rating agency reports; a review of statutory filings and an annual visit to insurers with whom the plan sponsor has a contract. He noted these visits, which took just one hour in 1989, had expanded to four or five hours by 1991.

The purpose of this review is to get answers to detailed questions. Mr. Kohler examines asset quality, capital, real estate investments, and the support of parent or affiliated companies and their earnings capacity. ■

Don't overexplain synthetic GICs

By JUDY GREENWALD

ORLANDO, Fla.—Pension plan sponsors should not be intimidated by the prospect of explaining synthetic GICs to plan participants.

GIC

"Synthetic GICs can be explained to participants, and they can be explained clearly, concisely and without causing anxiety," said Jeremiah H. Chafkin, senior vp and manager, structured fixed income investment management group, at Bankers Trust Co. in New York.

Mr. Chafkin spoke last month at "GICS '92, the Sixth Annual Symposium," which was sponsored by the Institute for International Research of New York.

Synthetic GICs are instruments generally offered by banks and other financial services companies that are usually backed by high-quality assets, like U.S. government obligations, whereby the assets are usually owned by the plan itself.

Explaining to investment professionals the contracts Bankers Trust offers can take 40 minutes, said Mr. Chafkin, but that's "not the right way to explain these products to participants." The basic rule, he said, is: "Keep it simple and keep it brief."

That message does not always get conveyed to plan sponsors. Some Bankers Trust clients like synthetics, but say "there's no way I'm going to be able to explain that to my participants," said Mr. Chafkin.

But, "it can be done briefly and accurately and clearly and without the technical detail that's normally presented," he said.

He gave three basic rules in explaining synthetic GICs:

- "Don't scare employees unnecessarily."

Like doctors, follow the rule of doing no harm, said Mr. Chafkin. If a plan sponsor is introducing a synthetic to foster employee satisfaction, it should not undermine itself by creating anxiety. So do not begin an introduction to a synthetic GIC with a phrase like, "In light of the recent credit crisis. . . ."

- Avoid the temptation to overexplain.

"Don't let your lawyer do this," he said. Bankers Trust went to an attorney concerning its own plan, and the lawyer came up with a two-page discussion "that I didn't understand, and it scared me."

The tendency is to compare how synthetic GICs work with how traditional GICs work. But, he said, "people don't really care about the mechanisms of these investments. What they care about is how the fund behaves."

- Never use the term "synthetic GIC," at least to participants.

The term means nothing to them. It is more helpful to say the fund is buying bonds and entering into agreements that reduce their market value fluctuations, he said.

Plan sponsors also should not use the word "guaranteed" in describing rates, but talk instead about expected rates.

Among the other points that should be made in explaining synthetic GICs to participants, said Mr. Chafkin, are that:

- Fund assets are currently well-diversified among life insurance companies and banks.
- The company decided to further diversify the fund by using the obligations of the U.S. government and agencies and high-quality corporate bonds.
- There is reduced potential for market volatility.

The plan sponsor must explain why changes are being made, the changes that are made and the implications of these changes, said Mr. Chafkin. ■

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ARCO litigation

Continued from page 2

nia for the costs of cleaning up more than 50 hazardous waste sites nationwide (*BI*, Dec. 3, 1990).

Dozens of U.S. insurance companies are named as defendants, including Aetna Casualty & Surety Co., Travelers Insurance Co. and Fireman's Fund Insurance Co. Dozens of foreign insurers, including Lloyd's of London syndicates also are included.

ARCO is seeking a declaration that the insurers, which wrote primary and excess comprehensive general liability coverage for the oil company and its predecessors from the 1940s to the present, are liable for defense and indemnification of all hazardous waste claims filed against the company.

Private parties and government entities, including the federal government, have filed dozens of lawsuits claiming ARCO is responsible for pollution on their property.

ARCO filed its lawsuit in California hoping to take advantage of a sweeping pro-policyholder ruling from the California Supreme Court involving FMC Corp. (*BI*, Nov. 26, 1990).

The California Supreme Court ruled that cleanup costs are covered "damages" as that term is used in the CGL policy.

The California high court also held that coverage should be granted whenever policy language is ambiguous—even when the policyholder is large and sophisticated (see story, page 25).

While this ruling will spare ARCO from having to litigate these particular issues with its insurers, it must still litigate dozens of other issues to win coverage.

'Each side has made compromises' during the negotiations, which are ongoing, says Mr. Goldberg.

And the costs in such mega-coverage disputes can be enormous.

To control the costs, ARCO is attempting to negotiate an agreement with its insurers about what will and will not be discovered during the coverage litigation. Discovery can be one of the more costly aspects of litigation, since each party seeks to uncover hidden information from the other side.

"Each side has made compromises" during the negotiations, which are ongoing, said Mr. Goldberg.

ARCO, for instance, agreed to give up the right to ask insurers for information about reserves, reinsurance coverage and policy drafting history, Mr. Goldberg said.

In addition, ARCO has agreed to accept corporate position papers from its insurers describing how they believe the CGL policy should be interpreted, rather than using discovery to ascertain their positions.

Insurers, in turn, have drastically reduced what they want from ARCO, Mr. Goldberg pointed out.

Originally the insurers asked ARCO for every document relating to every product and process stored or used at the 50 hazardous waste sites.

Insurers have compromised by agreeing to accept written answers to questions from ARCO describing its processes and how the pollution occurred. ARCO also will give insurers a limited amount of documentation relating to the information contained in its written answers.

"There are dozens of compromises that can be made in these negotiations," Mr. Goldberg said of the discovery process. He later declined to disclose any further details about the discovery agreement involving ARCO and its insurers.

Mr. Goldberg said he is hopeful that if ARCO and the insurers successfully curb document discovery, it could be a model for other hazardous waste coverage disputes.

"These agreements could signal a new day in this area of litigation," he said.

As the costs associated with coverage disputes soar, arguably the time has come for some compromises to be made.

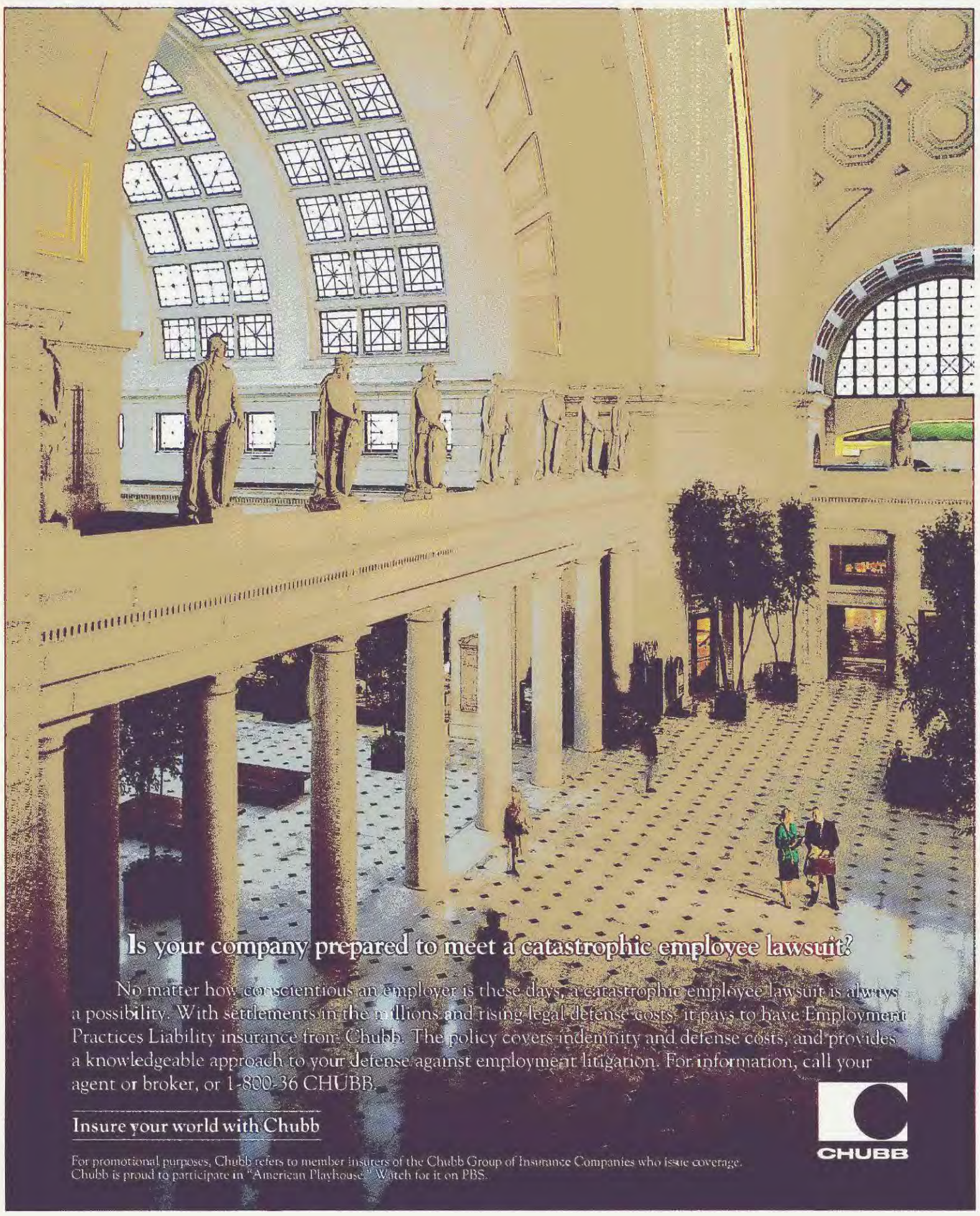
A recent Rand Corp. study showed that insurance companies and policyholders are spending hundreds of millions of dollars in legal fees in coverage disputes (*BI*, May 4).

Examples of exorbitant legal costs in this area of litigation are legion.

When Shell Oil Corp. litigated with its insurers over the coverage for just a single waste site, about 230 witnesses were deposed. When Boeing Corp. litigated with insurers for the costs to clean just two hazardous waste sites, about 150 witnesses were deposed.

Each day a witness is deposed can cost $3,000, and each witness can be deposed for three to four days, attorneys say.

Thus, policyholders and insurers can spend millions in deposition costs just on witnesses. This does not include the vast sums spent on producing and getting documents. ■



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Pension administration

As more demands vex administrators, new systems offer time, cost relief

by John Kelly

PENSION ADMINISTRATION HAS never been easy, but now, as we approach the year 2000, benefits administrators are challenged by increasingly complex and changing issues. Congress has enacted a plethora of pension laws, while at the same time employers are faced with constantly changing corporate structures and more demanding employees.

Employees are no longer content to wait until retirement to access information on pension plan benefits. Even spouses are looking at retirement programs as the source of their own financial security in the case of divorce.

All of these issues generate more work and additional costs for pension plan administrators at a time when they can least afford it. In many cases, technology can offer a form of relief.

Qualified domestic relations orders

If QDROs were the curse of the '80s, they are the plague of the '90s. Introduced in 1984 by the Retirement Equity Act, qualified domestic relations orders provide that a spouse may be entitled to a portion of the employee's pension benefits as part of a divorce settlement. As the legal community becomes more aware of the existence and use of QDROs, a growing strain is placed on pension plan administration.

Unlike defined contribution plans—in which the division of assets is normally a relatively simple matter—pension plan QDROs strike fear in the heart of the pension administrator. Not only do QDROs vary greatly in design and approach, in many cases they will not enter payment status until years after the document has been drafted. By that time, the plan administrator may be long gone.

Recently in Ohio, an employer calculated a pension benefit for a retiree. Upon receiving his first payment, the retiree called the employer to ask if his spouse had also received her payment. No reduction for his spouse had been made. Four years earlier, a QDRO was established and the paperwork had been misplaced. The pension administrator who was in charge when the QDRO was established had since left the company. Fortunately for the employer, the retiree agreed to the reduction in his pension amount. One can easily see that this might not always be the case.

Several East Coast employers also have reported incidents of employees with multiple QDROs. In the case of one employer, four sets of employees had "double QDROs." In another case, employers reported the existence of participants with "triple QDROs"—or a case of three QDRO beneficiaries.

Fortunately, new advanced pension administration systems have built-in QDRO administration features. These systems allow for the tracking of multiple QDRO beneficiaries for a single employee. System "guards" prevent the calculation of pension benefits without recognizing the existence of the QDRO. On letters and statements, a comment appears indicating the existence of a QDRO.

Some systems offer the ability to annotate QDROs so that the involved attorneys can be recorded and referenced later. In addition, these advanced systems can scan in the actual QDRO documents to maintain as a reference. These new "smart systems" also can perform some of the more common QDRO calculations, which saves substantial time and money.

Financial planning

As employees become more concerned about their long-term financial needs, there is an increased focus on qualified retirement plan projection calculations. Employees often seek the help of a professional financial planner whose first advice may be to request pension projections as of several different dates using several sets of assumptions. Likewise, when an employer offers an early retirement window program, the volume of calculation requests on multiple scenarios may become unmanageable. In large window programs, literally thousands of calculation requests may be made in a matter of weeks.

Administrators are faced with increased volume, multiple projection dates per employee and strict legal deadlines for when information must be given to the employee. In one case, as part of a work action, a union group simultaneously requested thousands of pension estimates.

Current technology allows employees direct access to pension estimates and calculations. Employers are using interactive touch-screen systems and voice response systems to transfer pension administration tasks to the employees. This can dramatically reduce both turnaround time and cost. In addition, the quality of the information is better, because there is less human intervention and variation among administrators. Some employers are distributing retirement modeling systems that can be used on a personal computer to assist with the retirement planning process.

Mergers and divestitures

Corporate restructuring has a significant impact on pension plan administration. Spinoffs can generate the need for a large number of calculations in a short period of time. The acquisition of a new unit can require the inclusion of complex grandfathered calculations and, in some cases, dramatically change the data that is stored for pension purposes.

Continued on next page

Reducing losses from storms

Action plan prevents firm from being blown away by net income losses

By The Insurance Institute of America

A.R.M. exercises

The following question and answer are drawn from the curriculum for the Associate in Risk Management designation awarded by the Insurance Institute of America. They represent the types of questions asked on, and possible answers to, the three examinations for the ARM designation.

The focus this month, based on material from a recent national examination in ARM 55—Essentials of Risk Control, is on how an organization can minimize its net income losses stemming from reduced revenues or increased expenses in the wake of violent windstorms. Many of these same measures would be equally effective after any natural disaster.

Q: Hurricanes, tornadoes and other violent windstorms cause net income losses to many organizations whose premises and operations are damaged by these winds. Reducing the severity of these net income losses depends partly on preventing or reducing the physical damage from these storms and partly on controlling other factors that affect the seriousness of an organization's net income loss.

- Identify four factors, other than the extent of physical damage, that influence the severity of an organization's net income losses from any single event, like a hurricane or tornado.
- Explain how, if at all, the extent of the physical damage to the organization's premises by a hurricane or tornado would affect each of the four factors identified in your answer above.
- Briefly describe three specific actions, other than relocating, that an organization can take to reduce the severity of the damage that violent winds may do to its premises.
- Other than reducing the frequency and severity of wind damage to its premises, describe three actions a firm may take to reduce its net income losses from hurricanes or tornadoes.

A: • Among numerous factors (other than the extent of physical damage) that would have earned national examination credit because they influence the severity of net income losses, four of the most important are: the length of time the organization's operations are disrupted by the storm, the degree of disruption, the profitability of these operations at the time of shutdown and the amount of extra expense the organization incurs during the shutdown.

- Of these four factors, the length of time operations would be disrupted by the storm and the extent of the disruption probably are affected by the extent of the physical damage from the storm. The profitability of the organization's operations at the time of the shutdown probably is not affected. The amount of extra expense the organization will incur during the shutdown may or may not be related to the physical extent of the destruction.
- Among many other appropriate answers, three measures that would reduce the extent of the physical damage caused by a hurricane would be, first, to "harden," or make more wind-resistant, the organization's property during its original construction; second, to salvage damaged and undamaged property after the storm subsides; and, third, to remove portable items of property to a safer location outside the hurricane zone.
- Regardless of the extent of storm damage to the premises, one of the best ways an organization can reduce its resulting net income losses is to minimize its continuing normal operating expenses until the organization can resume operations. Second, the organization should consider incurring extra expenses to restore operations as soon as possible, perhaps in substitute facilities. Third, as soon as a definite resumption date is set, the organization can advertise its forthcoming reopening to attract both old and new customers. ■

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

Pension administration

Continued from previous page

New-generation pension administration systems provide flexible benefit calculation facilities. Determining an accrued benefit for a division is no more difficult than for an individual. Systems also provide for actuarial data transfer on demand so that liability calculations are simple and quick.

Shorter vesting periods

The shorter vesting periods over the last few years have in many cases doubled the work and cost of pension administration. With a 10-year cliff vesting schedule, 100 employees might become vested in a year; with a five-year cliff vesting schedule, 200 pension determinations may need to be made. Older automated solutions were not built with this volume in mind. In addition, the number of vested employees and retirees is increasing, causing a need for better tracking of inactive employees.

New approaches in pension systems emphasize the integration of data with calculations. They store active data as well as inactive data, including information on retirees and terminated vested participants. Service histories are recorded rather than a service amount. In the case of rehired employees, the system records detailed information on breaks in service and leaves of absence. This approach adds flexibility and is useful when explaining the calculation of service credits to employees. Most modern systems generate a computer report that can be substituted for Schedule SSA for inclusion with the Internal Revenue Service's Form 5500.

New software technology also allows standard word processors to work in conjunction with some pension administration systems. This provides the flexibility to modify individual letters quickly and efficiently, thus saving large amounts of time. A variety of letters can be produced, including final calculation letters, worksheets, forms, estimate letters and letters to the trustee.

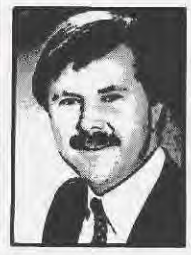
Human resource management systems

Human resource management systems are becoming more powerful. However, they can be weak in the area of benefits administration, especially pension administration. This weakness is generally caused by the customized manner in which benefits and pensions are administered.

Companies would rather not duplicate the same information in various systems. And, as employers downsize their human resources/payroll systems to personal computers, there is a need for pension administration to follow.

Recent advancements in software have led to greater connectivity between systems and the ability to store and access pension information directly from a human resource management system. Complex pension systems, even for large employers, can be installed on a network of personal computers.

Pension administration has never been easy, and the changing corporate environment will only increase the challenges faced by plan administrators. In order to keep up with increased demands while controlling costs, pension administrators will look to technology to meet their management and communication needs. ■



John Kelly is a consultant in the Boston office of Wyatt Software Services Inc., a subsidiary of The Wyatt Co.

Terminology without tears

Glossary takes the mystery out of insurance industry jargon

Glossary of Insurance and Risk Mangagement Terms (fifth edition)
Published by the International Risk Management Institute, 12222 Merit Drive, Suite 1660, Dallas, Texas 75251-2217
$18

By Kevin M. Quinley

Books & ideas

LAWYERS SPEAK AND WRITE in legalese. Doctors use 50-cent words derived from Greek and Latin origins. Each profession has its own lingo, argot, nomenclature and jargon.

Risk and insurance management is no exception. New risk managers and even experienced insurance professionals encounter unfamiliar insurance terminology. Although we may criticize the use of jargon over simple terms, every discipline tends to develop its own vocabulary.

The fifth edition of the Glossary of Insurance and Risk Management Terms by the International Risk Management Institute offers relief. It provides the definitions we all need in a format that is practical, usable and understandable.

This updated reference source has the key features to make it a "must have" reference for risk professionals of the '90s. The text has many user-friendly features, including:

- Definitions of more than 1,300 key insurance and risk management terms and phrases in language that risk managers can understand and apply.
- A glossary of more than 500 frequently used abbreviations and acronyms.
- A directory of state insurance departments in all 50 jurisdictions, complete with addresses and phone numbers.
- A directory of more than 90 risk management and insurance organizations and associations.

Keeping current with insurance terminology is like trying to hit a moving target. Old terms fall out of usage and new ones come into vogue. Ten years ago, would anyone have believed, for example, that we would find ourselves talking so much about "tails"? Many new terms were made necessary by extensive changes in commercial lines policies drafted by the Insurance Services Office Inc. in the 1980s. Hence the need for an updated edition of this reference.

This glossary is the insurance and risk management equivalent of a Swiss Army knife. For insurance agents, brokers and underwriters, this is a quick source for practical and accurate definitions that may be unfamiliar to them or to their clients. As a promotional item, it would be a very effective marketing tool for existing or prospective clients.

For risk managers and insurance buyers, this slim volume also will be a boon. It gives quick answers to questions involving unfamiliar terminology used in insurance proposals and risk management reports. It also can help risk professionals write more effective reports to management—always a plus—by explaining subtleties behind the jargon.

The reference book is not a tool just for the top offices in the organization. This glossary also can be used effectively up and down the organizational chart. Word processing and support staff personnel will find this dictionary a handy tool.

Risk management and insurance terminology can be confusing to all but the most seasoned clerical personnel. Use of the glossary can save valuable time and help eliminate embarrassing goofs in written documents. The definitions and handy acronym/abbreviation translations also can be useful tools in staff training programs.

In Canada, there exists a group of people who refuse to speak English. They tend to reside in Quebec and are called Separatists. In the United States, some believe, they are called actuaries.

The IRMI glossary, which provides English translations of terms used by the actuarial profession, is well worth the cost. ■

Kevin M. Quinley is vp of risk services for MEDMARC Insurance Co. Inc. and subsidiary Hamilton Resources Corp., both of Fairfax, Va. Mr. Quinley holds the Chartered Property & Casualty Underwriter and Associate in Risk Management designations.

Insurer ordered to defend club in bias suit

Legal briefs

A country club's discriminatory action constituted an "eviction" within a commercial general liability policy's definition of personal injury obligating the insurer to defend the club, according to an Arkansas appellate court.

Insurance Co. of North America issued a commercial liability insurance policy to the Forrest City Country Club, a private club that operated tennis courts and a golf course for members and guests. The policy required the insurer to defend any suit seeking damages for "personal injury."

Personal injury was defined, in part, as an injury arising out of enumerated offenses including wrongful eviction of a person from a room, dwelling or premises that the person occupies. In April 1988, Theresa Whitfield, a black high school student, was advised after she arrived at the club that she could not play at the club's tennis court because of club rules regarding race. She was then transferred to a civic center court to play her match. Ms. Whitfield filed a civil rights action in federal court alleging violation of federal antidiscrimination laws, as well as for the tort of outrage. The insurer filed this action seeking a declaration that it did not have a duty to defend the club. The trial court ruled against the insurer.

On appeal, the insurer argued that the facts alleged by Ms. Whitfield in her civil rights action did not constitute an "eviction" from the club property under the policy terms. The insurer maintained that "eviction" should be construed as a term limited to interference with a tenant's enjoyment of property. However, the court said the term, as used in the policy, was ambiguous and could, in the popular sense, also mean merely to force out or eject.

INA vs. Forrest City Country Club, Court of Appeals of Arkansas, Nov. 20, 1991 (*BI*/05/Ju.-$10).

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

Insurers play hardball in cleanup disputes

By STACY GORDON

NEW YORK—Policyholders litigating with insurers for coverage of environmental cleanup costs must brace themselves for a grueling battle in which the insurers likely will portray the policyholder as a willful polluter, an attorney says.

Insurance companies attempt to deny coverage for cleanup costs by proving that the policyholders expected or intended the pollution, he says.

"Policyholders are being put on trial by their insurance companies," said policyholder attorney Jordan Stanzler of Anderson, Kill, Olick & Oshinsky in New York.

"The insurance company that is supposed to be the protector becomes the prosecutor."

Mr. Stanzler discussed the inner workings of pollution cleanup coverage disputes at "Environmental Insurance Coverage Claims and Litigation: 1992 and Beyond," a seminar sponsored by the Practising Law Institute in New York earlier this month.

Most policyholders are sued by state or federal agencies for environmental contamination under the Comprehensive Environmental Response, Compensation & Liability Act. Better known as Superfund, the law imposes strict liability.

Under strict liability, the government is not required to prove that the policyholder recklessly or even negligently polluted the environment, Mr. Stanzler noted.

However, insurers point to language in the comprehensive general liability policy that defines an "occurrence" as "an accident, including injurious exposure to conditions, which results, during the policy period, in bodily injury or property damage neither expected nor intended by the insured."

Insurers have taken "neither expected nor intended" as an invitation to delve into the historical waste handling practices of the policyholder to prove intentional pollution, he said.

"Insurance companies have put their policyholders on trial in insurance coverage disputes in an attempt to show that their policyholders are intentional polluters who are undeserving of coverage," he said.

As a result, a policyholder's past environmental practices "are subject to a microscopic examination," he said.

One way insurers attempt to prove that policyholders intentionally polluted is by questioning former employees and people who formerly lived near the waste sites, he said.

"Insurers will go back 20 to 30 years questioning former employees about waste handling practices," he warned.

One example of this strategy working is the Shell Oil Co. litigation (*BI*, Dec., 26, 1988).

Shell had sought to recover $1.8 billion in insurance for a massive cleanup at the Rocky Mountain Arsenal near Denver. Shell operated a chemical plant at the site for some 30 years.

Insurers in the case were successful in discovering former Shell employees who testified that they were told to remove dead ducks from ponds at the arsenal. This was powerful evidence that helped to lead a jury to conclude that Shell must have known it was polluting, according to attorneys.

"Policyholders must be prepared to have every rock overturned," warned policyholder attorney Peter Kalis of Kirkpatrick & Lockhart in Pittsburgh.

Messrs. Stanzler and Kalis said these invasive discovery tactics often intimidate policyholders into not pursuing coverage for environmental claims.

Policyholders fear being portrayed publicly as a willful polluter, they said.

But policyholders need not be frightened by insurers' "expected or intended" defense, they say. There are several tactics policyholders can use to overcome this argument.

First, they can argue that if an insurer provided liability coverage to a company for 20 years, the insurer must have been aware of the policyholder's waste handling practices, said Mr. Stanzler.

He noted that insurers conduct plant inspections and provide loss control services to policyholders.

As a result, it is disingenuous for an insurer to argue 20 years later that what the policyholder did was wrong, he said.

Second, policyholders have been successful in arguing that the purpose of liability insurance is to protect companies against negligent acts, said Mr. Stanzler.

"Only if the conduct is willful is coverage denied."

Finally, Mr. Kalis suggested that policyholders retain experts who can testify as to how the pollution came about. Also valuable are experts who can testify that the policyholder's waste handling activities were the best available at the time, he added.

Mr. Kalis said it is important to teach juries that they cannot judge what policyholders did 40 and 50 years ago by 1992 standards of technology.

"You must create a time machine that takes the trier of fact back to the time of the contamination and waste handling," he said. ■

Unclear wording favors large policyholders

By STACY GORDON

NEW YORK—A New Jersey state court judge has ruled that coverage should be granted whenever ambiguous policy language is used, even when the policyholder is a large and sophisticated company.

In one of the largest coordinated coverage disputes in the nation, Superior Court Judge Lawrence Weiss ruled May 6 that although Westinghouse Electric Corp. is a large and sophisticated policyholder, ordinary rules of contract interpretation must apply. Thus, ambiguous wording must be construed in favor of the policyholder.

Pittsburgh-based Westinghouse is suing more than 140 of its property and liability insurers, seeking defense and indemnification for the costs of cleaning up 135 hazardous waste sites in 31 states, Puerto Rico and Australia, and to respond to more than 3,000 bodily injury claims alleging exposure to toxic chemicals (*BI*, May 29, 1989; Sept. 28, 1987; June 15, 1987).

Judge Weiss in 1990 coordinated the Westinghouse litigation with four other hazardous waste coverage cases pending in Union County, N.J. The cases are being coordinated for pretrial rulings, but will then be tried separately. The Westinghouse case—which is being closely watched by policyholder and insurer attorneys nationwide—is scheduled to go to trial Feb. 1, 1993.

Judge Weiss' bench ruling was reviewed by Westinghouse attorney Peter Kalis of the Pittsburgh law firm Kirkpatrick & Lockhart during "Environmental Insurance Coverage Claims and Litigation: 1992 and Beyond," a conference sponsored by the Practising Law Institute in New York earlier this month.

"The judge rejected the insurers' argument that sophisticated policyholders" should have their policies interpreted differently from other policyholders, Mr. Kalis said.

The decision is significant because New Jersey is an important jurisdiction for policyholders, he said. Many policyholders, like Westinghouse, file litigation over massive coverage disputes in New Jersey, seeking to take advantage of many pro-policyholder rulings that have been handed down by New Jersey courts, he explained.

"New Jersey is to environmental coverage disputes what Wimbledon is to tennis," quipped Mr. Kalis.

State and federal courts interpreting New Jersey law have found the pollution exclusion ambiguous and, in applying standard rules of contract interpretation, have adopted the meaning most favorable to the policyholder.

'All ambiguities will be resolved in favor of the insured,' according to Judge Weiss' ruling.

However, insurers in the coordinated case argued that they should be allowed to investigate what Westinghouse and the other policyholders believed their policies did and did not cover at the time they purchased them. Specifically, they sought to prove that the policyholders knew gradual pollution was excluded by the pollution exclusion.

The pollution exclusion bars coverage for all pollution that is not "sudden and accidental." Insurers argue that this bars coverage for all pollution that does not occur abruptly.

Policyholders, on the other hand, argue that the exclusion only bars coverage for intentional pollution.

The insurers believed they could show that Westinghouse and the other policyholders knew when they purchased CGL policies that the pollution exclusion barred coverage for all non-abrupt pollution incidents.

Judge Weiss, though, rejected the insurers' argument: "We are talking about the CGL policy. Everyone who bought the CGL policy, whether it was an individual, a corporation, or a mega-corporation, got the same pollution exclusion clause.

"The benefits of this standardization would be lost if the standard form language were given different meanings for different insureds based upon individual degrees of sophistication and bargaining power," he said.

Judge Weiss chastised the insurers for arguing that the policyholders could have reasonably anticipated when the coverage was purchased decades ago the environmental liabilities they now face.

This argument "defies logic and in fact is intellectually dishonest" said Judge Weiss.

"The policies in the instant matter were drafted years, and in many cases up to two decades, before society at large and the legislature in specific took a heightened interest in the ecological well-being of our planet. It has only been since the 1980s that various cleanup laws were passed so that toxic wastes could be purged from our lands, seas and air. No individual or corporation could have envisioned or dreamed of the instant type of litigation and coverage issued when the subject policies were drafted," the judge said.

In his ruling, Judge Weiss referred to an April 6 decision by New Jersey Appellate Court Judge David S. Baime in litigation involving Diamond Shamrock Inc. (*BI*, April 13).

Also rejecting insurers' so-called sophisticated policyholder argument, Judge Baime wrote: "Despite Diamond's sophistication, the critical fact remained that the policy in question was a standard form policy prepared by Aetna's experts, with language selected by the insurer. The specific language contained in the (pollution) exclusion was not negotiated. It appears in policies issued to big and small businesses throughout the country. . .It would seem that the benefit of this standardization would be lost if standard form language were given different meanings for different insureds based upon individual degrees of sophistication in bargaining power."

Meanwhile, property insurers litigating with Westinghouse made separate arguments as to why they should be able to take advantage of the sophisticated policyholder defense, even if liability insurers cannot.

Westinghouse broke new legal ground in 1987 when it sued its property insurers and liability insurers for cleanup costs.

The property insurers now are arguing that their policies only insure buildings and structures, not the land itself.

Westinghouse maintains the policies also cover the soil and land.

The property insurers asked the court for permission to investigate what Westinghouse believed the first-party property policies covered at the time the policies were purchased.

But, again, the court rejected the insurers' request.

"Although the plaintiff may have indeed selected insurance coverage from a 'menu,' the items to choose from were standard fare in the industry," Judge Weiss said. "There is nothing unique about the wordings in the policy. The first-party policies here may hardly be defined as 'manuscript'. . . .As such, the reasoning set forth by this court regarding CGL policies and the so-called 'sophisticated insured' is also applicable here. . . .All ambiguities will be resolved in favor of the insured."

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Environmental Insurance Declaratory Judgment Actions, New Jersey Superior Court for Union County; No. UNN-L-08573-89; Westinghouse vs. Liberty Mutual Insurance Co. L-069352-87.

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Advertising injury interpretations

Upcoming trial to rule on scope of clause in CGL policy

By STACY GORDON

NEW YORK—The advertising injury clause of the comprehensive general liability policy has become the newest high stakes battleground between policyholders and insurers.

Policyholders claim the clause is broad enough to encompass a wide array of claims including unfair competition, antitrust violations, patent infringement, securities fraud and other illegal business practices.

Insurers, on the other hand, claim the clause is limited only to certain unfair competition claims that are caused by a policyholder's advertising activities.

At stake in their dispute is hundreds of millions of dollars in liability insurance.

Policyholder and insurer attorneys squared off over the CGL endorsement during a May 15 program sponsored by the Practising Law Institute, a non-profit legal education organization.

"Three or four years ago no one knew about this clause," said insurer attorney William Savino of Rivkind, Radler, Bayh, Hart & Kremer in Uniondale, N.Y. "Today policyholders are seeking coverage for a wide range of business disputes under (it)."

The case that awoke both sides to the implications of the advertising injury endorsement was a 1990 decision from the California Court of Appeals that found that a San Francisco bank could tap the endorsement to its liability policy to pay claims alleging unfair business practices (*BI*, Dec. 3, 1990).

Soon all eyes will be on California again. On June 3, Bank of the West will ask the California Supreme Court to affirm the appellate court's ruling that coverage for "unfair competition" as defined under the advertising injury endorsement "encompasses any unlawful, unfair or deceptive act committed against both a business competitor or the public."

Industrial Indemnity Co., a unit of Crum & Forster Inc., will counter by asking the California Supreme Court to rule that "unfair competition" is limited to the common law definition of "palming off" or passing off a rival's goods as one's own.

Regardless of the outcome of this landmark case, coverage disputes based on the advertising injury endorsement will continue, according to the attorneys.

"No matter how *Bank of the West* is decided, it will not end the dispute in this area," said policyholder attorney Robert Horkovich of Anderson, Kill, Olick & Oshinsky in New York.

Robert D. Mooney, liability claims manager for Royal Insurance Co. in Charlotte, N.C., agreed: "Even if *Bank of the West* is overturned it will not end the controversy. It will only slow down (the litigation) coming out of California."

The standard pre-1986 CGL policy provides: "The company will pay on behalf of the insured all sums which the insured shall become legally obligated to pay as damages because of personal injury or advertising injury."

The broad form advertising injury endorsement to the pre-1986 CGL policy provides: "Advertising injury means injury arising out of an offense committed during the policy period occurring in the course of the named insured's advertising activities, if such injury arises out of libel; slander; defamation; violation of the right of privacy; unfair competition; or infringement of copyright, title or slogan."

The post-1986 CGL policy—dubbed the commercial general liability policy—excludes "unfair competition."

At least three separate issues are disputed by policyholders and insurers when litigating claims under the advertising injury endorsement:

- The meaning of "unfair competition."
- The meaning of "arising out of" the policyholder's advertising activities.
- The meaning of "advertising."

Policyholders and insurers disagree over whether the term "unfair competition" should be construed broadly to include statutory definitions or narrowly to include only the common law definition of "palming off" another's goods as own's own.

An example of a statute that defines unfair competition broadly is the California Business and Professions Code, which defines "unfair competition" to include "unlawful, unfair or fraudulent business practice" and deceptive advertising.

Looking at this statute, a California policyholder could argue it has coverage for claims alleging any unfair business practice.

But, insurer attorney Mr. Savino said unfair competition must be read narrowly to mean only the common law tort of palming off another's goods as one's own. Otherwise, the endorsement would encompass "a boundless litany" of acts, he said.

Policyholder attorney Mr. Horkovich disagreed: "Where does it say in the policy that it excludes statutory unfair competition? How can insurers argue the 'plain meaning' of unfair competition is common law unfair competition when it does not say this in the policy?"

Furthermore, Mr. Horkovich pointed out that Louisiana is not a common law jurisdiction, but rather follows law based on the Napoleonic Code.

"Does this mean this clause has no effect in Louisiana?" asked Mr. Horkovich.

Policyholders and insurers also disagree over whether a claim alleging unfair business practice because of advertising must stem directly from the advertising or merely occur during the course of the advertising.

Mr. Savino said that the phrase "arising out of" the policyholder's advertising activities must be read to mean "caused by" those activities.

"A causal relationship is absolutely required," he argues.

For example, if a policyholder is sued for patent infringement and unfair competition, the unfair competition claim is a result of the patent infringement and not any advertising activity. Therefore, there would be no coverage, explained Mr. Savino.

"The endorsement provides coverage only for those enumerated offenses arising from advertising activities," he said.

Mr. Horkovich did not agree. He asked the audience how many people were certain in their own minds what "arising out of" meant. No one answered.

Interpreting "arising out of" to mean "during" is reasonable, he argued. Again, the insurers writing the policy failed to make it more clear, he said.

Mr. Horkovich also pointed to statements made by insurance companies indicating they did not believe that there had to be a causal relationship to the advertising activity for there to be coverage.

For example, he said, International Insurance Co., another Crum & Forster unit, told an Illinois appellate court: "Under the terms of the (insurance policy,) advertising injury does not have to be directly caused by advertising activity for coverage purposes. Advertising injury must merely 'arise out of' advertising activity. There is no direct causation required whatsoever."

A third area of disagreement between policyholders and insurers is what "advertising activity" means.

Insurers contend that advertising must be the act of calling widespread attention to one's product or service by means of paid print or broadcast announcements.

Policyholders, on the other hand, argue that any attempt to communicate to a potential buyer can be construed as advertising.

Policyholder attorney Mr. Horkovich pointed out that one court found mailing three letters was enough activity to constitute "advertising."

"Advertising activity is not defined in the policy," and therefore, should be liberally construed, he added.

All of the attorneys agreed that it will be up to the courts in coming years to iron out these differences of opinion.

Comparing coverage litigation to baseball he said: "We had the asbestos league and the environmental league. Now we will have the advertising injury league."

"Both teams—policyholders and insurers—are prepared to play hardball," he added. "And neither team knows the full extent of the game schedule, the rule book or the strengths or weaknesses of the other team." ■

Licensing system

Continued from page 3

logical, and why they were reluctant to support this, I don't know."

Last December, CISI formally presented the concept to the National Assn. of Insurance Commissioners' winter meeting in Houston. The commissioners failed to endorse the licensing system—a crippling blow to the CISI project.

The NAIC's failure to endorse the project was not "to express disinterest" in a particular system, said Lewis E. Melahn, the Missouri director of insurance and chairman of the NAIC market conduct and consumer affairs committee. "The feeling was that it wasn't appropriate to endorse an outside vendor to develop a centralized licensing system."

Instead, the NAIC felt it was more appropriate to develop its own centralized data base that would track licensed intermediaries. However, the proposed NAIC system would not be a licensing system, Mr. Melahn noted. Its function would be to allow regulators nationwide to keep tabs on agents and brokers.

Mr. Melahn said he is in favor of a more uniform state-by-state system of regulating and licensing intermediaries, although a centralized system might not necessarily be needed.

LOMA also met in Connecticut in January with regulators and insurers from Connecticut, Massachusetts and Rhode Island. Despite initial interest in the system, the states decided not to participate in the licensing network.

The National Assn. of Insurance Brokers was not surprised that regulators rejected the proposed agent licensing system, said Barbara Haugen, director of federal affairs at the NAIB.

The association had heard that the CISI system might be "difficult to implement, politically," she said. Referring to the agent licensing systems already in place, she said: "There were a lot of special interests at stake—people who have a lot at stake in the state system. That makes it difficult to set up."

Ms. Haugen noted that NAIB members are not pleased with the current licensing and regulatory system. "A lot of our members are unhappy with the 50-state system. It's expensive and time-consuming. Our members are interested in streamlining the process in some way."

While no strong voice of support for the CISI system has come from any other state regulators, many do believe in at least partial centralization of the licensing process.

"We agree with the concept of some kind of national system, particularly with respect to nonresident agents," said a spokeswoman for the Illinois Department. of Insurance. However, no system has been developed that would be valuable enough to replace the department's own sophisticated system, she said.

"Without endorsing any particular system, I would like to see at least regional, if not national licensing," said Alaska Director of Insurance David Walsh.

The CISI system "or something like it" could help ease the licensing burden, he acknowledged.

Mr. Walsh said a few states in the Pacific Northwest are discussing implementing a licensing system that would allow a prospective intermediary to take any or all of those states' exams on a computer at a single location.

Montana Insurance Commissioner Andrea Bennett advocates that the NAIC operate a system similar to the one used to license securities brokers, a spokesman said. Under the National Assn. of Securities Dealers system, dealers can apply for licenses in more than one state through a single system.

While insurance buyers could see some benefit from a centralized licensing and regulatory system that tracks unsavory intermediaries, it is not a high priority among risk managers.

"The issue has never come up since I've been here," said Paul Brown, director of governmental affairs for the New York-based Risk & Insurance Management Society Inc.

However, the insurance industry was more enthusiastic about CISI's system, with 47 insurers issuing statements supporting implementation of the centralized licensing system, according to Mr. Merritt.

The proposed CISI system could be resurrected and offered to individual states if there is interest, according to Claire L. Stine, a CISI vp. But, he said no states have shown an interest in signing on, and "we have no resources to go out and knock on doors." ■

JUNE CLOSINGS

SET YOUR DATES

issue: June 15
closing: June 3
demographic section: Insurer Topics: Government Relations/Coalitions

issue: June 22
closing: June 10

issue: June 29 — Bonus Distribution: SHRM — Reader Service
closing: June 16
editorial feature: Agent/Broker Profiles
Directory: Agents & Brokers

issue: July 6 — Bonus Distribution: NAIC
closing: June 24
demographic section: Agent/Broker Topics: Compensation & Incentives

issue: July 13
closing: June 30
editorial feature: Risk Management: Mid-Year Market Report
Directory: Alternative Facilities

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Veterans

Continued from page 1

pret the vaguely worded bill as requiring employers to make some retroactive contribution. However, the bill does not say on what basis that contribution would be made.

And, presumably, the veteran would be entitled to the retroactive plan contributions even if he or she quit just one week after returning to the company.

On the health care side, workers joining the military, as well as their dependents, would have to be offered the same health care benefits that a company offers in its "most favorable" leave-of-absence program for other workers.

Another provision would only affect small employers, which are exempt from the extended health care provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985. Under that provision, firms with fewer than 20 employees would have to offer COBRA-like health care coverage to former workers who had joined the military and their dependents for 18 months, even if the employers did not offer leave-of-absence programs.

The IRS ruled before last year's Persian Gulf War that employers had to extend COBRA coverage for employees called up for military service. However, the IRS ruling only applied to companies with 20 or more employees, which is the minimum size employer covered under COBRA's health care continuation provisions apply.

These provisions are part of S. 1095, the Uniformed Services Employment and Re-employment Rights Act of 1991. It has been approved by the Senate Veteran Affairs Committee and comes up for a Senate vote next month.

A similar bill, H.R. 1578, was approved by the House last year.

Benefit lobbyists say the ramifications of both bills for employers and their benefit programs cannot be overstated.

"It is a disaster for employers," summed up John Woyke, a principal in the Valhalla, N.Y., office of TPF&C, the benefits consulting division of Towers, Perrin, Foster & Crosby Inc.

"The potential impact of this bill is very major. There will be major problems for any employer with returning veterans," said Gerald Uslander, a principal in William M. Mercer Inc.'s Washington office.

Indeed, there are so many problems—both technical and substantive—with the legislation that benefit experts say it is a virtual certainty that the legislation will not be passed without major changes.

The Veterans Affairs Committee staff is preparing amendments for adoption on the Senate floor to clear up certain problems, including the basis for retroactive defined contribution payments.

But benefit lobbyists say the amendments may not go far enough. "The amendments at this point appear to fall short. There still are gobs and gobs of problems," said Lynn Dudley, senior legislative analyst at the Assn. of Private Pension & Welfare Plans in Washington.

Those problems include:

- The potential for pension plan disqualification. While the bill requires employers to make retroactive contributions to defined contribution plans on behalf of returning veterans, it does not amend a provision of the IRS code that now restricts such contributions.

For example, under the IRS code, the maximum annual contribution to a defined contribution plan for an individual employee is $30,000 or 25% of an employee's compensation, whichever is less.

But since an employee on military duty most likely would receive no compensation from his or her employer, any retroactive contribution would violate the 25% IRS rule.

Plans that violate this rule could have their tax-favored status revoked by the IRS. That would mean that vested employees would be taxed on their benefits and employers would lose their tax deductions for contributions made on behalf of non-vested employees.

"Thus, the bill requires contributions that could cause the plans to lose their tax-qualified status under any of several different provisions of the IRS Code," the Washington-based ERISA Industry Committee wrote in a letter to Veterans Affairs Committee Chairman Sen. Alan Cranston, D-Calif.

"The measure raises concerns with regard to what compensation would be imputed to the employees when there is no compensation by the employer upon which to base any contribution" to meet IRS rules, the APPWP's Ms. Dudley said in a letter to Sen. Cranston.

- Administrative problems. For example, the bill sets no time limit on when a returning veteran would have to make salary deferrals to a 401(k) plan for the years he or or she was in the armed forces.

Conceivably, an employee might wait 20 years before making those deferrals. That would require employers to keep years of records to be sure that the contributions would not violate the IRS non-discrimination tests for 401(k) plans.

Benefit lobbyists also point out that the bill does not make clear whether an employer's retroactive contributions to defined contribution plans must include the investment income that would have been earned during the period the employee was in the military.

Benefit lobbyists also complain that the legislation goes too far in providing benefits to employees on leave for military service. For example, they question whether a company should have have to make profit-sharing contributions for employees in the armed forces, especially those who volunteered.

They contend that profit-sharing payments are short-term compensation—like salary—for work performed during a year and are not rewards for long-term service, unlike defined benefit pension plans.

Lobbyists also worry about abusive situations in which an employee returns after military service to his or her employer for a short time to collect a profit-sharing payment. "Employers are pro-veterans. But they don't want to see their costs driven up by abusive situations," Ms. Dudley said.

The bill also would require employers, in certain situations, to continue health care coverage to employees and dependents while the employee is in the military. Under the measure, if an employer offers health care benefits as part of a leave-of-absence policy, such coverage would have to be offered to workers joining the armed forces.

If different health care benefits are offered based on the type of leave, the most generous benefits provided would have to be offered to those entering military service and their dependents.

Employees who join the military probably would not need health care coverage from their former employers because they receive free coverage from the Defense Department. However, retaining employer coverage might be attractive for their dependents because the armed forces plan for dependents, known as CHAMPUS, generally requires participants to use a military health care facility if one is nearby—generally within 40 to 60 miles. ■

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Wanted: new insurance industry leaders

By JOANNE WOJCIK

SEATTLE—Current practices in the U.S. insurance industry will be forced to undergo a major metamorphosis for insurance to remain a competitive risk financing alternative, industry observers say.

And it will take vision and leadership to ensure the industry's survival into the next century, observers add.

"The insurance industry needs to look squarely at its own leadership," said R.C. Riley Jr., president and chief executive officer of Peel & Holland Inc., an independent insurance agency in Benton, Ky.

"Do we have individuals with vision, wisdom and commitment leading us into the next millennium? Are we grooming people, especially young professionals, to take on these responsibilities? Are we attracting strong people to leadership positions? The answer, unfortunately, to all three questions is. . .not enough," Mr. Riley said during a recent major issues forum in Seattle sponsored by the Society of Chartered Property & Casualty Underwriters.

The Seattle forum, titled "Building Vision: leadership," was the fourth in a series of seminars across the country hosted by the Malvern, Pa.-based organization.

"We in the insurance industry know that our future—or at the very least, our viability—depends on our willingness to change, to grow and to be innovative as we explore the future," Mr. Reilly wanred. "We need more leaders to step forward. Without them, we will certainly wallow in the current bed of consumer discontent in which we now find ourselves."

David Olsen, chairman, president and chief executive officer of broker Johnson & Higgins in New York, agreed.

"The industry is facing a crisis in confidence about our own competence," he noted in a speech delivered in his absence by Gerald R. Swanson, president and chief executive officer of Johnson & Higgins of Washington Inc. in Seattle.

"We must have vision if we're going to give our clients the services they need," Mr. Olsen added.

Indeed, increasing globalization, the growth of alternative markets, stepped-up regulation and litigation and demands from clients for quality service are changing the face of the insurance industry, according to Mr. Olsen.

"The 1980s will stand out as a time when commercial insurance lost significant ground to alternative markets," he said, adding that "ACE, X.L. and CODA have permanently changed the industry landscape."

'The insurance industry needs to look squarely at its own leadership,' says R.C. Riley Jr.

As a result, "risk management has become increasingly financial in nature," he said.

To respond effectively, the insurance industry must change communication patterns and delivery systems while also gaining a better understanding of alternative markets and tax treatments of insurance in other countries, according to Mr. Olsen's speech.

In addition, brokers must change the types of services they supply to insurance buyers, according to Mr. Olsen.

"We must retool to meet the needs of clients in the 21st century," he asserted.

For example, "if we anticipate clients will move to alternative markets, we will find other ways to invest capital than to create capacity," he explained.

Brokers also must offer other risk management services, like loss control, claims handling and computerization, said Mr. Olsen.

In addition, brokers must devote time and resources to monitor regulation and litigation, he asserted. "We must join the public debate about the future of the insurance industry."

While "this means a radical and rapid shifting of gears for brokers," Mr. Olsen stressed, "we simply can't ignore the consequences" of poorly written workers compensation laws, insurer insolvency, rate rollbacks and efforts to restrict free market practices.

"The rules of the game are changing, and some of us cannot afford not to play," he said.

To accomplish these goals, Mr. Olsen suggests that the insurance industry tap its most valuable resource: people.

"Your most valuable non-financial asset is your employees," agreed Cheri J. Hawkins, assistant treasurer and director of insurance for Weyerhaeuser Co. in Tacoma, Wash.

"Through empowerment—giving away responsibility and authority and demonstrating trust—a manager can unlock a tremendous amount of motivation and excitement," she said.

"This works horizontally as well as vertically. In other words, get out of their way," added Ms. Hawkins, a former president of the Risk & Insurance Mangement Society Inc.

Leaders who support total quality principles must be able to act as teachers and coaches, leaders who can listen and forge strong work teams, according to Ms. Hawkins.

In addition, quality leadership must "encourage employee participation at all levels and promote honest and open employee communications," she said.

Indeed, the insurance industry will make it into the next millennium not by managing better, but by leading better, according to J&H's Mr. Olsen.

And "excellent employees want and expect excellent leadership," he said.

"Young people want responsibility and freedom, on-the-job training, opportunities for advancement, fair treatment, feedback and recognition and reward for their achievements," Mr. Olsen stressed.

"Most of all, they want a sense of purpose—a sense of working for something bigger than themselves." ■

Non-profit groups find D&O capacity

Marketplace is 'buyer-friendly,' survey shows

By MARK A. HOFMANN

CHICAGO—The market for non-profit directors and officers liability insurance remains competitive, according to a recent survey by The Wyatt Co.

Almost any non-profit organization that wants D&O insurance can find an underwriter, according to "The 1991 Nonprofit Organization Directors and Officers Liability Survey," which was released last week. In fact, non—profit organizations are more likely to carry D&O insurance than for-profit organizations.

Wyatt sent detailed questionnaires to hospitals, colleges and other non-profit organizations in the late summer of 1991, said Phillip N. Norton, the Chicago-based Wyatt consultant who conducted the survey. A total of 803 organizations participated: 595 hospitals, 67 private colleges and universities, 57 public colleges and universities and 84 other non-profit groups, primarily trade associations. Of the 803 participants, 85%—or 685—reported having D&O coverage.

"Despite the difficult economic climate for many businesses, the directors and officers liability insurance market was buyer-friendly during the 12 months preceding the survey. Overall market trends recorded in the survey were generally positive for the insurance consumer," Mr. Norton said in the report.

"The majority of survey participants renewed their D&O insurance with no change in coverage limits, deductibles or exclusions. However, the survey data exhibited a slight trend toward lower deductibles," according to the report.

An overwhelming majority of the participants with prior D&O coverage reported no change in limits upon renewal. About 88% kept previous limits, 11% increased limits and 1% decreased limits. Nine out of 10 participants reported buying limits of $15 million or less, with the average primary and excess limit totaling slightly less than $6.96 million.

Among all survey participants with prior coverage, 84% renewed with no change in deductibles, 8% renewed with a decrease and 6% renewed with an increase.

In addition, three participants reported decreased exclusions for every participant reporting an increase in exclusions. But 84% of the survey participants reported no change in exclusions upon renewal.

Four underwriters accounted for more than 60% of the sample's total premium volume of $28.8 million. Warren, N.J.-based Chubb & Son Inc. led the underwriters with 20% of the sample's premium volume. New York-based American International Group Inc. ranked second with 18.3% of the sample's primary premium volume and Aetna Casualty & Surety Co.'s Simsbury, Conn.-based Executive Risk Management Associates unit ranked third with 15.9%. Mechanicsburg, Pa.-based PHICO Insurance Co. held fourth place among primary underwriters, with 8.9% of the sample's premium volume.

Only 84—or 12.3%—of the 685 non-profit organizations that reported having D&O coverage had excess policies. The survey did not rank insurance companies on the basis of premium volume for this small segment of the sample.

About 14.7% of the non-profit organizations in the survey reported carrying no D&O insurance. This is a significantly smaller proportion than that reported by corporate entities sampled in Wyatt's 1991 corporate D&O survey (*BI*, Feb. 24). Of the 1,501 participants in that report, 295—or nearly 19.7%—carried no coverage.

The chief reason cited for not carrying any D&O coverage was that there was no need for it. Twenty-eight percent of those non-profit organizations without coverage offered this reason, followed closely by "cost too high," cited by 25% of the participants without D&O coverage.

Twenty-two percent cited "other" reasons, which reflected public colleges' frequent response that they were protected by "sovereign immunity." Mr. Norton noted in the report that he hoped "such schools are aware that many employee claims, like discrimination, are federal grievances, and thus, schools are not afforded protection in those cases."

Other reasons sited for not carrying D&O insurance were "coverage too limited," cited by 12% of those without coverage; "advice of counsel," which accounted for 8%; and, in last place, "unable to obtain coverage," which was cited by only 5% of the sample. No educational institution reported being unable to obtain coverage.

Despite the organizational differences among the entities surveyed, they must contend with a common source of claims: employees.

"We find that across the board, employees are by far the single most important claims source," said Mr. Norton.

According to the survey, employees brought 80% of the claims against private educational institutions and 79.8% of the claims brought against hospitals. For public educational institutions, employees accounted for 87.2% of the claims. In addition, for all other non-profit institutions in the survey, employees accounted for 62% of the claims.

Wrongful termination is the most common claim issue, accounting for slightly more than one-third of all claims reported by survey participants, Mr. Norton pointed out.

For example, the 33.4% of all claims stemming from allegations of wrongful termination reported by hospital participants represents a significant increase over the 25.5% portion of claims reported by participants in Wyatt's 1990 health care D&O survey (*BI*, Feb. 25, 1991).

The percentage of claims involving allegations of wrongful termination brought against private schools was even higher—36.7%. For public schools, the percentage of claims attributable to wrongful termination was 21.3% and for other non-profits, 16.7%.

However, for both public schools and those non-profit organizations that fell into the "other" category—which includes trade associations—the single most frequent source of employee-generated claims was alleged discrimination.

This cause represented 42.6% of all claims brought against public schools and 31% of the claims brought against other non-profit organizations. By contrast, allegations of discrimination accounted for only 22.2% of the claims brought against private schools and 8.2% brought against hospitals.

"The fact that this employee exposure is so great in terms of frequency of claims is really important, because many of those employee claims, especially if they have to do with discrimination, are federal cases and they are not protected by certain state laws that would otherwise grant immunity to directors sitting on a non-profit board," said Mr. Norton.

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Copies of "The 1991 Nonprofit Organization Directors and Officers Survey" cost $200. Those who purchased the "1991 Wyatt Directors and Officers Survey" can purchase the non-profit survey for $150. Copies can be ordered from Mary Maze, The Wyatt Co., 303 West Madison St., Suite 2400, Chicago, Ill., 60606-3308; 312-704-0600.

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Business Insurance

INTERNATIONAL

Drastic broker contraction forecast

Few firms can meet global needs: Rowland

By GAVIN SOUTER

PARIS—There could be as few as three brokers capable of offering comprehensive global service by the turn of the century, a top brokerage executive says.

Dwindling profits at brokers and the increased sophistication of insurance buyers will lead to further insurance industry restructuring and more brokers will be out of jobs, he says.

Only after this painful readjustment is completed will profits start to take off again for the brokerage remaining in the market.

"By the end of the decade there will be three, or maybe four, firms of truly global capacity with worldwide representation coupled with efficient information systems capable of acting both as leading local intermediaries and as global operators of high standard," predicts David Rowland, chairman of Sedgwick Group P.L.C.

There currently are too many intermediaries chasing too little business, he said at the British Insurance & Investment Brokers' Assn. conference earlier this month in Paris.

"The middle-sized and poorly performing firms will be absorbed. Frank B. Hall is for sale today, its present owner having failed to produce any meaningful profit from it," Mr. Rowland said.

Reliance Group Holdings Inc. put Hall up for sale earlier this year (*BI*, March 30).

There could also be "blood-stained mergers" between leading brokers, as even the best-managed and largest firms have produced a "woeful performance" in terms of shareholder reward, Mr. Rowland said.

Sedgwick, for example, has doubled in size since 1981 but earnings per share have grown a "miserable" 20% during the

Continued on next page

Open E.C. market means opportunity, change for brokers

By GAVIN SOUTER

PARIS—The removal of trade barriers among European nations will transform the insurance business, a brokerage representative says.

The wider choice of insurers and products will lead to an enhanced role for intermediaries, and major decisions affecting the insurance industry will be made by European Community organizations rather than individual governments, he says.

And with the prospect of another E.C. non-life insurance directive being in place in 1994, intermediaries can look

Continued on next page

Lawyer eyes members' litigation strategies

By STACY SHAPIRO

LONDON—Some of the many lawsuits filed by disgruntled Lloyd's of London members over mounting losses may succeed, while others don't stand a chance, an attorney says.

At the moment, there are about 14 members' action groups comprising thousands of members who are fighting in the courts to have their losses either paid or negated or both, according to Oliver Carruthers, an executive with syndicate analyst Chatset Ltd.

The strength of the cases varies dramatically, said David Tiplady, a lawyer with D.J. Freeman in London who represents several of the members' action groups. "There is one which I won't name which seems to me so clear that it is unarguable," he says.

But "there are cases at the opposite side of the spectrum that should never have been brought. And there are lawyers who are encouraging them quite wrongly to litigate simply because a lot of money has been lost."

Mr. Chatset spoke at a seminar held by D.J. Freeman and accountants Smith & Williamson.

For example, Mr. Tiplady said he felt strongly that members would not succeed at imposing injunctions to stop Lloyd's from drawing down on their deposits to pay syndicate losses. He called this "kamikaze litigation."

Mr. Tiplady said he sent letters to all his clients—including members of the defunct syndicates formerly managed by Gooda Walker Ltd.—telling them not to support the injunction attempt by law firm Michael Freeman & Co. The action eventually failed (*BI*, April 20).

Mr. Tiplady also has refused to represent Gooda Walker names in an attempt to obtain judicial review of the Corporation of Lloyd's duties in London's High Court. The names currently are seeking an injunction to protect their deposits until the judicial review is heard.

Mr. Tiplady said he also thinks that the remaining members of the 1982 account of Richard Outhwaite's syndicate who were not party to a 116 million pound ($212.3 million at current exchange rates) settlement will be barred by statutes of limitations from receiving any compensation (*BI*, March 9).

However, he asked, "should names be in litigation at all? It is a sad fact that names have been

Continued on page 32

AGF loses lawsuit to increase role in Germany's AMB

LONDON—Assurances Generales de France Group, France's second-largest state-owned insurer, has lost the first round in its battle to increase its voting rights in German insurer AMB Aachener & Muenchener Beteiligungs A.G.

AGF holds a 25% stake in AMB and has been pressing the German insurer's board to register its shares, which would entitle the French company to voting rights proportionate to its stake. AGF currently is registered with only 9% of the voting rights at AMB.

AMB, wishing to deny boardroom influence to the French company, has steadfastly refused.

On Feb. 19, AGF took its case to the commercial court in Aachen, claiming that the German insurer's board was abusing AGF's rights in refusing to register its stake (*BI*, Feb. 24).

Last week, the commercial court judge rejected AGF's case. The judge cited Article 8 in AMB's statutes that grants it discretion over whether to register an investor's stockholdings.

The judge also agreed with AMB's contention that the fact that AGF was a state-controlled company could produce conflicts of interests if it acquired too much influence at the German insurer.

AGF said it would appeal the decision. A spokeswoman in Paris pointed out that the judge had rejected two of AMB's objections to registering AGF's shares: that it was French and that the move might threaten jobs at the German insurer.

In addition to the legal action, AGF has been pursuing somewhat friendlier talks with AMB in an attempt to help the German insurer out of some difficulties with its loss-producing banking operation, Bank fuer Gemeinwirtschaft.

AMB has indicated that if AGF can help relieve it of the burden of BfG, the German insurer may look more kindly on registering AGF's shares.

The French state-owned bank, Credit Lyonnais, has been proposed by AGF as a possible buyer of part of BfG, but has yet to come up with a firm offer.

Meanwhile, the legal battle will continue, AGF insists. In three weeks, it will receive the final published decision of the Aachen court. It will then have a month in which to appeal to a higher court in Cologne.

—By William Pitt

Gooda Walker members hit with $79 million cash call

By STACY SHAPIRO

LONDON

LONDON—Lloyd's of London members belonging to defunct syndicates once managed by Gooda Walker Ltd. have been hit with another set of whopping cash calls, this time for losses on syndicate 387, which wrote members' stop-loss coverage.

The calls, totaling 42.9 million pounds ($78.5 million at current exchange rates), stem from five of the syndicate's seven open years of account from 1983 to 1989. The syndicate's members already have been asked to pay cash calls amounting to more than 12 million pounds ($22 million), bringing the total sought to 54.9 million pounds ($100.5 million).

The worst results are on syndicate 387's 1989 year of account. The 384 members, which wrote a total of 5.8 million pounds ($10.6 million at current exchange rates) in capacity, face a cash call of 31 million pounds ($56.7 million), or 534.6% of the syndicate's capacity.

The total anticipated cash calls for the 1989 underwriting year for syndicate 387 could reach 750% of capacity, or 44 million pounds (80.5 million), confirmed Ralph Sharp, chairman of G.W. Run Off Ltd., which is running off the Gooda Walker syndicates.

As a result of the need to make additional cash calls on its members, syndicate 387, which was the lead syndicate on many member's stop-loss insurance policies, is slowing down in making claims payments. As a result, stop-loss policyholders facing cash calls on other syndicates could be forced to pay those calls themselves before obtaining reimbursement from syndicate 387.

Mr. Sharp dismissed that scenario.

"We will make (stop-loss) payments according to each policy's terms and conditions and on the proper due date," he said at a press conference in Gooda Walker's former offices.

He admitted that this has caused grumblings in the Lloyd's market, since many stop-loss syndicates generally pay policyholders facing cash calls in advance of the actual due date for the funds.

Syndicate 387, personally underwritten by Derek Walker, only wrote members' stop-loss

Continued on page 32

Focus liquidators' strategy

HAMILTON, Bermuda—Six defendants who recently were added to litigation against the former directors of Focus Insurance Co. Ltd. are not being accused of willful negligence or breach of fiduciary duty—which are the central allegations in the civil action brought by the Focus liquidators.

Those new defendants include Judith Hardy, the wife of former Focus chairman Mark Hardy, and five companies believed to be controlled by Mr. Hardy.

BERMUDA

The six defendants were added by the Bermuda Supreme Court at the request of lawyers for the Focus liquidators. The liquidators sought the additions so that, if the liquidators' case is successful, the defendants could not be used to preserve or protect Mr. Hardy's assets (*BI*, May 18).

"The (liquidators) have merely sought to add the additional defendants at this time in order to avoid separate lawsuits in the future to enforce judgment against (Mr. Hardy) should they succeed in the underlying action," explained Julian Hall, the Bermuda lawyer representing Mr. Hardy.

The liquidators began their action last July seeking damages of $19.7 million from Mr. Hardy and Focus co-directors David Thirkill and Douglas Pullen (*BI*, July 15, 1991).

—By Roger Scotton

Global brokers

Continued from previous page
same period, he said.

Competitors have posted similar records.

Although specialist brokers will continue to prosper, their opportunity for maintaining extraordinary profits will diminish and they will be forced to seek alliances with major brokers, he predicted.

And those brokers that survive the inevitable restructuring of the market will be rewarded more frequently on a fee basis rather than through commissions and will have to offer a wider range of services to clients, Mr. Rowland said.

Those services will include health care, risk management and environmental consulting, he said.

The brokerage industry restructuring is being caused by market forces, according to Mr. Rowland.

"There is nothing unusual about insurance distribution. It is subject to just the same pressures as all other distribution chains across the world. The costs of distribution are in question," he said.

Buyers of insurance have become more sophisticated and are no longer prepared to see insurers and brokers take such a large chunk of the premium they pay, Mr. Rowland said.

In the 1960s, only 63 cents of each premium dollar was available to pay claims, with the rest eaten up by transaction costs, he said. Today, that figure has improved only to 73 cents.

Twenty-five years ago, buyers were ignorant and did not realize that they need not pay so much toward the distribution costs of insurance, he said, adding that modern buyers are more sophisticated.

'You have to be seriously clever to make a profit as a Lloyd's underwriter,' says Mr. Rowland.

The unwillingness of insurers to meet the demands of modern buyers has accelerated the demand for captives, Mr. Rowland pointed out.

"The movement was fueled by a realization that a captive insurance company dedicated only to servicing its parent could be run sparingly and could purchase insurance with attractive discounts, the consequences being that around 90 cents in the dollar could typically be devoted to claims payments rather than transaction costs," Mr. Rowland said.

If the flight of buyers from the traditional insurance market is to be halted, insurers and brokers must cut their costs even further, he said.

"If 27 cents are still spent in the transaction of insurance, we must reduce this to 20 cents by the end of the decade or more business will leave the commercial insurance market," Mr. Rowland warned.

Lloyd's of London always had a competitive edge over insurance companies in the 1960s, as underwriters there were able to keep their expenses pegged to 30 cents of each dollar, he said.

"This was achieved by a greater simplicity in the Lloyd's system. Lloyd's underwriters sat in the (underwriting) room at Lloyd's and accepted risks. Brokers brought the business to them. There was no confusion of function," Mr. Rowland said.

"You had to be quite thick as a Lloyd's underwriter not to make profits with that kind of advantage," Mr. Rowland said.

But as insurance companies became more proficient at reducing their expenses, Lloyd's advantage eroded and Lloyd's underwriters were forced to take on riskier business to maintain their profits, he said.

"Now you have to be seriously clever to make a profit as a Lloyd's underwriter because of the competitive disadvantage," he concluded. ■

BIIBA conference draws 297

PARIS—The British Insurance & Investment Brokers' Assn.'s annual conference drew 297 to Le Palais des Congres de Paris in Paris April 30 to May 2.

Of those, 96 were BIIBA members with the balance being made up largely of insurers and exhibitors.

Next year's conference is moving back across the English Channel and will be held April 14-17 in Bournemouth, England.

For more information, call or write BIIBA at 14 Bevis Marks, London EC3A 7NT; 71-623-9043.

European Community

Continued from previous page
forward to flexible but unified regulations governing insurers, an E.C. official added.

"Today we are less than 250 days away from the ominous Dec. 31, 1992," the official date of creation of the single European market, said Hans Maeder, president of the Bureau International des Producteurs d'Assurances & de Reassurances in Paris.

The single European market will be made up of 345 million people, 30% higher than the population of the United States and three times the population of Japan, Mr. Maeder said at the British Insurance & Investment Brokers' Assn.'s annual conference, held in Paris earlier this month.

"This market will represent 25% of the world's insurance premiums," Mr. Maeder said.

The market will also include 4,000 different insurers that will be able to offer coverage across all E.C. borders, he said.

"The vast majority of customers, whether private individuals or large firms, will continue to seek and buy insurance as they do now, via an intermediary. They will do so because service is an essential part of the security offered by insurance," Mr. Maeder said.

However, all intermediaries, including British brokers, will be increasingly subject to regulations imposed by E.C. institutions, he noted. "Many major decisions affecting your professional situation are now taken in Brussels and Strasbourg rather than in Westminster."

These regulatory changes will enhance the role of intermediaries, Mr. Maeder said. For example, E.C. pollution rules, which likely will combine strict liability with compulsory insurance and compensation funds, will lead to pollution liability policies that will generate new business for brokers, he said.

Brokers "will be required to possess a high degree of professionalism and technical expertise if they are to assist their industrial clients, whether great or small, in taking up this challenge."

The first objective of the E.C. legislators on insurance is to ensure freedom of insurance sales, noted Geoffrey Fitchew, director general of financial institutions and company law at the European Commission in Brussels.

"We want to remove the barriers which prevent insurance being sold freely and competitively across Europe," he said.

The E.C.'s third non-life directive should be implemented by June 1994, Mr. Fitchew said. The framework for the directive seeks to remove requirements for product and tariff approval by home country legislators and harmonize key rules concerning insurer solvency, he said.

"The objective is to protect the policyholders by requiring companies to hold assets that meet minimum criteria as to their (security), liquidity and yield," he said. This will be achieved by three steps.

First, there will be a list of permissible assets for technical reserves. Member states will be able to apply stricter rules to domestic insurers if they wish, but not to branches of companies operating from another member state.

Second, rules will be imposed regarding the diversification of assets, with a cap on investments in certain types of assets. Again, nations can apply stricter rules to domestic companies.

Third, insurer assets will be permitted to be based anywhere within the European Community.

When implementing regulations, the European Commission is always eager to hear the views of brokers in all E.C. nations, Mr. Fitchew said. "We in the commission have only a small team to prepare community legislation and follow what is happening in all 12 member states. So we need your help and cooperation." ■

London recovery possible with changes: Coleridge

By GAVIN SOUTER

PARIS—The higher insurance rates that Lloyd's of London underwriters are demanding is the first step on British insurers' road to recovery, the chairman of Lloyd's says.

But, insurers and policyholders must maintain longer relationships for a sustained recovery, Lloyd's Chairman David Coleridge says.

And, all underwriters in London will have to strive for greater efficiency to compete with European insurers, he points out.

Stressing that all London insurers—not just Lloyd's underwriters—must take action to fuel an insurer recovery, Mr. Coleridge said: "I, for one, remain convinced that whatever may be our immediate difficulties, our future prospects are bright, provided we are prepared to act with vigor in addressing the problems that face us."

Lloyd's lost 509.7 million pounds in 1988 ($983.7 million at applicable exchange rates) and is likely to post losses again in 1989 and 1990 (*BI*, July 1, 1991). And, British insurance companies' earnings have been similarly dismal, Mr. Coleridge said at the British Insurance & Investment Brokers' Assn. conference in Paris earlier this month.

"Our colleagues in the company market have suffered similarly during these recent years. The top five U.K. composites have announced non-life underwriting losses of 2.8 billion pounds ($5.12 billion at current exchange rates) for 1991," he said. And, total non-life insurance company losses could amount to 6 billion pounds ($10.98 billion) for 1991, Mr. Coleridge said.

"It is a measure of the strength and security of U.K. insurers that they have managed to withstand such deficits with so few casualties," according to Mr. Coleridge.

The losses throughout the U.K. insurance market have resulted from a variety of factors.

Lloyd's has suffered particularly heavily from losses on U.S. liability policies, and insurance companies have suffered from large losses on mortgage indemnity policies, he said.

Both sides of the British insurance market also have had to contend with large catastrophes that in 1989 alone produced insured losses of more than $29 billion, according to Mr. Coleridge.

"If you are a world player in insurance markets, you have got to expect losses on this scale to have a major impact, and Lloyd's has certainly collected a few bruises as a result," Mr. Coleridge said.

But the underlying cause of the malaise in the U.K. insurance industry is the low cost of insurance, Mr. Coleridge said.

"We are underpricing our products. Quite simply, the premiums we collect have been insufficient to meet the claims we insurers have sustained," he asserted.

'No business. . . can survive for long if it sells its products at a loss,' says Mr. Coleridge.

Corrective action—higher rates combined with a drive to cut expenses—is now being taken at Lloyd's, Mr. Coleridge said.

"The number of operating syndicates has fallen from 401 in 1990 to 275 this year, and those that remain should be fully capable of withstanding today's tough market conditions and are determined to maximize returns to our names," he said.

That effort will include turning down business that does not provide underwriters an adequate premium for the risk, Mr. Coleridge said.

While this is bound to be unpopular with clients and brokers, such a stance is necessary if the market is to make a full recovery, he said.

"The fact remains that no business—no industry—can survive for long if it sells its products at a loss," Mr. Coleridge said.

Brokers should encourage clients to accept higher premiums in return for a long-term relationship with their insurers, he said.

"At a time of rising premiums, you may care to consider whether your clients will not ultimately benefit most from longer-term relationships with insurers, based on high levels of service and commitment and shared concerns for loss reduction," Mr. Coleridge said.

Long-term relationships are becoming even more important for insurers due to the change in the insurance cycle, he said.

Underwriters previously relied on a balance between good and bad years, but over the last decade, the number of lean years for insurers have outweighed the years of plenty, Mr. Coleridge said.

"I do not think we can view with equanimity the prospect of one or two years' profitable trading followed by a return to the conditions we are currently experiencing. There is a need for prudent, sensible and realistic long-term planning," he said.

Long-term planning will need to be coupled with greater efficiency if the London market is to compete with continental European insurers, Mr. Coleridge said.

The implementation of the LIMNET electronic network system in March helped British underwriters and brokers improve their service, he said.

"It provides the opportunity of participation at a variety of levels—up to and including the transaction of business over the network using an electronic slip—without face-to-face contact between broker and underwriter whatsoever," Mr. Coleridge said.

This streamlining should give London a competitive edge over other markets, he said. The network should help Lloyd's, in particular, significantly increase the 16% of total premium income that currently comes to the market from continental Europe, Mr. Coleridge said.

Despite LIMNET, Lloyd's will still face a tough battle to increase its market share in continental Europe, according to Mr. Coleridge.

"We are well aware that expansion will be neither quick nor easy, given the enormous power and strength of the larger European insurance groups and their highly professional approach to business," Mr. Coleridge said. ■

INTERNATIONAL

U.K. industry woes need teamwork: Exec

By GAVIN SOUTER

PARIS—The British insurance industry must tackle fundamental problems if it is to have a healthy future, advises the chairman of the Assn. of British Insurers.

Insurers have suffered both self-induced and unpredictable troubles that need to be addressed through increased rates, a reduction in the number of insurers and intermediaries and lower operating costs, said Ian Rushton, who is chairman of the ABI.

These problems can only be conquered if the whole British insurance industry works together to subdue them, he said.

"U.K. insurance companies, Lloyd's of London and intermediaries need to be addressing, both individually and collectively, certain fundamentals if our industry is to have a healthy future," Mr. Rushton said at the British Insurance & Investment Brokers' Assn. conference in Paris earlier this month.

The terrible financial results of 1990 and 1991 were in some cases the fault of insurers that provided overly generous coverage, charged too low a premium and failed to control expenses, Mr. Rushton said.

"We were all far too willing to chase business at increasingly unrealistic rates and at a time when good fortune was leaving the insurance industry in an unprecedented way," he said.

However, not all of the wounds were self-inflicted, Mr. Rushton said.

Nobody predicted the impact that the recession would have on the insurance industry, he said. The poor U.K. economy led to a sharp increase in crime-related losses, and the collapse in the housing market produced an unprecedented level of losses from mortgage indemnity guarantee policies, he said.

"We have also had to face dramatically increased losses from. . .a three-year period of very heavy weather-related claims," Mr. Rushton said.

There are too many insurance companies and intermediaries operating in the U.K., says Mr. Rushton.

British insurers currently are taking strong remedial action to counter the losses, he said.

Sound underwriting is returning to the market and in some cases premiums are being increased by several times more than the rate of inflation, according to Mr. Rushton.

"Let us not forget that if the original premium was only half the level it should have been, you have to have a 100% increase just to return to the correct rating level," he said.

However, while insurers must increase their rates, they also must be wary of pricing themselves out of the market, he added.

"We don't want a repeat of what happened in the United States (in the mid-'80s) when they put rates up so far that they suffered a public backlash," he said.

Currently, prices have not increased to that dangerous a level and there still is healthy competition between insurers that is keeping premium increases to a minimum, Mr. Rushton said.

But policyholders and brokers must recognize that insurers need to increase rates if they are to remain in business to pay claims, he said.

"Intermediaries have a key part to play in explaining the need for much higher premiums. I recognize that you have to do so against the backcloth of insurance companies looking very carefully at sales and intermediary outlets as well as commission levels," Mr. Rushton told the BIIBA members.

And as part of the industry's struggle to return to profitability, some insurers and intermediaries will be forced out of business, he said. "We have too many insurance companies operating in the U.K. and, likewise, far too many intermediaries.

The fittest operations will be those that can reduce expenses, he said, adding that insurers have made much progress in that area over the past year.

But even if insurers and intermediaries become leaner and more profitable, they still will need to work together if the industry is to regain its former health, Mr. Rushton said.

"It is of key importance for all sectors of our industry to be working closely together on some of the strategic issues we face, or could face in the future," Mr. Rushton said. ■

Careful planning key to global future

For any company, setting up shop overseas requires organization studies and risk projections

By MEG FLETCHER

CHICAGO—A manufacturer, insurer and broker are responding to the globalization of their marketplaces by reorganizing their operations and striving to develop quality services.

And good risk management is integral to those efforts, a risk manager says.

A trio of executives discussed the challenges posed by globalization of the insurance industry at a symposium in Chicago earlier this month sponsored by the International Section of the Society of Chartered Property & Casualty Underwriters.

Foreign insurers are tending to increase their U.S. operations, observed Thomas Hite, president of Zurich International-U.S., a Zurich Insurance Co. unit in Schaumburg, Ill.

Until the mid-1980s, those foreign insurers were primarily British and Canadian. Since then, continental European insurers increasingly have set up U.S. operations, with about 60% writing property/casualty coverage, he said.

For the most part, French and Japanese insurers have been "notably absent," Mr. Hite commented.

Foreign insurers are drawn to the United States because of its low barriers to entry, huge market and profit potential, Mr. Hite said.

Another attraction is U.S. restrictions on bank sales of insurance, though that may change here as it has in Europe, he said.

On the other hand, there is "relatively little" investment by U.S. insurers in foreign countries, Mr. Hite said.

One reason is that foreign markets are smaller, he said. In addition, efforts to unify the European Community nations, and thereby expand the size of that market, have shown "more comment than commitment," he said.

For any insurer, expanding into a foreign country is "discretionary," Mr. Hite said, because the insurance industry is less global than "multidomestic," meaning its stature in one country has relatively little impact on its standing in another country. In addition, an insurer can have different strategies for different countries.

Any insurer deciding to enter a foreign country often reorganizes its operations by combining the programs it offers with those offered by other service providers, especially companies that are already established in a targeted country, Mr. Hite said.

However, "strategic alliances have not shown to be particularly effective," he said.

A major heavy equipment manufacturer—which sells insurance to its clients through an insurance subsidiary—considers reorganization a key to its global future.

Caterpillar Inc., based in Peoria, Ill., reorganized itself into profit centers in 1989 to cope with the demands of global operations, among other things, said Joseph Negro, director of the risk management department for Caterpillar Insurance Services Inc. and president of Caterpillar Insurance Co. Ltd., both in Nashville, Tenn.

"We are changing our corporate culture amidst a new world order which provides new challenges to the enterprise," he said.

In addition, the company and its insurance unit established an international division in 1991 that opened for business in the United Kingdom in January.

As a leading U.S. exporter, Caterpillar has a lot of experience in the international arena, Mr. Negro said.

Caterpillar sent $3.4 billion in goods and services to foreign countries in 1990, almost 1% of total U.S. exports of $350 billion that year, he said.

In addition, the company also is a "global competitor" that manufactures its products in 32 facilities in 12 countries outside the United States. It also has manufacturing agreements and licensing arrangements in 14 other countries, according to Mr. Negro.

Nevertheless, Caterpillar and its financial services division approach new markets with "extreme caution," Mr. Negro commented.

'Effectively managing the risk—anticipating it, preparing for it, and whenever possible controlling or minimizing it—is essential for American companies to be successful in a tough, global marketplace,' says Mr. Negro of Caterpillar Inc.

New operations should be launched, or existing ones restructured, only after careful analysis, to which risk management input is critical, Mr. Negro said.

"Effectively managing the risk—anticipating it, preparing for it, and whenever possible controlling or minimizing it—is essential for American companies to be successful in a tough, global marketplace," Mr. Negro said.

From an insurance broker's perspective, globalization requires reorganization designed to provide the most cost-effective, technically correct service to new customers, said Teresa L. Pahl, senior vp with Willis Corroon International Corp. in Chicago.

Those new customers are often challenging because they are "technologically informed and aware" as well as increasingly proficient in risk management concepts, she said.

To meet their demands, a broker often must streamline and consolidate operations, yet remain flexible enough to identify and use effective local people who can provided necessary insurance-related services, Ms. Pahl said.

Those can include providers of good loss control services or good local policies, which are the foundation of an effective global insurance program, she said.

In addition, a broker must also remain responsive to a client's choices of individuals who should be involved in any transaction.

"The further south you go in the world, the more brothers-in-law are involved," Ms. Pahl quipped.

Developing an understanding of local customs is an example of how a broker must "grow up" culturally to increase his or her effectiveness, according to Ms. Pahl.

Not knowing a foreign client's language is not a real disadvantage because most transactions are conducted in English, she said.

However, fluency in a local language is a consideration when it comes to functions like claims handling, Zurich's Mr. Hite added.

The panel was moderated by Kathryn J. McIntyre, publisher/editorial director of *Business Insurance*. ■

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INTERNATIONAL

Lloyd's suits

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brought to this pass where they must sue in Lloyd's. It's a civil war, and really no one gains except perhaps the lawyers. I readily admit that, because at the moment, this form of litigation for a few firms is extremely lucrative."

Sadly, members' litigation has drawn in law firms that "in my view have no business advising (on) Lloyd's," Mr. Tiplady said. They may be good firms in their own right, but "very few firms indeed have the expertise to properly address these questions."

Many members have come to Mr. Tiplady claiming that they were defrauded and should not have to pay their syndicate losses.

"But to a lawyer, that is meaningless" as a starting point for litigation, because it is difficult to prove, said Mr. Tiplady.

Instead, members must look at their contractual relationships with agencies at Lloyd's.

Members' contracts prior to 1990 are contained in a "members' agency agreement" that spells out the members' agents' contractual obligations to members.

In ruling on members' attempts to get an injunction against Lloyd's, Justice Saville—the judge in London's High Court designated to hear all Lloyd's member litigation—"included some very encouraging remarks" about the right of members to sue their members' agents, said Mr. Tiplady.

"In his judgment. . .he makes it quite clear that members' agents under the old contractual relationship are impliedly liable," said Mr. Tiplady. "They are responsible for the proper management of your underwriting. And the mere fact that they delegate that responsibility on a day-to-day basis to an apparently competent managing agent does not exonerate them from their responsibility."

Justice Saville's remark "is an encouraging thing," said Mr. Tiplady.

Since it wasn't essential to the injunction case, "it doesn't bind anybody, but since he is going to hear all the other cases anyway, it doesn't really make a lot of difference. He'll probably be persuaded by his earlier judgment."

Members' agents should have provided members with a balanced portfolio of risks that fit the members' underwriting strategies, said Mr. Tiplady. If a member asked to be on all the high-risk, excess-of-loss reinsurance syndicates, then only the member is to blame for his or her current losses, he said.

However, members in many cases asked for a balanced portfolio and didn't get it from their members' agent, Mr. Tiplady said.

Having 30% to 40% of London market excess-of-loss reinsurance business in a member's portfolio isn't balanced, he said.

A members' agent also should have informed each member that stop-loss coverage was available to them, said Mr. Tiplady. Then it would have been up to the member to decide whether to buy it, he said.

If the members' agent said nothing about stop-loss cover, he or she may have been in breach of contract, the lawyer said. If the agent did tell the member about stop-loss, but the member decided not to buy it, the agent probably would be free of liability, he said.

However, whether to sue a members' agent depends on whether the agent has sufficient errors and omissions insurance to pay an award, said Mr. Tiplady.

Litigation has drawn in law firms that 'have no business advising (on) Lloyd's,' says Mr. Tiplady.

As of last year, members' agents do not have to buy E&O insurance, and many are running without the coverage, so all that a member would receive if he or she won litigation would be the value of the agency's assets, he said. This would be tiny in comparison to E&O cover, he added.

Meanwhile, for losses arising before 1990, managing agents cannot be sued because members did not have a contract with them, Mr. Tiplady said.

From 1991 on, though, members also have contracts with managing agents. Managing agents now can be sued for owing a duty of care to members, which Mr. Tiplady says his law firm is pursuing in cases involving names formerly on syndicates managed by John Poland (Managing Agency) Ltd.

In some cases, members might also have recourse against Lloyd's brokers who did not properly place reinsurance arrangements for troubled syndicates, said Mr. Tiplady.

Whether members can sue the Corporation of Lloyd's is being decided in the case of Oakley Vaughan Underwriting Ltd., said Mr. Tiplady.

After listening to arguments earlier this month, Justice Gatehouse will soon decide on whether Lloyd's owed a duty of care to 31 members of Oakley Vaughan who together face losses of 10 million pounds ($18.4 million).

The Lloyd's Act 1982 bars members from suing Lloyd's for negligence, said Mr. Tiplady. But the act does not bar members from suing Lloyd's for breach of contract or for fraud, he said.

In some cases, there may be a statute of limitations question, said Mr. Tiplady.

More than 1,000 members of syndicate 417/418 managed by Merrett Underwriting Agency Management Ltd. for the open 1985 account have set up an action group to oppose payment for losses from 11 run-off reinsurance contracts that were written by the syndicate.

According to a newsletter from the "Syndicate 418 (1985) Names' Action Group," the names have hired the same law firm, Richards Butler, and the same barrister, Anthony Boswood, who as a team successfully won a settlement for members of Outhwaite's 1982 account.

However, there is a six-year statute of limitations to consider when approaching the Merrett case, said Mr. Tiplady.

Mr. Tiplady warned that for many of these cases it will take two years from the time a writ is filed before there is a trial. If members lose a case, they may be liable to pay the defendants' costs, as well as their own, he said.

Asked about reports that Lloyd's is discussing a single-market rescue package for members, Mr. Tiplady warned that a rescue would mean dropping all lawsuits immediately and instead seeking arbitration.

Mr. Tiplady said arbitration would be more expensive, but it would be private, quicker and probably more informal.

"I have seen a polarity of views" on a possible rescue package, he added. Some members say, "I have no losses. Why should I bail these people out," said Mr. Tiplady. On the other side, he said, members say, "I have a damned good case, because David Tiplady told me so and I want to fight it out to the finish and get 100% (of my losses) back."

"Until Lloyd's can bring those opposite views together in some way, the chances of a market rescue are put back, though I won't say they're necessarily impeded," he said. ■

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insurance and was renowned in the market for leading line slips for the coverage.

In 1989, for example, Mr. Walker led stop-loss coverage of 100,000 pounds ($183,000) per member through policies that were offered through Lloyd's broker Carritt & Partners (*BI*, Feb. 20, 1989).

In what seems to be an unprecedented move, Syndicate 387 has kept open seven underwriting accounts, 1983 to 1989, said Mr. Sharp. Cash calls have been made on all but 1985 and 1986. He presumed they were left open because of uncertainty over the syndicate's reinsurance-to-close premiums.

The latest call on syndicate 387 members means total cash calls from Gooda's eight syndicates now totals over 293 million pounds ($536.2 million). Syndicate analysts have estimated the total gross liabilities from Gooda syndicates could total 820 million pounds ($1.5 billion) (*BI*, April 13).

Members of Gooda syndicates 164, 290, 298 and 299 have already received cash calls last year and this year totaling 238 million pounds ($435.5 million), including a 101 million pound ($184.8 million) cash call due March 31, which the members threatened not to pay (*BI*, Feb. 24).

However, following Justice Saville's decision that Lloyd's could draw down on members' deposits if the calls weren't paid, about 40% to 45% of the 101 million pound cash call has been paid voluntarily, according to Mr. Sharp.

He expects the money to continue flowing in and anticipates having a detailed report on Gooda results June 5.

Lloyd's study

Lloyd's of London's results since 1950 generally are in line with those of U.K. and U.S. insurers, concludes a recent report commissioned by Lloyd's.

"Lloyd's does particularly well when insurance is very profitable and less impressively when the business is less profitable," said stock analyst Chris Hitchings in the report. "On a like-for-like basis, Lloyd's syndicates have generally produced higher profit margins than insurance companies."

Lloyd's did better than U.K. and U.S. insurers in the 1950s and especially in the 1970s, concluded Mr. Hitchings, who is with Hoare Govett Investment Research Ltd.

Lloyd's profits totaled 7.7% of net written premiums between 1950 and 1959, while U.K. insurers averaged profits of 6% and U.S. insurers' profits averaged 4%. Between 1970 and 1979, Lloyd's profits averaged 11.4% of net written premiums, compared with 5.1% for U.K. insurers and 4.7% for U.S. insurers.

In the 1960s, when Hurricane Betsy dominated the market, the differences in results among the three sectors were "minimal," according to Mr. Hitchings.

In the 1980s, Lloyd's results lagged behind those of the U.K. insurers, but this is largely due to Lloyd's three-year accounting system, according to the report.

On that basis, Lloyd's disastrous 1988 loss of 509.7 million pounds ($983.7 million at appropriate exchange rates) corresponds to the major U.K. insurers' 1990 aggregate loss of 645 million pounds ($1.25 billion). Lloyd's estimated loss for 1989—to be announced at the end of June—of as much as 1.65 billion pounds ($3.09 billion) corresponds to U.K. insurers' 1991 aggregate loss of 1.3 billion pounds ($2.43 billion).

The 1989 losses for Lloyd's and the 1991 losses for U.K. insurers are "unprecedented in the post-war period," said Mr. Hitchings.

In an interview, Mr. Hitchings said the publicly quoted U.K. insurance sector has taken a beating, with shareholder funds dropping to 6 billion pounds ($11.22 billion) at the end of 1991 from 11 billion pounds ($17.71 billion) two years earlier. The sector's market capitalization also dropped to 8.5 billion pounds ($15.9 billion) at the end of 1991 from 13 billion pounds ($20.93 billion) in 1989.

This has caused the value of U.K. insurance company stocks to plummet, which could affect the portfolios of major institutional investors like pension funds or life insurance companies.

Meanwhile, Hoare Govett has found that Lloyd's "has maintained technical reserves (that are) much higher than those of U.K. companies and generally higher than those of U.S. companies," said Mr. Hitchings. "Consequently, we conclude that Lloyd's is probably more strongly reserved than the U.S. insurance industry."

Lloyd's also maintains significantly stronger solvency margins than either U.S. or U.K. insurers, he said.

Oakeley Vaughan

The question of whether Lloyd's of London owed a duty of care to 31 members who face 10 million pounds ($18.4 million) in losses awaits a judge's decision by the end of the month.

The members were all on loss-riddled syndicates managed by Oakeley Vaughan Underwriting Ltd. In a full trial, which was suspended last year, the members alleged that Lloyd's learned of irregularities in the managing agency through a 1981 investigation and subsequently should have warned members.

Contending that it had no duty to protect individual members' interests, Lloyd's argued that its object is to enable members to "carry on the business of insurance."

The preliminary hearing, which concluded May 13, is being heard before Justice Gatehouse, who during the full trial had ruled that both sides should first argue whether Lloyd's owes a duty of care to members (*BI*, June 24, 1991).

His decision that a preliminary hearing was needed was overturned on appeal, but the House of Lords eventually ordered the hearing to proceed (*BI*, March 2).

Justice Gatehouse is expected to issue a decision in the case later this month.

In the hearing, Michael Lyndon-Stanford, the members' lawyer, said that under the Lloyd's Act of 1911, the principal object of Lloyd's is the advancement and protection of the underwriting interests of the members.

"The object is not to further its own business; the first object is to further the carrying on of insurance of every description for the members of the society," Mr. Lyndon-Stanford said.

And members and managing agencies play a significant role in carrying out that business, as Lloyd's only permits members to join the market through underwriting agencies, he said. Members rely on agents to carry out their business at Lloyd's and seek their advice on which syndicates to join, Mr. Lyndon-Stanford said.

And, the members argue, they relied on Lloyd's to supervise the agents.

Lloyd's, though, contends that its duty to members does not extend to safeguarding the economic interests of individual members.

"The advancement and protection of the interest of members of the Society does not necessarily involve and may sometimes be inconsistent with the protection of the economic interests of an individual member; for example, the imposition of premium income limits on successful underwriters, designed to preserve the security of the policy," Lloyd's argued in court papers.

Lloyd's, therefore, argues that it has no duty to protect members' individual interests. Lloyd's main concerns are the security of the Lloyd's policy and the prevention of situations that would be harmful to Lloyd's as a market, court papers say.

Lloyd's does require members to use underwriting agents. But the possibility that an agency may fail to perform its part of a contract does not imply a duty of care, the corporation said.

The 1982 Lloyd's Act generally prohibits members from suing Lloyd's. This suit is proceeding because it stems from actions that took place before the law was passed.

Municipal Insurance

Municipal Insurance Group P.L.C., the United Kingdom's ninth-largest insurer, is seeking

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a buyer amid rumors that it posted sizeable losses in 1991.

The mutual insurer, which is a major insurer of U.K. municipalities and local governments, plunged into the red in 1990 with a 64.8 million pound loss ($125.1 million at year-end 1990 exchange rate) after an increase in claims from municipalities, reports say. The company's overall 1991 loss are expected to be about the same as that 1990 loss.

Municipal Insurance will not comment on its 1991 results.

However, the company has announced that discussions are under way that may lead to proposals for the transfer of its business to another insurer.

In 1990, Municipal Insurance reported net premium volume of 572.3 million pounds ($1.1 billion) with gross assets of some 1 billion pounds ($1.93 billion).

Weather coverage

Worldwide Weather Underwriting Agencies has opened an office in London to offer "protection against the adverse effect of weather," says the underwriting agent.

The company, which started in the United States in 1987 (*BI*, June 19, 1989), will offer weather-related insurance for business and commercial activities like television programs, commercials, festivals, concerts and sports meetings.

"Our insurance programs are based upon the most extensive data base of weather information in existence, with statistics dating back over 40 years for over 30,000 weather stations across the globe," said President Harold Mollin."From this we can assess the probability of excess or insufficient rain, high or low temperatures, winds, snow, or other potentially loss-causing weather phenomena."

Companies underwriting coverage marketed by Worldwide Weather include Commercial Union Assurance Co. P.L.C. and GAN Minster Insurance Group, among others.

For more information, contact the firm at Forum House, 15/18 Lime St., London EC3M 7AP; 071-283-3883; fax: 071-220-7939. ■

Consultant views workers comp crisis

'Vast structural changes' necessary to solve financial problems: Conning

By MARK A. HOFMANN

HARTFORD, Conn.—A combination of structural changes is required to restore the workers compensation insurance system to some semblance of financial health, according to a recent report by a consultant.

But while the authors of Conning & Co.'s "Workers Compensation at a Crossroads: Investment Opportunities. . .or Coming Fall" hold that "vast structural improvements must be made to correct the system for the long run," they caution that "no grand idea is apparent or, for that matter, realistic" for reforming the deficit-riddled system.

The system's woes stretch backward nearly a decade, report the authors.

"The insurance industry has not only suffered unsatisfactory losses in 1990 but has borne a similar load of operating losses in every year since 1984, producing a cumulative operating loss of $8.2 billion after investment income on reserves," they write.

"This $8.2 billion represents about 70% of the total implicit capital and surplus accumulated by the industry for workers compensation up to 1984."

The authors offer this analogy: "If the workers compensation industry had been represented by a single company, it would have lost over 20% of its capital, even assuming investment income on surplus, and it would have been curtailed in its growth years ago. Incidentally, if probable reserve inadequacies were taken into account. . .the insurance industry capital pertaining to the workers compensation line would have been entirely wiped out."

The authors "suspect" that the industry's reserves are short by about 15%. This is a somewhat more optimistic reading than those of the Boca Raton, Fla.-based National Council on Compensation Insurance, the trade group that represents workers comp underwriters, and the New York-based Insurance Services Office Inc., which have estimated the inadequacy to be in the 17.5% to 22.5% range, for a total of between $14 billion and $18 billion.

Conning places much of the blame for the system's woes on residual market loadings.

"Perhaps the greatest dynamic affecting the deteriorating health of the insurance industry —and one that has been until recently relatively misunderstood —is the impact of the residual markets' burden on the ability of a voluntary writer of workers compensation to make a profit (or maintain solvency)," wrote the report's authors.

According to Conning: "Sharing in the workers compensation residual market imposed an extra financial cost or burden of 4.8% on workers comp insurers in 1988. In effect, there was an average 4.8% deterioration in a company's otherwise voluntary combined financial results from sharing in residual market losses."

Because of the residual market burden, companies would have to write their voluntary business at a combined ratio of about 95% simply to break even, note the authors.

But residual market burdens are not the only outside forces stressing the structure of the workers comp system, according to the report.

For example, Conning estimates that somewhere between $15 billion and $18 billion in workers comp premiums now belong to the alternative market, which includes captive insurers, risk retention groups and self-insurers. "While alternative options may be beneficial to some employers, they force adverse selection against the insurance industry as the pool of risks becomes less and less attractive to choose from," the report states.

In addition to residual market costs and an exodus of certain risks to alternative markets, "the workers compensation system has fallen prey to escalating medical costs, now approaching 50% of total claims dollars," write the authors.

"Litigation is also growing in both frequency and severity at rates faster than wage growth or inflation, perhaps spurred on by attorney advertising," they add.

Still, the costs are not as problematic as the structure of the system, according to the authors.

"On a basis of profitability and return on capital, at least from an average countrywide industry perspective, the results are unsustainable, and capital markets may force participants in the industry to abandon the business unless prospects for improvement become evident.

"While the costs to the employer are real and increasing, they are not on average a major burden by themselves—representing a lower burden than Social Security, general corporate income taxes, group health benefits and often less than general liability or other insurance costs.

"Rather, the problems arise from the differences among states, the high relative burden focused on certain industry groups and the reality that increases also may be placed unevenly on certain industry classes," combined with the fact that employers must provide the coverage and they are experiencing reduced effectiveness or perceived value for the dollars spent.

According to Stephan Christiansen, a Conning senior vp who served as the study's chief author, the wide variation in workers comp costs among states and among classes of business was somewhat surprising.

A company's workers comp costs can run from 0.5% of payroll to more than 50% of payroll, depending on the state and industry class, according to the study.

For example, using 1991 figures, the manual workers comp rate for machine shops in Virginia is $2.76 per $100 of payroll, the study states. For machine shops in Montana, the rate is $11.07 per $100 of payroll, and in Texas it's $12.36 per $100 of payroll.

For carpentry, the rates in selected states run from a high in Montana of $41.04 per $100 of payroll to $7.27 per $100 of payroll in New Jersey. But Massachusetts, which has a relatively low rate of $5.82 per $100 of payroll for workers comp in machine shops, posts a $38.79 rate per $100 of payroll for carpentry, according to the study.

With these sorts of state differences "you understand why somebody might want to drive a truck up the statehouse steps" in protest, said Mr. Christiansen.

Conning recommendations for improving the system are:

- Level the playing field among state workers comp funds, insurers and self-insured entities by spreading the costs of residual markets among insurers, self-insurers and taxpayers.

"The burden of residual markets must be shared by all employers or taxpayers—not confined to the insurance industry," say the authors.

- Implement monetary incentives that would reduce the costs of the workers comp system.

"While expense efficiency and risk reduction initiatives must be encouraged, at least the better managed (insurance) companies must see a way for profits to be achieved," the authors say.

Instead of placing as much emphasis on benefits, the system should be changed to promote workplace safety, prompt quality medical care and an early return to work, the report indicates. Incentives should be developed to encourage employers to undertake these improvements, it says.

- Avoid changing the basic system structure by enacting measures like 24-hour coverage. Combining workers comp with other benefits to produce 24-hour coverage "is as likely to bring the ills of workers compensation to the other structures as the other way around," the report's authors say.

- Develop a simpler, more uniform workers comp system, with differences among state workers comp systems "minimized through standard provisions of a model law" that would deal with cost factors like litigation and medical cost containment.

'While the costs to the employer are real and increasing, they are not on average a major burden by themselves—representing a lower burden than Social Security, general corporate income taxes, group health benefits,' the report says.

For employers and employees, "the level of differences among industry classes must be reduced —through a subsidized effort to reduce workplace injuries, and possibly through incentives encouraging cost reduction techniques," they say.

Conning predicts that workers comp insurers' results will continue to deteriorate, at least in the short run. A projection of the combined ratio of stock companies shows a steady weakening of the combined ratio through at least 1993. Conning & Co. projects that the combined ratio for workers comp insurers organized on a stock basis will be 122.9% in 1993, compared with an estimated 120.6% last year and 119% in 1990.

"At the same time, we are concerned about the continuing emergence of loss costs from prior years in the self-insured arena and state-administered funds," write the authors. Even the "most sophisticated participants might be caught by surprise by the long-tailed nature of the claims problem and the escalating complexity of cost drivers," they say.

Despite the system's ills, the authors see some areas of potential investment opportunity related to workers comp. These include services relating to cost containment, claims management and technology. They also say there could be some opportunities in certain regional and specialty areas, but caution: "The dynamics of loss reserve development and residual market burdens are sinister and not to be underestimated."

●

Copies of "Workers Compensation at a Crossroads: Investment Opportunities. . .or Coming Fall" cost $450. They can be ordered from Conning & Co., Cityplace II, 185 Asylum St., Hartford, Conn. 06103-4106; 203-527-1131.

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Fireman's Fund names Loucks vp-benefits

Comings & goings: buyers

Jennifer Loucks, 47, has been promoted to vp-benefits at Fireman's Fund Insurance Co. of Novato, Calif., from assistant vp-benefits. Ms. Loucks is responsible for the design, implementation, budgeting and administration of all benefit plans, including health, life, and travel and accident programs, as well as pension and 401(k) plans for the insurer's 10,000 U.S. employees. One of Ms. Loucks' major projects since the 1991 acquisition of Fireman's Fund by Munich-based Allianz AG Holding has been to explore potential cost-efficiencies in coordinating the administration of major benefit programs with sister companies. Ms. Loucks reports to Kathryn A. Murrell, recently elected to senior vp-corporate human resources. Prior to joining Fireman's Fund in 1986 as director of benefits, Ms. Loucks held various management posts at the former Crown Zellerbach Corp., a San Francisco-based forest products company. Prior to that, she was a retirement plans analyst at the Kaiser Foundation Health Plan. Ms. Loucks received a bachelor's degree in English from the University of Michigan in Ann Arbor, and a juris doctor degree from Golden Gate University School of Law in San Francisco. She is president of the San Francisco Chapter of the Western Pension & Benefits Conference.

* * *

Joseph R. Perrello, 46, has joined Eastern Mercy Health System in Radnor, Pa., as vp-insurance and risk management. He replaced **Ted Schlert**, who left to join Alexander & Alexander Services Inc. in Philadelphia as vp-health care services. Mr. Perrello is responsible for the insurance and risk management programs for the Catholic health care system, including its captive insurance company. He reports to Kent Russell, executive vp and chief financial officer. Prior to joining Eastern Mercy, Mr. Perrello was director of corporate risk management at Himont Inc., a Wilmington, Del.-based producer of products used in plastic production. Before that, he was director of corporate risk management at pharmaceutical manufacturer SmithKline Beecham Corp. in Philadelphia. Mr. Perrello, who holds a bachelor's degree in marketing from La Salle University in Philadelphia, is a deputy member of the Risk & Insurance Management Society Inc. and holds the Associate in Risk Management designation. He also is a member of the Philadelphia Insurance Managers Assn.

* * *

Kevin E. Flint, 41, has been promoted to director of benefits financing at Bausch & Lomb Inc. in Rochester, N.Y. He currently is responsible for financial analysis and administration of the company's benefits plans. Mr. Flint reports to Alan Resnick, vp and treasurer. Mr. Flint joined the health care and optics products company in 1981 as manager of international credit and was named manager of treasury projects in 1983. Most recently, he was manager of treasury financial analysis. Prior to joining the company, he was an international lending officer with NBD Bancorp Inc. of Detroit. Mr. Flint earned both bachelor's and master's degrees in finance from Ohio State University in Columbus.

* * *

Steve Somsen, 45, has been appointed risk manager for the city of Fresno, Calif. He replaces **Cliff Fisher**, who left to accept a teaching position. Mr. Somsen is responsible for the city's risk management division, which involves placement of excess coverages, including property, liability, workers compensation, aviation and mass transit. He also directs the in-house property and liability claims operation. Mr. Somsen reports to James C. Dirlam, city finance director. Mr. Somsen had been assistant risk manager for the San Diego County Schools Risk Management Joint Powers Authority, the district's property, liability and workers compensation risk pool. Mr. Somsen holds the Associate in Risk Management designation and served as 1991 chairman for the Public Agency Risk Managers Assn. He also is a member of the California Assn. of Joint Powers Authorities. Mr. Somsen earned a bachelor's degree in public administration from California State University at Long Beach.

* * *

Paul Harvey, 33, has been named a vp at Transamerica Insurance Co. in Woodland Hills, Calif. Mr. Harvey had been assistant vp since 1990 and continues to serve as director of compensation and benefits responsible for all payroll activities, employee benefit plans, and policies and procedures related to compensation and benefits. He reports to Lon McClimon, senior vp-administration. Previously, Mr. Harvey was human resources manager at the home office in Los Angeles, with responsibility for employee relations activities in several regions and among several subsidiaries. He joined Transamerica in 1980 and spent seven years in the claims area. Mr. Harvey holds a bachelor's degree in labor and industrial relations from Michigan State University in East Lansing. He also is a deputy member of RIMS.

* * *

Rodger A. Cochran, 49, has been named director of risk management and insurance for Owen Steel Co. Inc. in Columbia, S.C. Mr. Cochran is responsible for the risk management program, property/casualty self-insurance administration, group benefits, and safety and loss control. He reports to Guy W. Hendley, executive vp-finance. Prior to joining Owen, Mr. Cochran was director of risk management and insurance for the Gate Petroleum Co. in Jacksonville, Fla. He is a deputy member of RIMS and holds the Certified Property Casualty Underwriter designation and the Insurance Institute of America Certificate.

* * *

Steven A. Contezac, 33, has been named director of corporate risk management services for CUNA Mutual Insurance Group in Madison, Wis. Mr. Contezac is responsible for the company's worldwide corporate risk management activities, including property/casualty coverage, corporate clams administration, and safety and loss control. He reports to Bill Jolicoeur, vp. Mr. Contezac previously was manager of corporate safety and loss control with CUNA Mutual. Prior to joining the company, he was an account representative for Wausau Insurance Cos. Mr. Contezac holds the Associate in Risk Management and the Associate in Loss Control designations. His professional memberships include RIMS, the National Safety Council, the American Society of Safety Engineers and the Board of Directors of the Madison Area Safety Council. Mr. Contezac earned a bachelor's degree in psychology and business administration from the University of Wisconsin in Eau Claire and a master's degree in occupational safety and health from the University of Wisconsin in Whitewater.

●

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All proposals shall be submitted in a form approved by the Authority. Copies of the form and information concerning the coverage may be obtained from the Authority at the Administrative Office.

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The Superintendent of Insurance of the State of New York, as Liquidator of Constellation Reinsurance Company, has filed a Petition with the Supreme Court of the State of New York, County of New York seeking approval of a Plan of Reorganization for Constellation. The plan of reorganization, if approved by the Court, may affect rights of creditors, cedants and retrocessionaires of Constellation. Copies of the Petition and all supporting documents are available for inspection at the Office of the Clerk, Supreme Court of the State of New York, County of New York, 60 Centre Street, N.Y., N.Y. (Index No. 43178/1986) and at the offices of the Liquidation Bureau, NYS Insurance Department, Attention: Stephen Ungar, 123 William Street, N.Y., N.Y. Copies of the Petition and all supporting documents will also be mailed at the request of any interested party upon payment of reproduction and mailing costs. Requests for copies should be directed to the Liquidation Bureau at the above address. The court will hold hearings on the Plan of Reorganization on July 2, 1992 at 9:30 A.M. in Court Room 228. Any interested party seeking to be heard in objection to the Petition must file written objections in writing with the Court and serve them on the Liquidation Bureau at the above address. Written objections must be received by the Court and by counsel for the liquidator by June 18, 1992 in order for the objectant to be heard.

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TOTAL 51,099

* Source Business/Occupational breakdown of qualified circulation, November 25, 1991 issue, as submitted to BPA for December 1991 BPA Publisher's Statement.

M&M names Smith chairman, chief executive

A.J.C. Smith was elected chairman and chief executive officer of Marsh & McLennan Cos. Inc. of New York, replacing **Frank J. Tasco**, who is retiring from the posts he held since 1986.


Mr. Smith

Replacing Mr. Smith as president is **Robert Clements**, who has been an M&M vice chairman since 1991.

Both Messrs. Smith and Clements have been with M&M for more than 30 years, with Mr. Smith coming up in the human resources/consulting divisions and Mr. Clements through Marsh & McLennan Inc., the brokerage division.

In other agent/broker changes:

Gary R. Griffith, who was named president of Republic Hogg Robinson Inc. in 1991, named to the additional title of chief executive officer, replacing **Charles Keller**, who will remain chairman. Mr. Griffith joined RHR, the Boston-based U.S. unit of Hogg Group P.L.C., as executive vp in 1990.

Alvin F. Johnson named executive vp in the Irvine, Calif., office of Rollins Burdick Hunter Co. He is responsible for property/casualty coverages, consulting, risk management services and quality control standards for clients. Also at the Aon Corp. unit, **David D. Kavanaugh** named vp of Rollins Burdick Hunter of Michigan Inc. in Grand Rapids; and **William B. Freiheit** named vp at RBH of New York Inc.

Theodore J. Fuller named manager of the Johnson & Higgins office in Philadelphia, succeeding **Sam W. Aiena**, who will work on special assignment for J&H. Mr. Fuller is a director and executive vp of J&H of Pennsylvania. Also at J&H, **Brian da Costa** promoted to vp in the property department and **Ronald K. Tucker** promoted to vp in the middle market department. Both are based in New York.

Willis Corroon P.L.C. announced these changes: **Phillip A. Marsh** appointed president and CEO of Willis Corroon Corp. of Sacramento, Calif., succeeding **James O. Burpo**, who will remain chairman; **William E. Gabbert** elected executive vp with Willis Corroon Corp. of Arizona in Phoenix; and **Wayne W. Brown** appointed managing director of the construction industry division of Southern California in Pasadena.

Daniel Sandberg promoted to executive vp with Kelter-Thorner Inc., a Bloomfield, Mich., agency specializing in environmental insurance and lawyers professional liability.

Thomas M. Redmond Jr. joined F.J. Wilkes & Co. Inc., a brokerage based in Jersey City, N.J., as senior vp of new business production.

Charles J. Gehrke promoted to executive vp and **J. Ray Davis** to senior vp at Frank B. Hall & Co. of Georgia in Atlanta.

Michael R. Machanich and **John A. Legnitto** named vps with American Business Insurance Brokers, an American Business Insurance Inc. unit in San Francisco.

Frank Yerger promoted to vp with Ross & Yerger Inc., an agency in Jacksonville, Miss.

Michael J. Mitchell promoted to vp at The Graham Co., a Philadelphia brokerage.

Comings & goings: industry

Insurers

Shivan S. Subramaniam has been elected president of Allendale Mutual Insurance Co. of Johnston, R.I. As president, he replaces **John J. Carey**, who remains chairman and chief executive officer. Mr. Subramaniam has been with Allendale for 18 years and was promoted to executive vp last year.

Also at Allendale, **Michael C. Williams** named vp-Dallas operations manager, replacing **Daniel W. Schaffer**, who is now operations manager in Boston.

William Z. Fornshell named president of Continental Guaranty & Credit Corp. of New York. He previously had been executive vp of the Continental Corp. unit's surety division.

Barry Persofsky named executive vp of Commerce & Industry Insurance Co. in New York, responsible for worldwide environmental and pollution business with the American International Group Inc. unit. **Kenneth B. Cornell** named vp of C&I Insurance and head of its pollution liability division.

James W. Entringer joined Selective Insurance Group Inc. of Branchville, N.J., as president and chief operating officer. **Frederick H. Jarvis**, who had been president, remains chairman and chief executive officer. Mr. Entringer formerly was a life insurance executive with Merrill Lynch & Co. Inc.

Tom Rowe named president of the commercial insurance division of Fireman's Fund Insurance Co., the Allianz A.G. Holding unit in Novato, Calif. Mr. Rowe was most recently senior vp with the company's specialty insurance division in New York.

Louis F. Marioni resigned as chairman and chief executive of Superior National Insurance Co. of Calabasas, Calif., the company he helped found in 1981. Mr. Marioni, formerly CEO of Mission Insurance Group, is retiring. Replacing him as chairman and CEO is **Neal Stanley**.

Other suppliers

Richard J. Shima joined San Francisco-based investment banking and consulting firm Russell Miller Inc. as managing director and head of a new office in Hartford, Conn. For the previous 30 years, Mr. Shima had been with Travelers Corp., most recently as vice chairman.

Crawford & Co. has promoted four executives of its chief operating divisions and one of the four, the company says, will likely be named chief executive officer within the next few years.

The promotions are:

- **P.A. Bollinger**, promoted from executive vp to president and chief operating officer of the HealthCare Management Group.
- **C.C. Lefler**, promoted from executive vp to president/COO of the Risk Management Services Group.
- **Frank Semancik**, promoted from executive vp to president/COO of the Claims Services Group.
- **James G. Sybert**, promoted from vp to senior vp/COO of the Risk Control Services Group.

All four executives report to Forrest Minix, president and chief executive officer of the Atlanta-based provider of risk management services.

Dr. S. Jeffrey Ackerman named president and chief executive officer of Intracorp, the Berwyn, Pa.-based health care cost management subsidiary of CIGNA Corp., replacing **Warren D. Fuller**, who is retiring. Dr. Ackerman had been president of CIGNA's managed dental care subsidiary.

Dr. Dwight Robertson named president of Conservco Inc., a managed care subsidiary of Travelers Corp. in Hartford, Conn. Previously, Dr. Robertson had been vp of workers compensation managed care in the property/casualty claim department. Also at Travelers, **Bruce Butler** named senior vp of managed care and employee benefit operations in Hartford. He has been with Travelers for 30 years.

Robert W. Stein named national director of the insurance industry services practice at Ernst & Young in New York. Mr. Stein, formerly the national director of actuarial services, replaces **Robert L. Posnak**, who is retiring.

Kenneth W. Ayers appointed a vp in the environmental services division of Willis Corroon Advanced Risk Management Services. Before joining the Willis Corroon P.L.C. unit, Mr. Ayers was an environmental engineer with the federal Superfund program.

Edward Stetzer, formerly corporate director of managed health care for Campbell Soup Co., joins North, Clawson & Bolt Ltd. as a vp. The Sacramento, Calif., firm is an employee assistance and managed care consultant.

Richard M. Wald joined the Minneapolis office of The Wyatt Co. as director of the health care and group flex practice.

Robert J. Doyle Jr. named senior vp at Mandeville Financial Services Inc., a regional brokerage and consulting firm based in Bala Cynwyd, Pa.

Robert Koch named principal with The Administrative Management Group Inc., an employee benefit consulting firm in Arlington Heights, Ill.

Stephen B. Goodell joined Admar Corp., a managed care firm based in Santa Ana, Calif., as president of its employee benefits division.

HMOs/PPOs

Dr. David M. Lawrence, the chief executive officer of Kaiser Permanente Medical Care Program, the nation's largest health maintenance organization, takes on the additional title of chairman following the resignation of **James A. Vohs**. From 1980 until Dr. Lawrence was promoted last year, Mr. Vohs had been president, CEO and chairman of the Oakland, Calif.-based HMO.

Marie Sinioris named senior vp and chief operating officer with Rush Health Plans, a group of HMOs and preferred provider organizations in Chicago. The group, which is owned by Rush-Presbyterian t. Luke's Medical Center, consists of Rush-Anchor/Rush-Access HMO and Rush Contract Care PPO.

Reinsurance

John D. Schuck joined North American Reinsurance Co. of New York as executive vp-corporate planning. He had been a partner with management consulting firm McKinsey & Co.

F&G Re Inc., a USF&G Corp. unit in Morristown, N.J., announced these promotions: **John R. Berger** to executive vp and **Dwight R. Evans** to senior vp in the property underwriting unit.

E. Michael Joye joined American Re-Insurance Co. in Princeton, N.J., as senior vp and special counsel in corporate operations. He resigned as general counsel of American International Group Inc. Also at American Re, **Thomas Walker** was promoted to senior vp of issues management and planning from vp. Mr. Walker serves as the company's primary liaison with its risk and captive management unit, Becher & Carlson Risk Management Inc.

Lewis H. Paul promoted to president of the U.S. branch of Frankona Reinsurance Co. in Kansas City, Mo. Most recently, Mr. Paul was senior vp and chief underwriting officer with the unit of the Munich, Germany-based reinsurer.

Clement S. Dwyer Jr. promoted to executive vp from senior vp at Guy Carpenter & Co. Inc., the reinsurance brokerage subsidiary of Marsh & McLennan Cos. Inc. in New York.

Thomas A. Rogers named executive vp in charge of a new Aon Reinsurance Agency Inc. office in Philadelphia. Also, at the Aon Corp. unit, **Bruce Paterson** named vp/actuary in the Chicago office.

Franklin Montross IV appointed senior vp at General Reinsurance Corp. Also at General Re, **Charles R. Barr** and **Robert D. Graham** promoted to vps and assistant general counsels. All three are based at General Reinsurance Corp.'s Stamford, Conn., headquarters. **John W. Cleveland** appointed to vp in the company's Chicago office. ■

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Panel considers a cure for 'sick' industry

By LORI BLOCK

CHICAGO—The property/casualty insurance industry is a "sick business" and that the current pricing situation is "lunacy," a leading industry analysts told members of the Casualty Actuarial Society.

Myron Picoult, a managing director and senior financial analyst with Oppenheimer & Co. in New York, expressed his critical views of the insurance industry at the society's annual spring meeting in Chicago May 13. Mr. Picoult was part of a four-person panel that discussed insurance solvency issues.

Mr. Picoult's assessment may be considered harsh by some, but it was clear from the session that various factions of the insurance industry believe that some form of reform is needed or, at least, inevitable.

For instance, Vincent Laurenzano, the assistant deputy superintendent and chief examiner of the New York State Insurance Department, discussed the development of risk- based capital standards. And, Paul McCrossan, a partner with the Eckler Partners Ltd. actuarial and consulting firm in Don Mills, Ontario, and a former member of the Canadian House of Commons, outlined some of the regulatory steps Canada has taken to prevent insolvencies.

To support his assessment that the current condition of the insurance industry is the "sickest" he has ever seen, Mr. Picoult cited the following facts concerning insurers:

- Premium growth has "basically stalled."
- Net investment income growth is slowing and may even turn negative.
- Insurers' cash flow levels have fallen by more than 25% in both 1990 and 1991.
- Reserve levels are "horrendous and the combined ratio numbers are "distorted."
- Return-on-equity results are "lousy."

And, while insurers' stocks continue to perform reasonably well and the industry continues to attract capital, Mr. Picoult isn't sure that this investment situation will continue.

"There is an incredible amount of frustration out there" on the part of portfolio managers, he said. When he visits with portfolio managers, the first thing they want to know is when the soft market is going to turn around, Mr. Picoult explained.

Soon, he said, "portfolio managers are going to start voting with their feet."

But portfolio managers aren't the only ones frustrated with the insurance industry. Ronald E. Ferguson, the chairman and chief executive officer of General



Oppenheimer's Myron Picoult says the commercial insurance industry's current condition is the 'sickest' he has ever seen.

Re Corp. in Stamford, Conn., and the session's moderator, said, "Clearly, insurance solvency and regulation are center stage.

"It's pretty clear nobody's very happy with us right now," he said.

The investment community's concerns over insurers' earnings and the public's concerns over insurers' solvency demonstrate the need for change. One change being considered by the National Assn. of Insurance Commissioners is the adoption of a risk-based capital standard.

Under this standard, several elements of an insurer's business —including the investment mix, reinsurance program and the types of policies written—would be weighted according to the financial risk they pose. The idea is to tie an insurer's minimum capital requirements to the riskiness of its assets and products (*BI*, Dec. 9, 1991).

"In effect, what we're trying to do is raise the safety net," explained Mr. Laurenzano, the chairman of the NAIC's property/casualty working group on risk-based capital. "Hopefully, a risk-based capital standard will encourage prudent practices on the part of the industry," easing insurance cycles and mitigating the size of insolvencies, he said.

That's exactly what Michael A. Goldberg, the vp of Berkshire Hathaway Inc., is hoping. Mr. Goldberg, who heads Berkshire's insurance group from the company's Omaha headquarters, said that the adoption of a risk-based capital standard "should make it more difficult for irresponsible people to get in and stay in this business."

In addition, "increasing capital requirements. . .should, over time, force our competitors to raise their prices," Mr. Goldberg noted.

That remark, as well as others made by the panelists, piqued the curiosity of at least one attendee who asked what impact a risk-based capital standard would have on competition.

Mr. Laurenzano remarked that it is not the goal of regulators to "discourage competition," citing the benefits that competition brings to the industry and its consumers, like product innovation and cost-cutting efforts. But he conceded that regulators' jobs are made more difficult in an insurance industry based on competition.

"We want to encourage all kinds of competition," said Mr. Goldberg, "but we also want safety nets." Policyholders, he noted, don't always benefit from unfettered competition. And, when people buy insurance policies, they are actually buying them from the industry, not just



Canadian insurers are learning to live with regulations mandating that an actuary be appointed to their staff, says Paul McCrossan.

from a particular insurer, Mr. Goldberg remarked.

"Understand, you've got responsible and irresponsible competition," Mr. Picoult added.

Furthermore, Mr. McCrossan noted that risk-based capital standards may spur new product development, since the standards are likely to reveal which products currently sold are unsound.

In Canada, where Mr. McCrossan conducts his business, life and property/casualty insurers are learning to live under a new set of regulatory guidelines that go beyond capital requirements.

The cornerstone of these new requirements is one mandating that all insurers have an appointed actuary on staff. This actuary is charged with the task of being an independent reporter of the insurer's financial condition both to the insurer's officers and to regulators.

To assist the actuaries in their duties, they have been provided with legal protection from libel and slander charges as well as tort damages, as long as they are acting in good faith, Mr. McCrossan explained.

"Interestingly enough, it was the Canadian Bar Assn." that pushed for the actuaries' legal immunity, he said.

While Canada may be ahead of the United States in the realm of insurance reform, there are reasons for the two countries to take different approaches.

There are strong constitutional differences between the two nations, Mr. McCrossan observed. In the United States, the emphasis is on the adage, "life, liberty and the pursuit of happiness." In Canada, the emphasis is less on individual rights and more on "collective security," he said.

Meanwhile, no one is touting the risk-based capital standard as a cure-all. The risk-based capital standard "won't be a perfect capital system for the industry," Mr. Laurenzano pointed out. "This formula may not detect all troubled insurers."

He also cautioned that this formula should not be used as a basis for determining whether policyholders deserve a refund, just as it shouldn't be used to definitively determine that an insurer is insolvent. Mr. Laurenzano said the formula is designed to guide regulators, who should then consider the individual characteristics of each insurer.

Panel members fielded a few other questions relating to solvency. It was in this forum that one attendee commented on the negative impact one state insurance department can have on the health of other states' insurance markets if the former sets rate levels too low or orders rebates, actions that can hurt insurers' profitability.

Specifically, the attendee asked the panel why other NAIC members don't "gang up" on renegade regulators.

This question drew laughter from the audience and this response from Mr. Laurenzano: "There's no movement I know of to gang up on California." ■

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Datebook

JUNE

JUNE 1-2. Profitable Opportunities for Insurance Fronting seminar in New York City, sponsored by Executive Enterprises Inc.; $1,090. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-831-8333; 212-645-7880.

JUNE 1-2. Managed Care Solutions conference in Chicago, sponsored by The Institute for Employee Benefits Training; $700. **Also June 29-30** in Tampa; **September 10-11** in New York City. The Institute for Employee Benefits Training, Seminar Division, 1926 Arch St., Philadelphia, Pa. 19103; 215-567-4000.

JUNE. 1-3. Fundamentals of Insurance seminar in San Francisco, sponsored by the Risk & Insurance Management Society Inc.; $700 for RIMS members; $800 for non-members. RIMS Education Department, 205 E. 42nd St., Suite 1504, New York, N.Y. 10017.

JUNE 1-3. Environmental Regulation Course in Louisville, Ky., sponsored by Executive Enterprises Inc.; $1,045. **Also June 3-5** in Chicago; **June 17-19** in Indianapolis. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-831-8333; 212-645-7880.

JUNE 2-3. Advanced Risk Management Analysis seminar in Boston, sponsored by the Risk & Insurance Management Society Inc.; $700 for RIMS members; $800 for non-members. RIMS Education Department, 205 E. 42nd St., Suite 1504, New York, N.Y. 10017.

JUNE 2-3. Understanding Today's London Insurance Market conference in New York, sponsored by Executive Enterprises Inc.; $1,090. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-831-8333; 212-645-7880.

JUNE 3. Annual ERISA Reporting Requirements: Form 5500 seminar in Stamford and Hartford, Conn., sponsored by the Southern New England Chapter of the International Society of Certified Employee Benefit Specialists; $15 for members; $25 for non-members; add $5 each for Hartford meeting. Brian Booher, A. Foster Higgins & Co., 203-353-6510.

JUNE 3. Where are the Changes? In-Depth Review of the Commercial Property Policy seminar in Sioux Falls, S.D., sponsored by the Society of Chartered Property & Casualty Underwriters and the Sioux Empire Chapter; $85 for society members; $95 for non-members. Bonnie Kinsley, The Society of CPCU, 720 Providence Road, P.O. Box 3009, Malvern, Pa. 19355; 215-251-2735.

JUNE 3. Managed Care; The New England Experience seminar in Boston, sponsored by the New England Employee Benefits Council; $135 for NEEBC members; $195 for non-members. Linda Viens, 617-239-1767.

JUNE 3-5. ERISA Basics: A Primer on ERISA Issues in San Francisco, sponsored by the American Bar Assn.; $525 for ABA members; $550 for non-members; some discounts available. ABA, Division for Professional Education, 541 N. Fairbanks, Chicago, Ill. 60611-3314; 800-964-4253.

JUNE 3-5. Practical Environmental Regulation Course in Chicago, sponsored by Executive Enterprises Inc.; $1,090. **Also June 8-10** in San Diego; **June 15-17** in East Rutherford, N.J., and Memphis, Tenn.; **June 17-19** in Indianapolis; **June 22-24** in Albuquerque, N.M.; Baltimore; and Oklahoma City; **June 30-July 2** in Pittsburgh; **July 8-10** in Boston; **July 15-17** in Washington, D.C.; Dallas; **July 20-22** in Minneapolis; Atlanta. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-831-8333; 212-645-7880.

JUNE 4. Reviewing Possible Gaps in Umbrella/Excess/CGL Coverage seminar in Jacksonville, Fla., sponsored by the Society of Chartered Property & Casualty Underwriters and the North Florida Chapter; $80 for society members; $90 for non-members. Bonnie Kinsley, The Society of CPCU, 720 Providence Road, P.O. Box 3009, Malvern, Pa. 19355; 215-251-2735.

JUNE 4-5. High-Rise Fire Prevention and Protection seminar in Boston, sponsored by Arkwright Mutual Insurance Co.; $295. **Also June 22-23** in New York City. Dianne Muise, Arkwright Mutual Insurance Co., P.O. Box 162, Waltham, Mass. 02254; 617-890-9300, ext. 3920.

JUNE 7-10. Group Health Institute program in Minneapolis, sponsored by Group Health Assn. of America; $650 for GHAA members; $750 for non-members. GHAA, Department 0612, Washington, D.C. 20073-0612.

JUNE 8-10. 1992 Retiree Health Care Benefits Conference in Boston, Mass., sponsored by the International Foundation of Employee Benefit Plans; $555 for IFEBP members; $600 for non-members. IFEBP, Registrations Department, P.O. Box 69, Brookfield, Wis. 53008-0069; 414-786-6700.

JUNE 8-12. The Fundamentals of International Employee Benefits conference in Brookfield, Wis., sponsored by the International Foundation of Employee Benefits; $1,050 for IFEBP members; $1,175 for non-members. **Also Oct. 12-16**. IFEBP, P.O. Box 69, Brookfield, Wis. 53008-0069; 414-786-6700.

JUNE 9. Weathering the Storm: Catastrophe and Insurance symposium in Farmington, Conn., sponsored by the Society of Chartered Property & Casualty Underwriters and the Agency Administration, Claims, Loss Control, Risk Management and Underwriting Sections; $95 for society section members; $115 for non-section members; $135 for non-members. Mari Stambaugh, The Society of CPCU, 720 Providence Road, P.O. Box 3009, Malvern, Pa. 19355; 215-251-2741.

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Olympia & York

Continued from page 1

pounded in March, when concerns about O&Y closed off the firm's access to the commercial paper market, cutting out a source of short-term financing for its operations, the filings say.

U.S. insurers, already plagued with problem real estate investments, face more headaches on O&Y properties. The extent of these headaches varies greatly from insurer to insurer, though, and many insist the pain will be relatively minor.

Insurer involvement in O&Y properties has taken at least three forms:

- Direct mortgage loans on O&Y-controlled buildings.
- Investment in publicly traded notes or bonds issued to finance the acquisition of commercial buildings by O&Y partnerships.

O&Y used bond issues rather than mortgages to finance several acquisitions because bond interest rates were lower than prevailing mortgage rates, insurance company observers say.

Rent revenues from a given bond-financed building are used to make interest payments to that building's bondholders. In case of default, bondholders may foreclose on the building but have no recourse against O&Y itself.

- Financial guarantees issued to back interest payments on bonds.

Aetna Casualty & Surety may face the biggest immediate loss on O&Y properties because of the $46 million financial guarantee it wrote to cover interest on bonds secured by a 53-story office tower at 55 Water St. in lower Manhattan. That building is described by the developer as the world's largest office building.

The building—which faces a costly asbestos removal problem—secures $548 million in debt, including a $435 million interest-bearing bond issue and a $113 million zero-coupon bond issue.

At a bondholders meeting in New York last week, O&Y confirmed that leases on about 40% of the building's space will expire by next June and that the building's cash flow will not be enough to cover interest payments to bondholders in 1993.

A $36 million payment is due bondholders on June 30, and the building will have only about $10 million available, along with $50 million in credit supports from Aetna and Swiss Bank Corp.

An Aetna spokesman confirmed the insurer may suffer at least a partial loss on its $46 million guarantee on June 30, with additional losses possible. Aetna would have to try to recover its losses as a general creditor of O&Y in Canada.

Along with the guarantee on the 55 Water St. bond issue, Aetna also wrote a $140 million guarantee on commercial paper issued by Olympia & York Capital Inc.

This guarantee is secured by a 26-story Los Angeles office tower, the spokesman said.

Aetna units also wrote about $14 million in other guarantees for O&Y, all secured by bank letters of credit, and has a $197 million mortgage loan on a 44-story office building at 245 Park Ave. in New York. The spokesman said the Park Avenue building has adequate cash flow to cover its debt obligations.

Separately, principal and interest on some 55 Water St. bonds sold on the secondary market are backed by a financial guarantee reinsured by Credit Reinsurance Co. Ltd. of Bermuda and Maryland-domiciled of Capital Reinsurance Co. Capital Re is a unit of Capital Re Corp., which is also Credit Re's largest shareholder.

A Capital Re spokeswoman would not identify the primary insurer that wrote the guarantee but said it was not Aetna. The two reinsurers guarantee a total of about $30 million, with Credit Re responsible for the first $16.3 million in claims.

Capital Re Corp. announced last week that its 1992 aftertax income will be reduced by $1.5 million because of a $4.8 million loss reserve set up by Credit Re.

Several other insurers, meanwhile, are bondholders of the troubled 55 Water St. building and last week were starting to consider what action to take if the bonds go into default.

"Nobody has any answers. We hardly know what the questions are yet," one insurance company official said. Noting that the building's value was estimated at $742 million in 1986, he added, "This was a highly secured transaction, and it has taken an unprecedented decline in real estate values to get us into this situation."

Investors selling their bonds now would take a substantial loss, one insurer official said, noting that the bonds are currently trading at 25% to 50% of par value.

Bondholders could also foreclose and try to sell the building, though this could also produce big losses: The tower's current market value has been estimated as low as $200 million, well below the $548 million in outstanding debt.

Investors might also renegotiate the terms of the note issue and allow O&Y to remain in control of the property.

Insurers say they are unlikely to liquidate their holdings at a loss and may instead wait to see if the properties' outlook improves.

New England Mutual Life Insurance Co. of Boston, with a total investment portfolio of $12 billion, holds bonds on 55 Water St. with a par value of $21 million, confirmed Charles Wallis, president of Back Bay Advisors Inc., a New England Mutual investment unit.

He noted the extent of any loss on the property is unclear, since it isn't known whether the building's leases will be renewed and at what rent, what the building's value would be if it is put on the block, or how quickly the New York real estate market will recover.

"We know we are not going to lose 100 cents on the dollar. We may not lose a penny," he said.

London Pacific Life & Annuity Co., a Raleigh, N.C., insurer with $480 million in assets and $27 million in surplus, also holds 55 Water St. bonds with a par value of about $8.5 million, said James Catington, the insurer's president.

Other insurers with investments in O&Y-related properties include:

- Alexander Hamilton Life Insurance Co. of America in Farmington Hills, Mich., which holds $24.4 million par value of a $970 million bond issue secured by three New York office buildings.

Interest payments on the floating-rate issue are current, said Vp and Treasurer Frank A. Thiel.

He added that he doesn't expect problems of the type experienced on the 55 Water St. issue and doesn't expect to be liquidating the investment anytime soon.

Alexander Hamilton and affiliates had assets of about $5.7 billion and surplus of $435 million at the end of the first quarter.

- SAFECO Corp. of Seattle, one of whose property/casualty units holds $15 million par value of a bond issue secured by First Canadian Place, a Toronto office tower, said George P. Yonker, assistant vp-finance.

The building is included in O&Y's bankruptcy filing, and SAFECO is uncertain of the affect of Canadian bankruptcy law on the bondholders' lien, Mr. Yonker said. Though the building generates sufficient cash flow to cover interest payments, O&Y defaulted on an $800,000 payment due bondholders in May, he added.

SAFECO has about $10.5 billion in invested assets.

- Prudential Insurance Co. of America of Newark, N.J., which made a $155 million mortgage loan on Aetna Canada Centre, a Toronto office building, and holds about $15 million par value of the bond issue secured by First Canadian Place, a spokesman confirmed.
- USLIFE Corp., which holds $10 million par value of a bond issue secured by a 44-story tower at 59 Maiden Lane in New York.

USLIFE Chairman Gordon E. Crosby Jr. observed that the building is fully leased and that the leases don't expire until after the bond issue matures in 1995.

- Transamerica Life Insurance Cos. of Los Angeles, which holds $2 million par value of the bond issue secured by 59 Maiden Lane, a spokeswoman confirmed.
- Manufacturers Life Insurance Co. of Toronto and Standard Life Assurance Co. of Montreal, which made mortgage loans of $40 million on a Willowdale, Ontario, office building developed by Yonge-Sheppard Holdings Ltd., a company part-owned by O&Y, confirmed Lorne Down, assistant vp-Canadian mortgages for Manufacturers Life.

Loan payments are current and should not be affected by O&Y's bankruptcy filing, he said. ■

Banking bill compromise

Continued from page 2

Washington, the key provisions of the agreement include:

- Interstate banks would have the same powers to sell insurance that state-chartered banks currently enjoy in their respective states.

This provision would not give interstate banks automatic entrance into all states. For instance, interstate banks would be able to sell insurance in Wisconsin, where currently only state-chartered banks enjoy that right, Mr. Rusbuldt said. But in Illinois, which prohibits state-chartered banks from selling insurance products, interstate banks also would be prohibited.

Mr. Leggett said the net result is that interstate banks would have the opportunity to sell insurance products in 20 states.

"We're going to a pure states' rights position for the national banks," Mr. Rusbuldt explained. The national banks "can do no more or no less than the state-chartered banks."

- Banks would have to adhere to solicitation restrictions, which would prohibit them from marketing insurance products to prospective borrowers while their loan is being approved. "This provision will not eliminate credit tie-ins, but we believe it will reduce the possibility of credit tie-ins," Mr. Rusbuldt said.
- Banks could not favor an agent affiliated with their institution over independent agents and would be required to advise potential policyholders that insurance products could be purchased elsewhere.
- Banks would be required to disclose that the Federal Deposit Insurance Corp. does not insure the insurance products—for example, annuities—that banks sell. Policyholders would be required to sign a form indicating they are aware such products aren't backed by the FDIC.
- Banks would have to provide federal banking regulators with information regarding their insurance business.

In forging the agreement, the two sides "bridged a gulf that many thought was unbridgeable," said Joel Wood, the vp of government affairs for the National Assn. of Casualty & Surety Agents.

While Mr. Wood does not believe the agreement will create a completely level playing field, he said that the provisions should eliminate the most "egregious" competitive inequalities.

"The fact that we've reached this compromise doesn't mean we don't still think that banks should be banks and insurance agents should be insurance agents," Mr. Wood added.

Messrs. Wood and Rusbuldt said two key hurdles need to be overcome before banking reform becomes a reality.

Smaller banks—represented by the Independent Bankers Assn. of America—must agree to the interstate banking provisions and then legislators must approve the package.

"As much as this makes a lot of sense, as strongly as we support it, it's going to be tough to sell in an election year," Mr. Wood said. ■

L.A. riot lawsuits

Continued from page 3

placed an advertisement in a local newspaper offering free consultation to business owners on how to recover lost income and expenses "even if you did not suffer fire damage or looting."

While the firm initially received inquiries mainly from small mom-and-pop operations, at least one movie studio has asked whether it can seek coverage for royalties lost when movie theaters were shut down because of the curfew, he said.

In addition to movie producers, other businesses that may have similar claims include fast-food franchisers that receive a percentage of franchisees' profits and retail property landlords whose lease contracts include payment of a share of their tenants' receipts, he added.

Such claims could drive up the estimate of insured losses from the riots, which was set at $775 million last week by the Property Claim Services division of the American Insurance Services Group.

Even at $775 million, the Los Angeles riots would probably rank as the fifth-costliest U.S. catastrophe in terms of claims payments, said Gary R. Kerney, a PCS director in Rahway, N.J.

"Only Hurricane Hugo, the Oakland fire, the Loma Prieta earthquake and the 'Siberian Express' of 1983 caused more insured damage," he said. The Siberian Express is the nickname given to wind, snow and freezing that gripped 41 states in 1983.

Other attorneys agree that some businesses that did not sustain property damage from fire or looting may have legitimate business interruption claims.

"There's a provision in most (commercial insurance) policies that provides coverage for business interruption due to a declaration of a governmental authority," provided the stated loss is covered under the policy, said Ray Cotkin, a partner in Los Angeles-based Cotkin & Collins.

Because insurers are unlikely to willingly pay such claims, attorneys predict coverage litigation may continue through the end of the decade.

"While the court system moves faster than it did 20 years ago," the Los Angeles riot cases "will likely be resolved in 10 years or so," predicted Mr. Cotkin, who was involved in coverage litigation after the 1965 Watts riots.

"First, there will be a frontal attack on first-party coverage," said Steven L. Paine, managing partner at Cotkin & Collins.

While most commercial property policies provide coverage for riots, Mr. Paine anticipates that some insurers may cite policy exclusions for civil insurrection and war to deny coverage.

In addition, "a lot of lost policy cases may arise" as attorneys attempt to reconstruct coverage on behalf of property owners whose policies burned up in the numerous blazes.

And while there undoubtedly will be a "spate of lawsuits against law enforcement agencies for their failure to provide adequate protection," Mr. Paine predicts "99% of them will fail" because municipalities have sovereign immunity under the state's government tort liability doctrine.

"We'll probably see a good test of sovereign immunity, but recent court decisions make it awfully tough to sue a municipality," he said.

Specifically, he cited a recent decision by the California Supreme Court that held the city of Westminster could not be held liable even though its undercover police officers did not come to the aid of a woman who was stabbed in a laundromat they had been staking out.

What the courts must decide is whether the Los Angeles Police Department and city officials were negligent in their failure to quell the disturbance that followed the Rodney King verdict.

Two lawsuits have been filed against government entities:

- The American Civil Liberties Union of Southern California, the Legal Aid Foundation of Los Angeles and the Western Center on Law and Poverty are asking a federal judge to force the U.S. Agriculture Department to invoke an emergency regulation designed to provide temporary food stamp assistance during a disaster.
- Robert Brill, a United Press International reporter, is seeking damages from Los Angeles Mayor Tom Bradley, Police Chief Daryl Gates and various city departments for injuries he suffered while covering the beating of truck driver Reginald Denny. ■

Health cost study

Continued from page 1
timer. "It shows that we've seen some success in controlling costs but employers don't feel that they've gotten over the hump at all. More needs to be done."

The MBGH survey polled 150 members, as well as 200 nonmembers, about their experiences in 1991 and 1990, and expectations for 1992 through 1994.

Less than half of the employers surveyed—45%—said per-employee health care costs increased by 13% or more last year. In contrast, 57% of employers surveyed in 1990 said their per-employee health benefit costs had increased by 13% or more.

The largest percentage of employers—27%—reported costs rising 6% to 10% in 1991. A year earlier, the most common increase, reported by 29%, was in the 16% to 20% range.

The percentage increases include increases for all group health care benefits covered by indemnity and managed care plans and may or may not include employee contributions, the survey authors note.

The MBGH's findings closely mirror those of a study released earlier this year by A. Foster Higgins & Co. Inc., which reported that per-employee health care costs rose 12.1% on average in 1991, compared with 17.1% in 1990 (*BI*, Jan. 27.)

While Messrs. Rosenberg and Mortimer could not pinpoint the reasons behind the apparent moderation in cost increases, they said respondents' opinions on cost containment programs may offer some insights.

Eighty percent said they consider their cost control efforts to be "somewhat effective" because their health care costs are rising slower than most other firms', the survey reported. And 4% said their cost control efforts are "very effective" in keeping costs under control. Eight percent, though, said their cost control efforts were not effective and were only adding to the company's administrative costs, while another 8% were unsure.

Two types of plans are widely regarded as effective in containing health care costs, the survey reported. Negotiating individual, direct contracts with providers was cited by 93% of respondents, while 89% cited group purchasing arrangements, in which several employers pool their health risks in order to get better arrangements with insurers and health care providers.

In addition, 76% of employers said preferred provider arrangements are effective, 75% cited health maintenance organizations, 66% indicated point-of-service plans and 64% cited indemnity plans with utilization review. Only 3% said indemnity plans without UR features are effective at controlling costs.

None of those cost control efforts, however, is regarded as very effective in providing quality care, the survey found.

For example, only 59% of employers said point-of-service plans delivery quality care, 48% cited indemnity plans without UR and 44% cited both direct contracting and PPOs.

Employers appear optimistic that the moderation in health care inflation will continue over the next two years, Mr. Rosenberg said. Although 66% of employers still expect the rate of health care inflation to increase over the next two years, that is down compared with 81% of employers in 1989 and 78% in 1987.

In fact, 7% of the employers surveyed expect the rate of health care inflation to drop over the next two years. No one surveyed for the 1989 study believed health care costs would drop.

Despite the success of some employers' cost containment efforts, the majority of survey respondents—77%—expect health care cost management to become more difficult in 1992-1994.

"Many employers feel their current cost containment efforts are already impacting costs, so there is little room for improvement," Mr. Rosenberg pointed out.

"There is some concern about where we go from here."

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Copies of the MBGH Fourth Biennial Member Survey are available for $50 from Larry Boress, vp of member services, Midwest Business Group on Health, 8303 W. Higgins Road, Suite 200, Chicago, Ill. 60631; 312-380-9090.

Price Waterhouse award

Continued from page 2
bility insurance "substantially in excess of $100 million" that will cover a portion of the award, she said. The coverage is placed by Minet International Professional Liability Ltd. in Montreal.

"The big firms are being hit," observed Dan L. Goldwasser, an attorney with Vedder, Price, Kaufman, Kammholz & Day in New York and special counsel to the New York State Society of Certified Public Accountants.

The period following an economic downturn generally is marked by claims against accountants filed by plaintiffs looking for "deep pockets" to help cushion hard times, he said.

And, "there is the savings and loan debacle," added Mr. Goldwasser, explaining that the Resolution Trust Corp. and the Federal Deposit Insurance Corp. continue to bring suits against accounting firms to help fund S&L bailouts.

Ernst & Young recently agreed to pay $63 million to settle civil fraud suits related to the failure of Lincoln Savings & Loan Assn. Claims against New York-based Ernst & Young were related to audits conducted for American Continental Corp., Lincoln's parent (*BI*, April 6).

Accountants are trying to reverse this trend by stepping up efforts to pass legislation to limit their liability.

"The major firms are trying to mobilize the effort to get remedial legislation" that will limit liability awards, Mr. Goldwasser said.

Price Waterhouse's Ms. Baird said changes will have to come about if accountants are to continue to operate as they have.

If big awards against accounting firms become routine, the firms won't accept the risks associated with some work, she warned. The $338 million award is "excess of any risks that could be reasonably assumed."

In a speech in New York last month, Arthur Andersen & Co. Chairman Lawrence Weinbach contended that litigation costs in 1991 amounted to 9% of the Big Six accounting firms' revenue. ■

Superfund liability

Continued from page 1
much narrower view and have uniformly resulted in a victory for the government," said PRP attorney Norman W. Bernstein of Arent, Fox, Kinter, Plotkin & Kahn in Washington. "This decision creates for the first time a very clear holding on divisibility."

"Defendants have the right to show divisibility of the harm," explained Mr. Bernstein. "If they can show a reasonable basis for apportionment, they will only be liable for their share of the harm."

In the case before the 3rd Circuit, Alcan Aluminum Corp. of Cleveland was one of 20 companies named as potentially responsible for cleaning up the polluted Susquehanna River.

All the companies except Alcan settled with the U.S. Environmental Protection Agency, which sought to recoup about $1.3 million it had already spent to clean the river. The EPA then sought to recover the balance of its costs—$473,790—from Alcan, the only defendant not to settle.

But Alcan argued that it should not be held liable for the balance of the cleanup costs because its wastes did not contribute to the pollution of the Susquehanna River. Alcan's waste was a cooling emulsion used in the manufacture of aluminum sheet and plate products.

"Our material is cleaner than dirt," said Alcan Senior Counsel Lawrence A. Salibra II. "There is less copper in our material than in milk."

The 3rd Circuit remanded the lawsuit to a lower court so that Alcan can attempt to prove that the harm is divisible and that there is a reasonable basis for apportionment.

"If Alcan proves that the emulsion did not or could not, when mixed with other hazardous wastes, contribute to the release and resultant response costs, then Alcan should not be responsible for any response costs," wrote Judge Morton I. Greenberg for the three-member court.

Prior to this court's ruling, the EPA was able to "bludgeon people into settlements," said Alcan's Mr. Salibra. "They can't do that anymore."

He explained that the EPA often sues and settles with only a few PRPs and then demands that the remaining PRPs pay the balance of the costs.

"The 3rd Circuit's ruling could force the government to sue most if not all the PRPs potentially liable at a site," agreed Mr. Bernstein. "That may mean an added burden on the government, but it will improve the fairness of the process." Further, if all PRPs are brought into the litigation early, it will reduce the need for contribution actions against PRPs, and this will lower their transaction costs, according to Mr. Bernstein.

But, Mr. Salibra noted that forcing PRPs to prove that the harm is divisible and that they are liable for only a portion of the cleanup costs could once again increase PRP transaction costs.

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U.S. vs. Alcan Aluminum Corp. et al., 3rd U.S. Circuit Court of Appeals; No. 91-5481.

Update

New FASB draft on benefits

Continued from page 2
Failing the first two criteria, employers would be required to account for the obligation when it is probable that a liability has been incurred and the amount can be estimated.

Since the implementation of the earlier FASB statements, "employers have been doing what they feel like," said Robin Simon, a consultant with Buck Consultants Inc. "Some have done it on a pay-as-you-go basis. Others account for the benefits as the liabilities are incurred, and others have done it in advance."

Emotional distress claims

SAN FRANCISCO—Workers' claims of intentional or negligent infliction of emotional distress by employers must go through the workers compensation system even if there is no compensable physical injury, the California Supreme Court has ruled.

But the court did leave open the possibility of civil action by workers if an employer's alleged misconduct is egregious.

In the case, Apostol Livitsanos contended that his employer, yogurt manufacturer Continental Culture Specialists Inc., falsely accused him of embezzlement and other misconduct before discharging him. Mr. Livitsanos, who charged that Continental Culture intentionally inflicted emotional distress and defamed his character, is seeking to sue the company in a civil action.

The court said in its May 18 decision that there would be a "glaring anomaly" if an employee could file a civil suit because of "purely emotional" distress but had to go through the workers comp system if that distress caused physical harm.

If this were allowed, "it would then be in the employer's best interest to make conditions so intolerable for an employee and to cause such a level of emotional distress that the employee could not work as a result. Then the employer could avoid civil liability for the most egregious conduct," the court explained.

The case was remanded to a lower court to determine if the alleged misconduct was extreme enough to warrant a civil suit.

Proposition 51 loophole closed

SAN FRANCISCO—The California Supreme Court has ruled that a manufacturer ordered to pay damages to a worker injured partially as a result of his employer's negligence is liable for only its share of damages under Proposition 51.

The 1986 law limits tort defendants' liability for non-economic damages to their percentage of fault.

The case centers on a 15-year-old boy whose arm was mangled in a mechanical grape harvester manufactured by Up-Right Inc. while working at Van Erickson Ranches. The boy sued Up-Right, and a Fresno jury awarded him $355,000 in economic damages and $300,000 in non-economic damages.

The total award was reduced by $98,250 after the jury found that the boy was 15% at fault. The trial judge further reduced the non-economic damages award by $135,000, because the jury found the boy's employer was 45% at fault for the accident.

Up-Right appealed, arguing the award should be trimmed by the $23,676 of workers compensation benefits paid to the boy.

The appeals court, though, ruled the trial court erred in invoking Proposition 51 to reduce the non-economic damages award. The appellate court ruled that Proposition 51 did not apply in this case because one of the defendants is the plaintiff's employer, which is immune from civil action under workers comp law.

But, the California Supreme Court ruled on May 8 that the "express purpose of Proposition 51 was to eliminate the perceived unfairness of imposing all the damage on defendants who were found to share only a fraction of the fault."

Briefly noted

Under an agreement in principle with the Pension Benefit Guaranty Corp., New Valley Corp.—formerly known as Western Union—would be allowed to **terminate its pension plan**. The PBGC would receive various assets valued at about $200 million. The plan has $334 million in unfunded benefits. . . .**Chevron USA Inc.** has agreed to pay $8 million, including $6.5 million in criminal fines, for violating the federal Clean Water Act in California. . . .The U.S. Supreme Court has refused to overturn any portion of a **$21.5 million award**, including $12.5 million of punitive damages, that Texaco Inc. was ordered to pay to the widow of a Coast Guard seaman who contracted leukemia after being exposed to benzene in the mid-1970s (*BI*, Nov. 25, 1991). . . .Wind, hail, tornadoes and flooding caused an estimated **$55 million of insured property damage** to portions of Arkansas, Louisiana, Oklahoma and Texas May 10-15. . . .Some 2,200 troubled members of Lloyd's of London have been granted leave to apply for a **judicial review into the Lloyd's market**. Judicial review—which is like a court-directed investigation—is being sought by the Gooda Walker Action Group, whose members face huge cash calls (*BI*, April 13). . . .A Los Angeles judge has frozen the bank accounts of **Physicians Benefit Plan** of Simi Valley, Calif., and extended a temporary restraining order against the company, which California regulators charge is writing group health insurance illegally. A hearing on regulators' request for an injunction against the firm is scheduled for May 27 (*BI*, May 18). . . .Lloyd's of London underwriter Richard Outhwaite's open 1982 account is expected to report a further deterioration of 24 million pounds ($43.9 million), bringing the account's total loss to 224 million pounds ($409.9 million). **R.H.M. Outhwaite (Underwriting Agencies) Ltd.** has settled out of court litigation over the validity of 32 run-off reinsurance contracts that have been blamed for the syndicate's losses.

Ticker

A return to conservatism?

Many insurers now abandoning whiz kid theories, but some never subscribed

By MYRON M. PICOULT

Special to Business Insurance

FROM OUR PERSPECTIVE, the beginning of the end of conservatism in the industry began in the early 1970s with the introduction of "modern portfolio theory." This was the product of professors confident that they could consistently calculate the right curve of aggregate returns from investment alternatives for the management of "modern" portfolios. "Efficient" markets supposedly discounted all factors, and with professors' help, the portfolio managers could match assets, liabilities and the right rewards with the right risks.

The trend extended into the 1980s with the rise of super high interest rates. In property/casualty parlance, straying from the straight and narrow path was justified by cash flow underwriting. The severe compromising of underwriting standards was not viewed as a problem because ongoing superior net investment income growth would bail everyone out. However, investment income is not the panacea it was purported to be, as is evident in the current flat or negative growth of many underwriters.

The glue also got stickier in the life insurance sphere. Competition in the financial services market catered to institutional clients' needs and the avaricious desires of individuals. Hence, the rise of the "bullet loan," unbridled growth in real estate and mortgages, and the birth of junk bonds. The rapid rise in the stock and bond markets also fueled a false sense of security among insurance executives who believed their company capital bases had virtually no bounds.

The era of fast finance also got a boost from financial whiz kids who developed hedges, straddles, programmed trading and various assumptions that failed to work out. While the blame for the deviations from conservative accounting and reporting standards rests with top management, some responsibility must be shared by accountants and actuaries eager to maintain jobs and revenue.

A funny thing happened on the road to recovery. Synthetic confidence eroded, derivative securities and hedges didn't work as expected and "optimal returns" became elusive. Adding to the trauma in some jurisdictions was the rise of the dictatorial insurance commissioners, which led to rate suppression. The public's confidence in financial institutions has been severely eroded by the well-publicized problems in both the banking and savings and loan industries. The rating agencies, in an attempt to regain the high ground, continue to muddy the water with inconsistent ratings. Last but not least, the advent of risk-based capital standards for both the life/health and property/casualty industries is starting to cause some ripples. Risk-based capital rules are being fashioned by industry actuarial groups and others before less palatable standards emerge from other quarters.

Gresham's Law still prevails, as the displacement of sound capital by unsound capital is still exerting its unhealthy effect on insurers.

All this hanky panky has led to rapid growth in synthetic earnings over the past few years. A cash squeeze has started, and asset sales are popping up. Insurers remain slow to recognize problem assets and liabilities, notwithstanding the cries of capital sufficiency. Many weaker players continue to sell equity, preferred stock or debt issues.

In short, Gresham's Law still prevails, as the displacement of sound capital by unsound capital is still exerting its unhealthy effect on the insurance industry. We strongly believe in the theory of survival of the fittest. However, those least able to survive are doing anything they can to stay alive; hence, the emergence of a bankruptcy segment on the industry landscape.

The displacement of conservatism is reversing with a strong return to basics sparked by cautious regulators and legislators, industry consultants and policyholders in a flight to quality. Signs of this are everywhere and prominent companies are involved in the change:

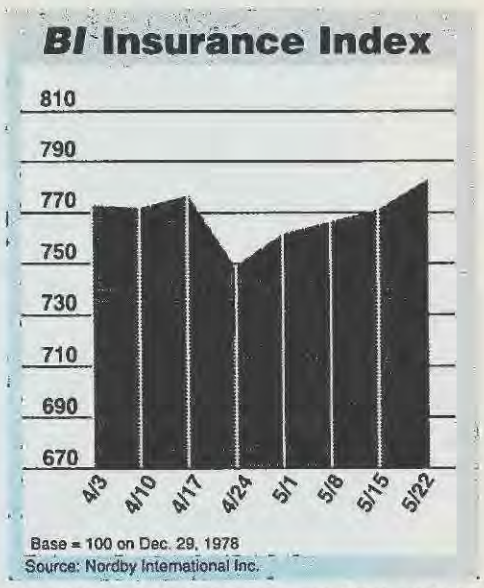
- Aetna Life and Casualty Co. is in discussions for the sale of its American Re-Insurance Co. subsidiary. The main benefits of the sale would be balance sheet strengthening and a cash influx.
- Executive Life Insurance Co. is already history and First Capital Holdings is up for bids.
- Mutual Benefit Life Insurance Co., whose capital account belongs to its policyholders, was clearly financially distressed and subsequently parceled out for sale.
- Travelers Insurance Co. is streamlining operations and raising capital to maintain its resources and assure outsiders that it can meet commitments. A costly commercial mortgage loan portfolio deteriorated sharply last year and Travelers is determined to contain the damage.

In addition, several companies have withdrawn from the personal automobile insurance business in a handful of states. The numbers of departures is unprecedented in our memory. Furthermore, competitors in various aspects of health care plans that are either based on managed care or indemnity contracts have publicly acknowledged that the business is too capital intensive. Some are exiting the business and we expect others will follow.

The irony is that throughout the entire process a group of insurers did not stray from their conservative roots. Mark Twain once noted that it is difficult to compete with ignorance. It appears that a few fellows have found the right path. ■



Myron M. Picoult is managing director and senior insurance analyst with Oppenheimer & Co. in New York. He is the past president of the Assn. of Insurance & Financial Analysts and a member of the New York Society of Security Analysts.



Insurance industry stocks surged last week as the *Business Insurance* Index climbed 11.8 points to 782.3 on May 22 from 770.5 on May 15. Advancing issues were led by Frontier Insurance Group, up 9.8%; United Healthcare Corp., up 8.6%; and U.S. Healthcare, up 6.7%. Declining issues followed HMO America Inc., down 19.8%; Statesman Group Inc., down 10.9%; and Navigators Group, down 6.9%. The most active issue was U.S. Healthcare, 3.7 million shares traded. The *BI* Index was up 1.5%; the NYSE Composite was up 0.9%; the S&P 500 was up 1.0%; and the Dow Jones 30 Industrials rose 1.0%.

British Issues

May 21 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence	pence
Comml Union	508	N/M	31.5	6.2	510—504	
Genl Accident	496	N/M	35.7	7.2	496—491	
Gdn Royal Exch	156	N/M	10.0	6.4	157—155	
Royal	247	N/M	15.0	6.1	251—246	
Sun Alliance	321	N/M	19.0	5.9	325—321	
Brokers						
Bradstock	152	17.1	6.3	4.1	152—151	
CE Heath	408	26.9	34.5	8.4	409—407	
Hogg Group	162	10.8	10.9	6.7	165—162	
JIB Group	200	14.7	10.0	5.0	201—200	
Lloyd Thompson	255	25.5	6.0	2.3	255—246	
Lowndes Lmbrt	319	13.3	17.3	5.4	320—319	
PWS Holdings	53	5.8	5.3	10.0	53—53	
Sedgwick Grp	225	17.7	16.0	7.1	227—225	
Steel Brrl Jones	300	15.0	17.7	5.9	300—300	
Willis Corroon	263	17.117.6	6.7	263—254		

Source: Philip Olsen, Insurance Industry Analyst, London

BI Industry Stock Report

MAY 18, 1992 THROUGH MAY 22, 1992

		Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
BROKERS												
Alexander & Alexander	NYS	20.63	5.10	0.61	23.38	18.00	209	1.00	4.85	129	9.77	2.11
Gallagher Arthur J. & Co	NYS	23.38	0.54	4.47	25.25	19.00	70	0.64	2.74	18	5.88	3.98
Frank B. Hall	NYS	3.63	-3.33	-14.71	5.50	3.13	31	0.00	0.00	-3	-5.24	-0.69
Hilb, Rogal & Hamilton	OTC	12.50	2.04	-5.66	17.25	11.00	17	0.40	3.20	20	3.56	3.51
Marsh & McLennan	NYS	76.50	1.32	-5.99	83.75	70.00	165	2.60	3.40	18	14.77	5.18
Poe & Associates	OTC	14.25	-1.72	18.75	16.00	10.00	4	0.40	2.81	16	2.82	5.05
BROKERS	AVERAGE		0.7	-0.4					2.4	28		
CONGLOMERATES & HOLDING COMPANIES												
Berkley W.R. Corp.	OTC	32.25	0.00	5.74	36.25	23.50	215	0.36	1.12	11	23.89	1.35
Berkshire Hathaway Inc.	NYS	9100.00	0.28	0.55	9100.00	254.69	0	0.80	0.01	29	4612.00	1.97
ITT (Hartford Group)	NYS	64.63	-1.90	11.90	70.63	50.00	723	1.84	2.85	11	64.01	1.01
Sears (Allstate)	NYS	44.25	1.43	16.83	48.00	32.50	2964	2.00	4.52	12	37.38	1.18
CONGLOMERATES	AVERAGE		0.0	8.8					2.1	16		
INSURERS/REINSURERS												
AEGON N.V.	NYS	67.50	2.27	-3.57	71.75	54.75	2	2.30	3.41	6	N/A	N/A
Aetna Life & Casualty	NYS	40.63	0.00	-7.67	47.00	31.88	897	2.76	6.79	8	64.23	0.63
Allied Group Inc.	OTC	20.25	-1.22	19.12	23.00	16.00	45	0.64	3.16	7	19.85	1.02
American General	NYS	47.00	0.53	5.62	48.25	37.50	565	2.08	4.43	11	37.14	1.27
American Heritage Life Ins.	NYS	28.13	1.81	-8.16	30.00	20.06	3	0.84	2.99	14	N/A	N/A
American Indemnity/Fin'l	OTC	7.88	5.00	65.79	9.25	4.50	6	0.08	1.02	6	12.93	0.61
American International	NYS	86.63	2.67	-11.94	99.38	78.63	1666	0.48	0.55	12	45.34	1.91
Aon Corp.	NYS	43.25	-0.57	9.15	45.25	34.75	257	1.68	3.88	11	18.50	2.34
Argonaut Group	OTC	26.00	0.00	9.47	31.50	21.75	41	0.84	3.23	8	48.26	0.54
AVEMCO Corp.	NYS	26.00	0.72	4.00	28.00	19.63	4	0.40	1.54	23	9.55	2.72
Baldwin & Lyons Inc	OTC	28.50	4.11	10.68	28.50	22.75	3	0.28	0.98	7	24.29	1.17
Belvedere Corp.	ASE	6.25	2.04	92.31	6.25	2.88	21	0.04	0.64	17	7.65	0.82
Chandler Insurance	OTC	5.50	-2.22	69.23	6.00	2.13	37	0.00	0.00	50	5.95	0.92
Chubb Corp.	NYS	67.13	2.09	-12.82	78.00	60.75	647	1.60	2.38	10	35.19	1.91
CIGNA Corp.	NYS	50.25	-4.29	-17.79	61.75	41.25	596	3.04	6.05	11	73.15	0.69
CNA Financial Corp.	NYS	84.88	3.82	-13.39	104.50	75.50	70	0.00	0.00	9	70.23	1.21
Continental Corp.	NYS	28.63	1.33	3.62	30.38	23.25	1092	2.60	9.08	24	37.83	0.76
EXEL Ltd.	NYS	33.38	1.14	-11.00	40.25	27.38	1231	0.92	2.76	7	N/A	N/A
Fund American Corp.	NYS	69.00	0.36	-1.25	70.25	62.00	406	0.68	0.99	23	36.11	1.91
Fremont General Corp.	OTC	21.50	1.18	-11.79	26.00	17.00	101	1.00	4.65	5	19.13	1.12
Frontier Insurance Group	NYS	38.00	9.75	40.74	38.00	20.91	72	0.60	1.58	14	11.20	3.39
Gainsco Inc.	ASE	14.25	4.59	1.79	15.00	9.00	73	0.04	0.28	15	3.37	4.23
General RE Corp.	NYS	82.00	1.55	-19.51	104.75	77.50	992	1.80	2.20	11	37.50	2.19
Guaranty National Corp	NYS	14.88	-0.83	2.59	17.00	12.63	36	0.48	3.23	10	N/A	N/A
Hanover Insurance Co.	OTC	36.50	-5.19	2.10	42.75	27.13	114	0.44	1.21	9	37.44	0.97
Harleysville Group	OTC	19.75	1.28	-7.06	23.25	16.75	29	0.64	3.24	8	22.99	0.86
Hartford Steam Boiler	NYS	53.75	-1.15	-6.52	62.38	45.13	88	2.00	3.72	16	17.05	3.15
Kemper Corp.	NYS	25.50	-0.97	-33.11	46.13	23.75	380	0.92	3.61	7	34.20	0.75
Lawrence Insurance Group	ASE	7.75	-4.62	-30.34	11.13	7.75	1	0.48	6.19	18	4.71	1.65
Liberty Corp.	NYS	27.50	1.85	24.29	28.75	19.50	51	0.48	1.75	13	23.86	1.15
Lincoln National	NYS	57.25	3.15	4.57	61.00	45.38	616	2.92	5.10	10	45.16	1.27
Markel Corp.	OTC	26.38	0.48	19.89	28.25	15.88	33	0.00	0.00	7	3.22	8.19
Mutual Risk Mgmt. Ltd.	NYS	30.00	-4.76	-14.59	37.75	17.00	122	0.12	0.40	20	-	-
NAC Re Corp.	OTC	25.50	-2.86	-19.05	33.00	21.75	75	0.16	0.63	11	18.90	1.35
National Re Holdings Corp.	NYS	19.13	-3.77	N/A	23.63	17.00	29	0.12	0.63	10	N/A	N/A
Navigators Group	OTC	34.00	-6.85	-17.07	48.25	29.50	2	0.00	0.00	20	13.52	2.51
Nobel Insurance LTD.	OTC	5.13	3.79	28.13	6.00	3.38	58	0.00	0.00	4	7.76	0.66
NWNL Companies	NYS	36.38	1.39	16.87	38.50	18.63	92	1.48	4.07	11	42.73	0.85
Ohio Casualty Corp.	OTC	54.38	3.57	9.85	58.25	43.50	188	2.68	4.93	9	36.38	1.49
Old Republic Int'l	NYS	20.50	-1.80	15.49	21.13	13.75	114	0.36	1.76	8	33.09	0.62
Orion Capital Corp.	NYS	32.00	0.00	1.19	34.25	27.00	62	0.92	2.88	5	29.68	1.08
Phoenix RE Corp.	OTC	11.00	6.02	4.76	11.75	8.50	337	0.20	1.82	27	13.30	0.83
Provident Life	OTC	21.38	-6.56	-8.06	24.25	16.75	343	1.00	4.68	9	25.88	0.83
Re Capital Corp.	ASE	15.13	0.83	5.22	18.25	13.13	3	0.24	1.59	16	15.05	1.00
Reliance Group Holdings	NYS	5.50	2.33	33.33	6.13	3.50	559	0.32	5.82	3	5.61	0.98
RLI Insurance Corp.	NYS	19.38	4.73	17.42	20.38	11.88	26	0.48	2.48	8	14.41	1.34
St. Paul Companies	NYS	70.00	0.00	-3.95	75.75	57.13	408	2.72	3.89	7	52.00	1.35
SAFECO Corp.	OTC	49.25	-1.01	1.03	50.13	35.50	662	1.64	3.33	11	31.50	1.56
SCOR U.S. Corp.	NYS	16.00	4.92	4.07	18.88	11.63	34	0.28	1.75	9	11.19	1.43
Seibels Bruce Group	OTC	5.63	0.00	2.27	8.75	4.00	39	0.36	6.40	-3	7.35	0.77
Selective Ins. Group	OTC	19.00	-1.30	13.43	20.00	13.75	31	1.12	5.89	7	18.91	1.00
Statesman Group Inc.	OTC	5.13	-10.87	-10.87	6.88	2.63	214	0.00	0.00	3	2.48	2.07
Tokio Marine & Fire	OTC	39.75	2.58	-22.82	55.25	32.25	3	0.00	0.00	-	70.93	0.56
Torchmark Corp.	NYS	58.38	0.65	0.86	61.50	46.50	222	1.60	2.74	12	16.70	3.50
Transamerica	NYS	42.88	2.08	7.52	46.75	31.25	231	2.00	4.66	29	36.56	1.17
Transatlantic Holdings	NYS	31.50	-1.18	-18.97	39.63	29.00	474	0.24	0.76	10	18.38	1.71
Travelers Corp.	NYS	20.00	0.00	-7.51	25.13	17.25	977	1.60	8.00	8	41.44	0.48
Trenwick Group Inc.	OTC	27.38	-0.45	-3.95	30.75	23.00	47	0.72	2.63	10	21.71	1.26
United Fire & Casualty	OTC	57.50	1.77	27.78	62.00	42.00	10	1.32	2.30	11	35.39	1.62
USF&G Corp.	NYS	10.88	2.35	50.00	11.50	5.63	1087	0.20	1.84	-7	11.96	0.91
UNUM Corp.	NYS	38.88	4.36	-4.01	40.63	28.81	646	0.64	1.65	12	37.25	1.04
USLIFE Corp.	NYS	45.75	2.52	-4.44	47.88	38.50	144	1.68	3.67	9	60.34	0.76
Unitrin	OTC	34.25	0.37	-4.20	39.00	31.00	164	1.00	2.92	14	30.70	1.12
USLICO Corp.	NYS	18.38	1.38	-0.68	21.00	17.00	48	1.00	5.44	-15	29.44	0.62
Washington National	NYS	18.88	-1.31	18.90	20.63	13.38	133	1.08	5.72	-33	26.86	0.70
Zenith National Ins.	NYS	17.75	0.71	5.19	18.50	13.75	161	1.00	5.63	8	13.14	1.35
INSURERS/REINSURERS	AVERAGE		0.5	4.7					3.4	11.8		
HEALTH MAINTENANCE ORGANIZATIONS												
FHP International	OTC	16.88	3.85	18.42	27.00	9.88	759	0.00	0.00	16	5.44	3.10
HMO America Inc.	OTC	11.13	-19.82	-33.58	24.88	11.13	2043	0.00	0.00	12	0.61	18.24
Pacificare Health Sys.	OTC	54.75	0.46	38.61	62.50	21.50	435	0.00	0.00	20	6.55	8.36
Safeguard Health Enter	ASE	12.00	0.00	28.00	14.75	5.13	3	0.00	0.00	18	3.53	3.40
Sierra Health Services	ASE	19.38	1.97	4.73	27.50	12.38	26	0.00	0.00	10	1.78	10.88
United Healthcare Corp.	NYS	83.50	8.62	12.08	93.00	40.25	709	0.03	0.04	32	3.76	22.21
United Medical Corp	ASE	7.63	-4.69	8.93	10.88	5.88	10	0.20	2.62	29	8.79	0.87
U.S. Healthcare	OTC	51.63	6.72	24.40	57.75	21.25	3666	0.56	1.08	23	3.38	15.27
HMOs	AVERAGE		-0.4	12.7					0.5	20		
ALL COMPANIES	AVERAGE		0.2	6.4					2.8	14		

System design: Nordby International Inc.

Performance Without Consistency Isn't Enough.

Any group insurance company can promise fast claims service, but we guarantee it. ◆ We're confident enough about the quality of our claims service to put our high standards in writing, guaranteeing to meet our promised



turnaround time. We're comfortable offering this guarantee because we routinely exceed industry standards in turnaround time of claims processing. Our resources include an advanced cost-management technology in processing systems -- a Personalized Claims Administration system which provides flexible, adaptable administration of any benefits program. ◆ Clients who depend on your advice want to know what group insurance companies promise. Now you can tell them what we *guarantee.* For more information, call Patrick Moeschler at 1-800-877-1052.

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