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Update

AT&T, labor unions square off over health care cost sharing

WASHINGTON—Employee cost sharing in health care benefits was the major stumbling block last week in contract negotiations between New York-based American Telephone & Telegraph Inc. and its two major labor unions.

AT&T had "proposed the possibility of a deductible of about $150 for employees, plus copayments" on some covered health care services under the company indemnity plan, a company spokeswoman said. AT&T also may pro-

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Top 20 merger: RBH to buy No. 10 BMF

By LINDA J. COLLINS

CHICAGO—The planned merger of Rollins Burdick Hunter Group and Bayly, Martin & Fay International Inc. announced last week positions RBH to unseat the sixth-largest U.S. insurance brokerage and will strengthen RBH's niche markets.

The proposed merger also would bring RBH into 14 new cities and bolster the broker's presence in the South and West.

Terms of the purchase transaction, which is expected to be completed by the end of June, remain confidential.

RBH will purchase all outstanding BMF stock. Internike, a London-based affiliate of the Nikols Group in Milan, Italy, Bass Brothers Enterprises Inc. of Fort Worth, Texas, and BMF employees each hold 30% ownership in BMF. The remaining 10% is held by prior management, including former BMF President Joseph N. Tate.

If the transaction is finalized, BMF's ongoing retail, wholesale and facultative reinsurance brokerage operations will be combined with RBH's.

However, RBH would not acquire "several" BMF operations currently in runoff, noted BMF Chairman and Chief Executive Officer Greg B. Kent.

Chicago-based RBH, a subsidiary of Aon Corp., ranks seventh among U.S. brokers based on 1988 gross revenues of $266.9 million. Commercial retail brokerage business accounted for $200.2 million, or 75%, of gross revenues.

Fort Worth, Texas-based BMF ranks 10th with $74.7 million in 1988 gross revenues, with retail brokerage business accounting for $51 million, or 68.3%, of gross revenues.

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No sight of cycle turn despite insurer losses

By JUDY GREENWALD

A 46.1% jump in property/casualty insurers' underwriting losses in the first quarter of 1989 will not bring a quick end to cheap insurance rates, industry analysts say.

Many observers believe pricing may not turn upward before the middle of next year at the earliest, which would be too late to allow insurers to salvage their 1990 results.

And although multiline insurers' group health insurance results are improving, they may not be strong enough to offset declining property/casualty insurance profits.

Industry analysts described major property/casualty insurers' first-quarter results as essentially "more of the same."

The trends evident last year continued, said Michael A. Lewis, first vp at Dean Witter Reynolds in New York.

Premium growth declined, cash flow slowed, investment income continued to increase at smaller rates, and reserves "didn't seem to be particularly strong," Mr. Lewis said.

"The bottom lines on the property/casualty side results are continuing to erode, reflecting the tougher pricing situation," he said.

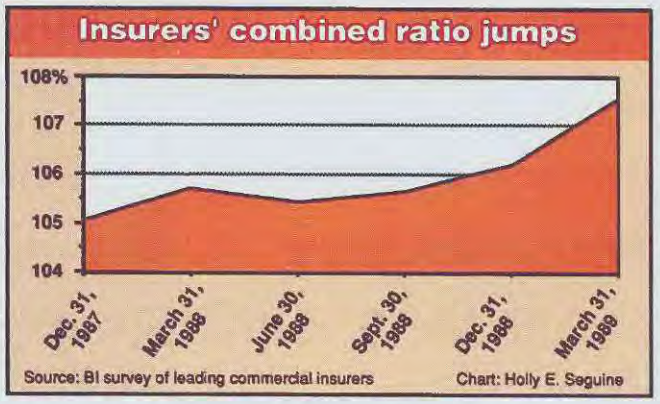
But, at least the earnings deterioration was orderly, he added. "There weren't any major surprises," said Mr. Lewis. "It was just kind of an erosion."

"I couldn't get excited about (first-quarter results) either way. More of the same, I guess," summed up Gordon D. Luce, assistant manager at Brown Bros. Harriman & Co. in New York, discussing the results.

"I don't think anybody has a real good sense of when there's going to be a change," he added.

While Mr. Luce said he is normally optimistic about the insurance industry's future, "I have nothing very concrete to hang my hat on at this point" concerning a turn in the market.

"It is really very much like the fourth quarter" of 1988, agreed analyst Gloria Vogel, associate director at Bear Stearns & Co. Inc. in New York. "More of the same is the outlook, at least for now," she added.



Property/casualty insurers in the first quarter "continued a lot of trends that you'd seen in the last few quarters," said Udayan D. Ghose, an analyst with Shearson Lehman Hutton Inc. in New York.

The effect of cheap rates was reflected in the first-quarter results of the 29 major commercial property/casualty insurers surveyed by *Business Insurance*.

The surveyed insurers reported a 46.1% increase in underwriting losses in the first quarter to $1.8 billion from $1.3 billion in the first quarter of 1988. This was almost double the 23.2% increase in underwriting losses in all of 1988 (*BI*, March 20).

The insurers' combined ratio also reflected depressed rates: The surveyed companies reported a 107.7% combined ratio in the first quarter, compared with a 105.6% combined ratio for the same period a year ago.

The 27 insurers participating in *BI*'s year-end 1988 survey posted a 106.3% combined ratio for the year (see chart).

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Group health bills equal a third of profits

By DONNA DiBLASE

WASHINGTON—Health care costs now amount to more than one-third of the profits of the nation's manufacturers, a new survey shows.

Average health care cost increases in 1988 for more than 2,000 employers recently surveyed by the National Assn. of Manufacturers averaged 29.6%. And, total health care costs equaled 37.2% of those employers' profits, according to the survey.

The survey defined health care costs as premiums employers paid to insurers for group health plans, or the equivalent for self-funded employers.

Nearly all of the surveyed employers offer health benefits to their employees and dependents and the vast majority pay for all or a portion of the monthly premium cost for individual coverage.

However, almost all of the survey respondents oppose federally mandated health care benefits, contending that such mandates would reduce their ability to offer cost-effective employee benefits programs.

The study also found that most of the respondents have some form of cost-containment program in place in their health care plans, although the study did not explore deductibles, copayments or other cost-sharing arrangements included in the employers' plans.

"Employers are getting desperate," said Sharon Canner, assistant vp of industry relations for NAM, a Washington, D.C.-based business association with more than 13,500 member companies nationwide.

The realization that health care costs represent such a large percentage of profits "may very well move employers to go for some regulatory environment that we can't foresee at this point," such as regulation of health care providers or health care prices, she said.

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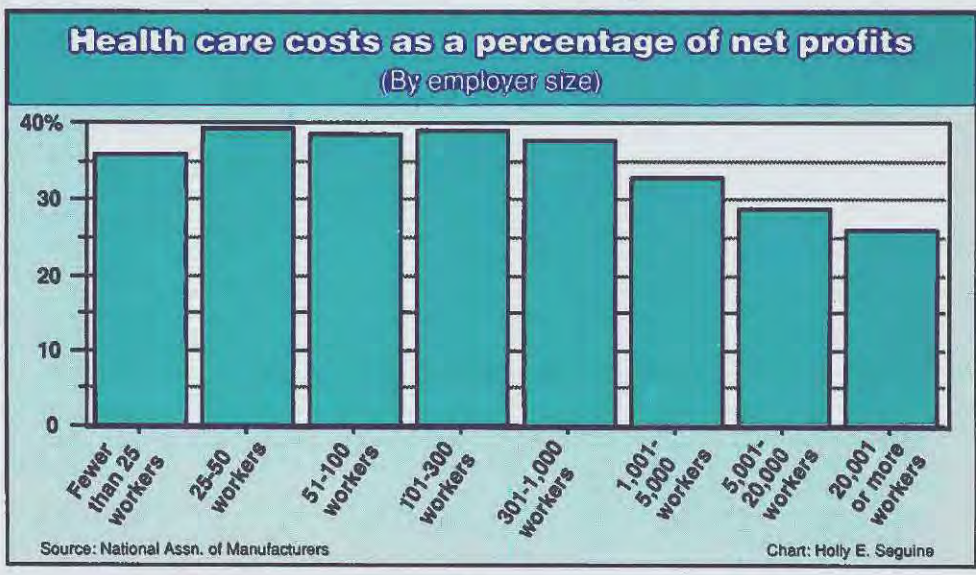

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Former A&A execs take stand, tell of Howden officials' deceit Page 3

NEWSPAPER

Update

AT&T health care changes

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pose requiring employees to make some contribution toward monthly premiums for its other health care plans, she said.

However, officials of the Communication Workers of America and the International Brotherhood of Electrical Workers charged late last week in a joint statement that AT&T's proposed benefits cost-sharing plan is an "outrage" and that the company has "stonewalled" the unions' negotiators by not providing data on the company's health care costs.

IBEW President John J. Barry quipped: "AT&T spends megabucks urging Americans to reach out and call our relatives to make sure they're OK, but the only reaching out the company is doing is into its employees' pockets."

However, the AT&T spokeswoman said the company has "provided them with literally boxes of data. But, there's still some data we are crunching and haven't had an opportunity to provide yet."

Under its current contract with the two unions, AT&T provides its 175,000 union employees with first-dollar health care coverage through either a traditional indemnity plan or a health maintenance organization, the spokeswoman explained. In addition, union employees do not contribute to the monthly premium for either plan, which also includes cost-containment features such as hospital pre-admission certification and second surgical opinion programs, she said.

AT&T expects to spend about $1 billion this year on health care for all of its 301,000 employees, 99,000 retirees and 618,000 dependents, the spokeswoman said.

The contract, which was ratified in July 1986 (*BI,* July 14, 1986), expired at midnight Saturday.

Achille Lauro lawsuits

WASHINGTON—The Supreme Court last week cleared the way for liability suits stemming from the October 1985 hijacking of the cruise ship Achille Lauro to be tried in U.S. courts.

The justices, on complex technical grounds, unanimously ruled that the owners of the ill-fated ship must wait until there has been a trial in a U.S. court before they can argue that the suits must be filed in Italy.

Language on tickets sold to the passengers for the ship's Mediterranean cruise contained a clause specifying that any litigation involving the voyage would have to be litigated in Naples, Italy. But several suits were filed in U.S. District Court in New York.

In 1987, a federal judge rejected a motion by the shipowners to dismiss the suits, ruling that the passengers did not receive "fair warning" that they had waived their rights to sue in the United States.

The 2nd U.S. Circuit Court of Appeals last year upheld the federal judge's decision as a procedural ruling. A procedural ruling can be appealed only after there is a trial, the appellate court ruled, and the U.S. Supreme Court concurred.

Advisory rate proposal refined

KANSAS CITY, Mo.—Most property/casualty insurance rating organizations should continue to provide data on prospective loss costs, including adjustments for trends, a National Assn. of Insurance Commissioner's working group recommended last week.

The latest recommendation represents a refinement of the working group's earlier decision calling for rating organizations to cease offering members fully developed advisory rates, which include components for expenses and profits (*BI,* March 13).

The Insurance Services Office Inc. said it would voluntarily stop issuing fully developed advisory rates next year but wanted to continue issuing prospective loss costs and trending data to aid member companies in developing their own rates (*BI,* April 10).

Small insurers say the group's current recommendation would help them stay competitive if approved by the NAIC.

Health care worker safety plan

WASHINGTON—The federal government is proposing safety standards to protect health care workers from blood-borne diseases such as acquired immune deficiency syndrome and the hepatitis B virus.

The standards would affect an estimated 5.3 million employees at such facilities as hospitals, dentists' offices, blood banks and laboratories, said the Occupational Safety and Health Administration.

OSHA could not estimate how many AIDS victims are infected in the workplace, but it estimated that up to 7,400 cases of hepatitis B result annually from direct worksite exposures.

Under the proposal, employers would be required to:

- Provide employees with a written evaluation of their exposure to infectious diseases and measures for reducing that risk.
- Educate employees on the transmission of diseases, controlling viruses in the workplace and emergency procedures.
- Distribute protective clothing and equipment.
- Disinfect the worksite after contact with blood or other potentially infectious materials and dispose of all materials in leakproof and puncture-resistant containers labeled with warning signs.

Former AIG exec sent to prison

NEW YORK—A state judge last week sentenced former American International Group Inc. official Robert M. Guarnaccia to one to three years in prison for embezzling more than $1.8 million from the insurance group and for city and state tax evasion.

Mr. Guarnaccia, a former vp of American Home Assurance Co., received the minimum sentence from New York State Supreme Court Judge Robert Haft after pleading guilty March 16 to charges of grand larceny and filing a false tax return.

A 74-count indictment filed last October charged that Mr. Guarnaccia created phony invoices for engineering surveys that were never performed, then deposited checks totaling $1.8 million he had authorized in an account he controlled to pay gambling debts (*BI,* Oct. 10, 1988).

A civil lawsuit AIG filed against Mr. Guarnaccia in New York State Supreme Court in Brooklyn last July is still pending.

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Court refuses to splinter pollution cover litigation

By STACY ADLER

HACKENSACK, N.J.—A recent New Jersey state appellate court ruling that massive hazardous waste coverage disputes involving one policyholder should be heard by one court swells New Jersey's reputation as a pro-policyholder mecca, attorneys agree.

Policyholders nationwide embroiled in large hazardous waste coverage disputes are expected to increasingly swarm to New Jersey as a result of the state appellate court ruling that massive coverage litigation involving Westinghouse Electric Corp. should be reconsolidated and heard in one court, attorneys say.

The Westinghouse decision is binding on New Jersey trial courts.

In addition, some attorneys expect that the ruling will influence courts outside the state that must decide whether to consolidate or break up other large coverage dispute cases.

A New Jersey appellate court on May 15 overturned a decision by New Jersey Superior Court Judge Lawrence Weiss that he would hear coverage litigation pertaining only to nine New Jersey hazardous waste sites and about 125 personal injury claims resulting from exposure to toxic substances in New Jersey (*BI,* March 28, 1988; April 4, 1988).

Westinghouse is suing more than 140 of its property and liability insurers, seeking defense and indemnification for the costs to clean 81 hazardous waste sites in 23 states and to respond to more than 3,000 personal injury claims alleging exposure to toxic substances (*BI,* Sept. 28, 1987; June 15, 1987).

Judge Weiss' ruling would have forced Pittsburgh-based Westinghouse to litigate with its insurers in 23 separate state courts.

In overturning Judge Weiss' ruling, the appellate court said: "When comprehensive nationwide coverage is purchased, it is surely the expectation of both the insured and the insurer that what the insured has bought and the insurer has sold is a single protection from liability irrespective of the particular state law under which that liability is determined so long as the risk, whether or not ultimately resulting in liability, is within the policy language."

In addition, referring to insurers that seek to break apart massive hazardous waste cleanup coverage disputes with policyholders, the appellate court said that splintering these disputes "is a most potent weapon in the arsenal of the litigant whose primary and subversive aim is to impose both upon the judicial system and the adversary by endlessly delaying the day upon which the entire controversy will finally come to an end."

In ruling that the Westinghouse case should be splintered, Judge Weiss said, among other things, that hearing such a massive coverage dispute would create a "formidable administrative puzzle" that would burden his court.

But the appellate court blasted Judge Weiss for this statement, saying the judge was splintering the Westinghouse case as a form of case management.

"Even cases as difficult and cumbersome as this one cannot be 'managed' by the simple expedient of dis-

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BI to publish RMIS vendor directory

Business Insurance will publish its annual directory of risk management information systems vendors in the July 24 issue, which will include a report on trends in risk management automation systems and analysis.

There is no charge to be listed in the directory, but companies wishing to be included must fill out and return a questionnaire provided by *Business Insurance.*

If your company produces and supplies software to corporate risk management personnel and you have not yet received a questionnaire, please request one by writing Christine Woolsey, Associate Directory Editor, *Business Insurance,* 740 N. Rush St., Chicago, Ill. 60611; 312-649-5460.

The deadline for returning completed questionnaires to *Business Insurance* is June 19.

ACIC won't appeal Prop. 103 decision

SACRAMENTO, Calif.—The Assn. of California Insurance Companies will not seek review of the California Supreme Court's May 4 decision that upheld most of Proposition 103.

ACIC was one of eight petitioners that had asked the state court to overturn the controversial insurance initiative after voters approved it in November (*BI,* May 8; Nov. 14, 1988).

The insurer group is satisfied the court "essentially rewrote" Proposition 103 with its ruling that insurers are entitled to a "fair and reasonable return," said Edward Levy, ACIC general manager.

Other petitioners have not indicated if they will ask the U.S. Supreme Court to review the decision.

Meanwhile, Hartford, Conn.-based Aetna Life & Casualty Co. resumed writing new property/casualty business in California last week after reviewing plans for implementation of Proposition 103.

Aetna stopped writing new policies May 8 after the state Supreme Court ruled on the insurance law (*BI,* May 15).

Aetna, California's ninth-largest property/casualty insurer, now is satisfied that the Department of Insurance will implement Proposition 103 "in a manner consistent with the court's ruling," according to a company statement.

Under the department's plan, property/casualty insurers must file applications for rate relief by June 3 or roll back their rates to 20% below November 1987 levels as required by Proposition 103.

Meanwhile, California State Farm Mutual Auto Insurance Co. automobile insurance policyholders charge in an amended lawsuit that the insurer is retaining too much of its policyholders' premiums as surplus, rather than issuing dividends (see story, page 47). ■

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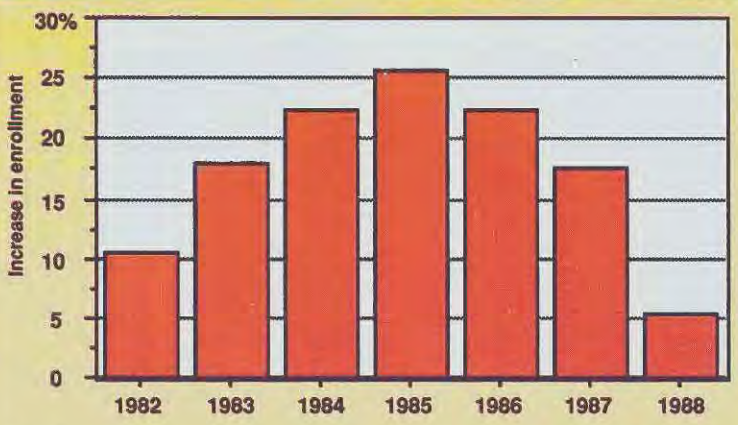
HMO enrollment growth ebbs



Source: Interstudy

Chart: Holly E. Seguine

HMO enrollment growth in 1988 near record low

By DONNA DiBLASE

HMO enrollment growth languished in 1988 as health maintenance organizations felt pressure from forces both outside and inside their industry, a new study concludes.

Externally, the changing managed care preferences of employers —as well as employers' efforts to reduce the number of health care plans with which they contract—contributed to the slow rate of HMO enrollment growth in 1988.

Internally, HMOs concentrated more on improving their financial conditions by increasing premiums and concentrated less on increasing market share by slashing premiums, slowing enrollment growth in 1988, the study says.

In addition, the financial woes of Los Angeles-based Maxicare Health Plans Inc. have hurt both enrollment growth among HMOs and the confidence of employers in HMOs' financial health, the study concludes.

These observations are included in the "Interstudy Edge," a semi-annual study published by Interstudy, an Excelsior, Minn.-based HMO research group. The current issue reports on changes in the HMO industry during the second half of 1988.

"We truly believe that it was a combination of these factors that led to this enrollment slowdown," said Lynn Gruber, vp of managed care research for Interstudy.

The study reports that while HMO enrollment reached 31.9 million at the end of 1988, the HMO industry experienced only a 5.4% enrollment growth rate for all of 1988. That is the second lowest annual growth rate since the 5.2% growth rate reported in 1977, the dawn of a nationwide HMO movement.

And, the 5.4% annual growth rate in 1988 pales in comparison with the 13.6% growth rate of 1987, the study reports (see chart).

Of the 1.6 million new HMO members enrolled as of Jan. 1, 1989, 635,660 were added between June 30, 1988, and year-end 1988.

Meanwhile, the total number of HMOs decreased to 607 as of Jan. 1, 1989, from 643 as of June 30, 1988. A total of 23 HMOs closed, while others were merged or consolidated.

This dramatic drop in the number of HMOs was mainly due to the

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Howden fallout

Former A&A execs tell of uncovering deceit

By STACY SHAPIRO

LONDON—Four former Alexander Howden Group Ltd. executives hid their ownership in allegedly bogus reinsurance companies and a Swiss bank during merger negotiations with Alexander & Alexander Services Inc., former A&A officials say.

Knowledge of the four executives' secret holdings could have affected the outcome of A&A-Howden merger negotiations, former A&A Chairman John A. Bogardus Jr. testified last week in the criminal trial of two of the executives and former Lloyd's of London underwriter Ian R. Posgate.

However, A&A did not realize that anything was amiss at Howden until after A&A's acquisition offer became unconditional, Mr. Bogardus confirmed.

Mr. Bogardus, who retired as A&A's chairman last year, and two other former A&A executives last week for the first time publicly recalled how A&A discovered the misappropriation of millions of dollars from Howden and Lloyd's syndicates underwritten by Mr. Posgate.

Mr. Posgate and former Howden Director Jack Carpenter are standing trial in Southwark Crown Court in London on charges of conspiracy to defraud Howden, its subsidiaries and syndicate members (*BI*, May 8).

Also on trial is former Howden Chairman Kenneth V. Grob, who is charged with theft, receipt of stolen goods and false accounting.

All three defendants have pleaded innocent.

British prosecutors allege that Messrs. Grob and

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Defunct syndicate 126 makes large cash call

By STACY SHAPIRO

LONDON—Lloyd's of London members who belonged to a now-defunct syndicate once underwritten by Ian R. Posgate are being asked to pay 33.1 million pounds ($51.6 million) by July 14 to cover losses from the syndicate's deteriorating 1982 underwriting account.

The members and their member agents first learned earlier this month about the cash call from Alexander Syndicate Management Ltd., which is running off nonmarine syndicate 126, formerly underwritten by Mr. Posgate.

The members previously had thought they would only have to pay 10.2 million pounds ($15.9 million) in connection with 1982 losses.

The huge 1982 loss, which was partially created by the syndicate's participation on an accountants professional liability line slip, has come as a "shock" to syndicate members, said Colin Turner, managing director of Alexander Howden & Beck Ltd., a members' agency that represents the majority of the syndicate's 3,000 names.

"I am appalled by the size of the loss and the suddenness of it," he said. "I am trying to understand how it came about without warning."

Mr. Turner said he plans to ask ASM why the sizeable loss "has come so suddenly. Having a loss in the sixth year of runoff is hard to understand."

One syndicate member said the loss will destroy any profits members who stayed in the market had ex-

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Managed care plans create risk for employers: Lawyer

By KARI BERMAN

MINNEAPOLIS—Employers contracting with managed care providers could be held liable for errors made during medical treatment and should take steps to limit such exposures, an employee benefits attorney says.

"You have to look at the situation from the perspective of the plaintiff who has been harmed and protect yourself from damages that he might try to collect," William E. Mattingly, an attorney with Katten Muchin & Zavis in Chicago, told employers attending the National Assn. of Employers on Health Care Action's National Health Management Conference May 18-19 in Minneapolis.

When an employee suffers damages as a result of negligent care by a provider under contract with an employee benefit plan, the employer can be sued on both the state and federal levels, Mr. Mattingly explained.

However, whether a state or federal court will hear the negligence suit against an employer depends on whether or not state benefit laws are involved, which are pre-empted by the Employee Retirement Income Security Act.

Because of the ERISA pre-emption, most lawsuits against employers involving benefit plans generally are tried in federal court, Mr. Mattingly noted.

When an employee's suit is tried at the federal court level, the employer also can be held jointly and severally liable for damages to the employee, he pointed out.

Mr. Mattingly said an employee can sue his or her employer on the state level on the following grounds:

- Corporate negligence, under which an employer is liable for the negligent selection of a health maintenance organization or preferred provider organization.

In this type of claim, employers are responsible for the treatment administered to an employee in a health care facility with which the employer specifically contracts.

- Respondent Superior, which holds employers liable for the neg-

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Liberty Mutual covers warehouse loss

DALLAS—Highland Superstores Inc. is fully covered for potentially tens of millions of dollars of damages caused by hurricane-force winds and rain that tore open a Dallas warehouse full of merchandise.

Claims for property damage to the warehouse, destroyed and damaged inventory and business interruption will be paid under a policy written by Liberty Mutual Insurance Cos. of Boston, said Ira Sternback, treasurer of the Plymouth, Mich.-based retailer.

Highland has $85 million of limits under the policy, which provides coverage for the retailer's 20 stores in Texas, according to Mr. Sternback. Highland has a $100,000 deductible, he said.

A May 5 storm packing winds estimated at between 100-110 mph ripped away a 180-foot section of the warehouse's wall and a portion of its roof. The collapsing wall and roof burst pipes and activated a sprinkler system that, along with the rain, drenched the inventory.

Mr. Sternback said he could not provide a damage estimate because total damages to the building and the inventory of home electronic equipment and appliances are still being assessed.

However, Nelson Bean, president of Evans American Corp. in Houston, the reconstruction company handling repairs to the warehouse, estimated that the total loss—including damage to the building, contents damage and business interruption—was more than $10 million and would probably reach "the middle eight figures," perhaps as much as $30 to $35 million.

The cost of repairs to the building will top $2 million, according to Mr. Bean.

Meanwhile, business interruption losses have been accumulating at $100,000 per week since the storm, he said.

Heavy rains totaling as much as eight inches during the week of May 14 slowed reconstruction efforts, according to Bob Valentine, regional vp for Highland in Dallas.

However, Mr. Bean explained that his company specializes in high-speed reconstruction and completely restoring the Highland warehouse will take approximately three weeks "compared to three and a half months it would take a normal contractor."

Reconstruction, which began May 12, should be completed by Wednesday, he said.

—By Michael Bradford and Mark A. Hofmann

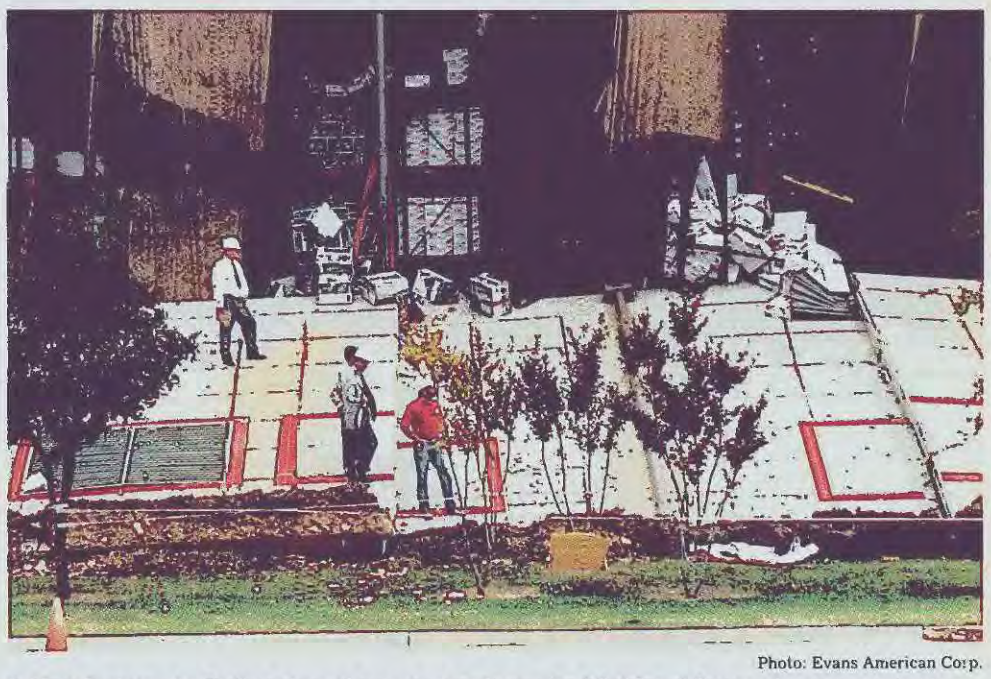


Photo: Evans American Corp.

A May 5 storm in Dallas ripped away a section of a Highland Superstores warehouse.

Offset ruling benefits Mission's estate

By MEG FLETCHER

LOS ANGELES—Insolvent Mission Insurance Co. will collect about $300 million more from its reinsurers because a California Superior Court earlier this month severely restricted a reinsurer's right to offsets.

The summary judgment against Newark, N.J.-based Prudential Reinsurance Co. is "a major win" for Mission policyholders, said Insurance Commissioner Roxani Gillespie in a statement.

The ruling, however, is a blow to reinsurers' right to offsets, and it "changes the law that has existed nationally for more than 100 years," said a Pru Re attorney from Adams, Duque & Hazeltine in Los Angeles.

As a result, Pru Re is appealing the ruling by the Superior Court in Los Angeles County.

The ruling effectively prohibits Mission's reinsurers from reducing the amount they owe Mission under reinsurance policies by the amounts that Mission owes them, either in premiums or claims payments.

"It means policyholders will come out ahead at least $300 million in claims by the reinsurance companies," Ms. Gillespie said in the statement.

The decision permits Pru Re only to exercise its right to offset after Mission pays claims from policyholders and guaranty funds.

Those claims are expected to exhaust Mission's assets, therefore precluding reinsurers from taking any offsets said Dean Hansell, a LeBoeuf, Lamb, Leiby & MacRae attorney in Los Angeles who represents other Mission reinsurers.

The significance of the issue is underscored by the fact that Ms. Gillespie's office is joining Pru Re and other reinsurer representatives in asking the California Court of Appeals to rule on the case, although each for different reasons.

Ms. Gillespie is seeking appellate court certification of the lower court's decision, while the reinsurers hope the higher court will overturn the decision.

In his seven-page decision Judge Kurt Lewin rejected "rote application" of bankruptcy law statutes and cases that allow for offsets because "in the insolvency of an insurance company there is broader public concern for policyholders. In bankruptcy, for example, there is no industrywide fund such as CIGA (California Insurance Guarantee Assn.) to protect and indemnify creditors of an unregulated commercial industry."

"Other than costs of administration, taxes, etc., the insureds (policyholders and CIGA claims) have priority over 'all others'," he emphasized.

"All others" refers to the category of creditors that stand in line behind policyholders and guaranty funds.

Any apparent conflict with California statutes that allows offsets "demonstrates that the Legislature never contemplated mammoth reciprocal reinsurance contracts which might, as here, constitute a major portion of the insolvent insurer's distributable assets, to be within the concept of setoff," Judge Lewin said.

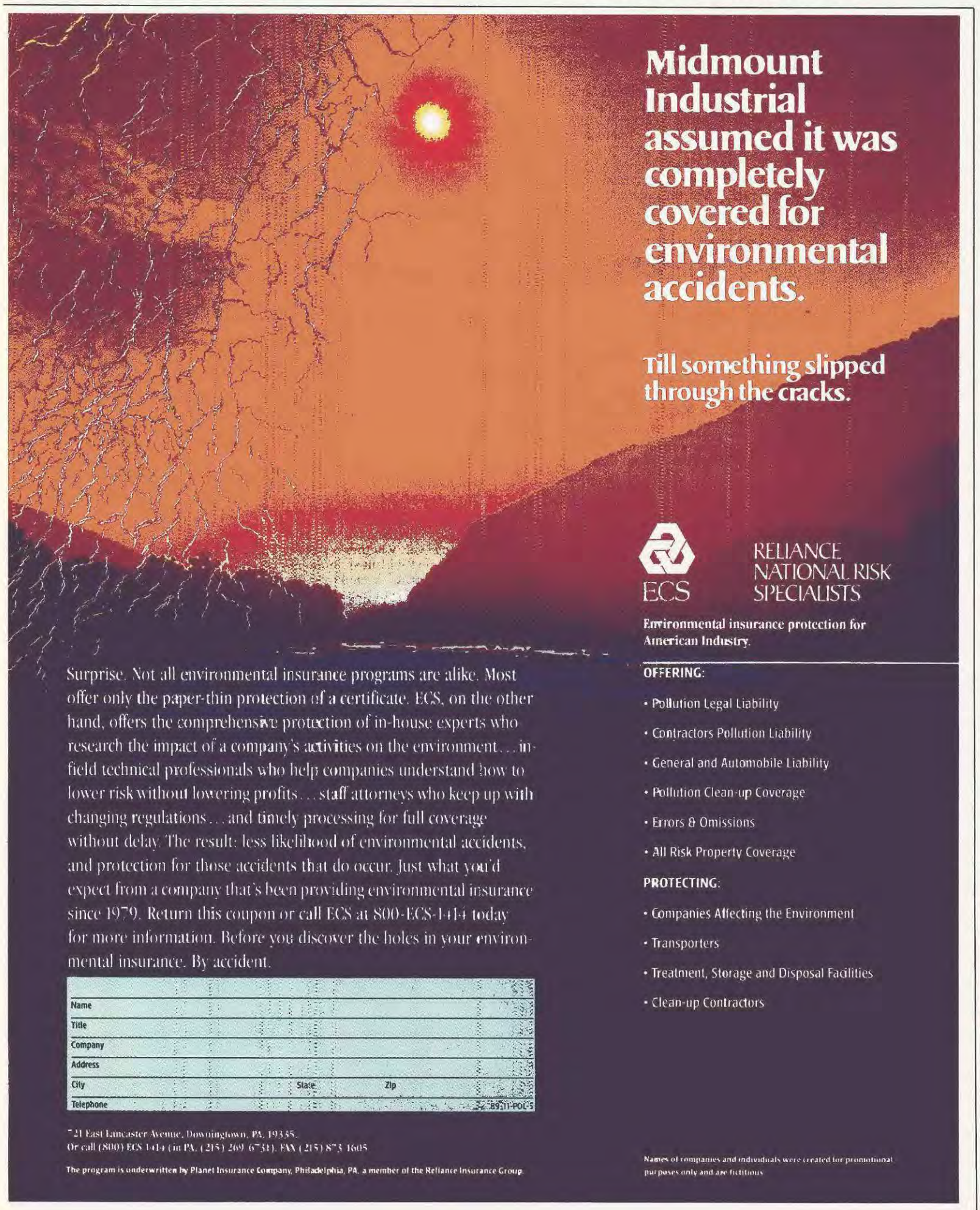
In addition, the judge rejected Pru Re's attempt to offset an unspecified amount owed Gibraltar Casualty Co., a Newark, N.J.-based subsidiary that ceded business to Mission, against the sums Pru Re owed Mission, a Pru Re attorney said.

Robert M. Hall, general counsel and secretary of American Re-Insurance Co. in Princeton, N.J., said the decision "is totally unworkable."

"The court's decision evidences a complete misunderstanding of the statute in question and will be impossible to justify on appeal," added Mr. Hall, who chairs a study group on reinsurance offsets for the National Assn. of Insurance Commissioners.

If the decision is allowed to stand, it will have "a profound affect on the reinsurance and insurance industry," the Pru Re attorney said.

"It will make reinsurance more expensive and reinsurers more reluctant to do business with small and marginal insurance companies," said Mr. Hansell of LeBoeuf, Lamb. That may drive small insurers out of the marketplace, which will reduce competition and possibly capacity, making reinsurance more expensive, he said. ■



BI sales staff adds 2 reps in New York

Cynthia Bykowski and Kathryn A. Premetz have joined the New York advertising sales staff of *Business Insurance* as district managers, Advertising Director Donald A. Walsh announced.

Ms. Bykowski will be responsible for accounts in New York and portions of New England, while Ms. Premetz will have responsibility for accounts in Pennsylvania, Maryland, Virginia and North and South Carolina.

Ms. Bykowski

Before joining *Business Insurance*, Ms. Bykowski, 25, was an advertising sales executive with P.R. Week in New York, a weekly trade newspaper. She also has served as a sales account executive with Business Wire Inc., a New York-based news wire service, and held account supervisor positions with The Financial Relations Board Inc. in New York, a public and investor relations agency.

Ms. Bykowski received a bachelor of arts degree in English from St. Bonaventure University in Olean, N.Y.

Ms. Premetz

Ms. Premetz, 26, most recently was Northeast sales manager for Communication Channels Inc., a New York-based magazine publisher. She also has served as a media planner with Lintas: New York, an advertising agency, and as an account executive for Pennysaver Group Inc., a publisher in Elmsford, N.Y.

Ms. Premetz received a bachelor's degree in communications from Hunter College in New York City.

Ms. Bykowski can be reached at 212-210-0757; Ms. Premetz can be reached at 212-210-0135. ■

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Employers' outpatient costs up 25%: Study

Employers spent 25% more for outpatient health care services for employees and dependents in 1988, says a health care data analysis firm.

Employers' outpatient care costs rose to an average of $396 per person last year from $316 per person in 1987, according to a study by Westport, Conn.-based Corporate Health Strategies Inc., a subsidiary of Metropolitan Life Insurance Co.

"The 25% rate of increase in outpatient costs experienced in 1988 would, if continued, result in employer costs for outpatient health care benefits doubling in just over three years," said David Rinaldo, director of Corporate Health Strategies' Health Care Data Center.

The 25% increase in outpatient costs in 1988 far exceeds the 18.6% increase in total annual health plan costs last year as measured by an A. Foster Higgins & Co. Inc. survey (*BI,* Feb. 6).

To examine the amount that employers pay for outpatient care, Corporate Health Strategies examined all claims submitted on behalf of 100,000 individuals under age 65 enrolled in health care plans administered by Metropolitan Life.

Corporate Health Strategies looked at three criteria in calculating the rise in outpatient costs:

- The increase in "benefits per person," or the amount of outpatient benefits paid on behalf of the company for each person.
- The increase in "benefits per unit of service," or how much the employer paid for a particular outpatient service.
- The increase in "number of services per person," or the number of times each covered individual obtained outpatient care.

In examining these three criteria, Mr. Rinaldo noted that increased utilization of outpatient services—rather than the rising cost of services—is responsible for the bulk of employers' cost increases.

For instance, while the unit cost of diagnostic laboratory and X-ray tests rose only 4.8% in 1988, the number of services per person rose 21.2%, causing benefits per person for laboratory and X-ray costs to rise 27%.

Likewise, while the cost of an outpatient visit to psychologists and psychiatrists rose by an average of 5.6% last year, the number of visits per covered individual rose by 16.9%, fueling a 23.5% increase in the amount of benefits paid by employers.

Mr. Rinaldo noted that to control rising outpatient costs, employers must track increased utilization of services as well as increases in costs.

"While the conventional wisdom is that health care costs are going up because of increases in costs as measured by the Consumer Price Index, it is increased utilization that is fueling the overall increases," he said.

Free copies of the report, "Management of Benefits for Outpatient Services," may be obtained by writing Employer Health Care Data Center, Corporate Health Strategies Inc., 276 Post Road. W., Westport, Conn. 06880.

Long-term care

Sixty percent of actuaries do not expect employers to be prefunding long-term care coverage as a standard employee benefit in the year 2000, according to a recent survey by five actuarial organizations.

The survey was conducted earlier this spring by the American Academy of Actuaries, in conjunction with the Society of Actuaries, the Canadian Institute of Actuaries, the Conference of Actuaries in Public Practice and the Casualty Actuarial Society. Some 536 actuaries responded.

"I think employers may make the plans available, but we don't see prefunding happening in today's tax climate," explained James J. Murphy, executive vp of the American Academy of Actuaries.

Unless the government offers employers tax deductions for funds set aside for long-term care, employers will have little reason to put the money aside, Mr. Murphy said.

Respondents were asked to name, from an actuarial perspective, the biggest problems impeding funding for long-term care expenses. The largest percentage—25%—chose the lack of public education and awareness of the problem.

Close behind that group, 23% of the respondents selected the lack of tax incentives for employers and the role of government as the largest funding problems.

Mr. Murphy said future government action may include creation of individual tax-deferred savings plans for long-term care, which could be set up similar to Individual Retirement Accounts.

"That would be the most effective way for the government to encourage planning for long-term care," given the size of the federal deficit, he said.

Other funding problems cited in the study were the increased high cost of long-term care, selected by 17% of the respondents, and the difficulty of projecting utilization of long-term care services, selected by 9%.

Actuaries also were asked to predict how much the United States would be spending on long-term care for those 65 and over in the year 2000. Forty-seven percent of the respondents predicted that long-term care would cost $100 billion to $200 billion in the year 2000, as expressed in 1987 dollars.

Another 36% projected the costs would rise to between $50 billion and $100 billion and 10% projected the costs would rise to more than $200 billion. Seven percent did not respond.

According to the survey, the Brookings Institution estimated the cost of long-term care in 1987 for those 65 and over at $42 billion.

Actuaries also projected how long-term care expenses will be financed in the year 2000.

According to the survey, 42% of the respondents predicted that Medicare/Medicaid will pay the greatest share. And, 32% expect individuals/family will shoulder the greatest portion of the bill. Another 23% predicted private insurance will pay the greatest proportion and 3% chose other parties.

Copies of the survey are available free from Elizabeth Kelley, Daniel J. Edelman Inc. 1420 K St. N.W., Washington, D.C. 20005-2401; 202-371-0200.

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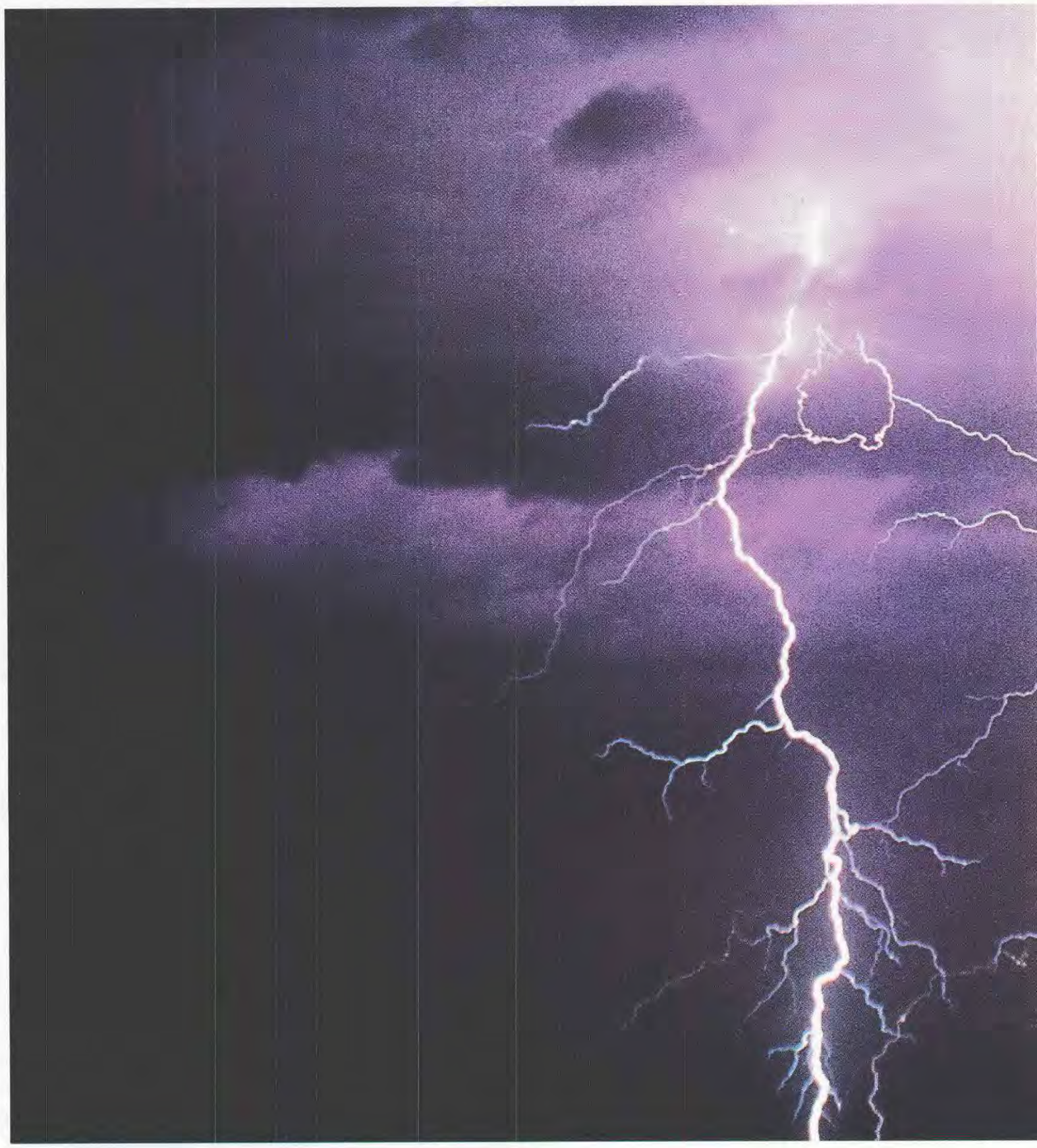
Benefit beat

Benefit beat keeps insurance and employee benefit managers informed on what other companies are doing and of current developments in the employee benefit field. We'd like to know if you've made any changes. Write Michael Schachner, Associate Editor, Business Insurance, 220 E. 42nd St., New York, N.Y. 10017-5806; 212-210-0143.

The recent storm of controversy in the insurance



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HMO growth

Continued from page 3

restructuring of Maxicare, according to the study

Among the forces outside the industry affecting HMO growth is employers' increasing preference for other types of managed care plans that provide more flexibility than HMOs in pricing and provider choice, the study found.

In addition, employers are reducing the number of health care options they offer to employees, the study says.

Also, employers have become increasingly concerned with the financial stability of HMOs. As a result, employers are more closely scrutinizing the HMOs with which they contract to ensure that the companies meet their financial requirements, Ms. Gruber said.

"Employers realize that they have much more of a burden on them when selecting HMOs. They are taking such steps as asking HMOs to provide employer-specific health care data. This is all because the health care dollars employers are spending require them to be more careful" when selecting health care plans, she explained.

"But, employers will zone in on offering fewer HMOs in an effort to look for building long-term relationships with HMOs that match the employer's needs. That's not such a bad thing" for employers or for the HMO industry, she added.

In addition to pressures from employers, HMOs have experienced a slowdown in new enrollment growth because HMOs themselves in 1988 focused more on strengthening their management structures and finances.

HMOs have increased premiums, at the risk of losing enrollee market share, in an effort to cover their costs for delivering health care services and to keep up with the overall health care inflation rate, Ms. Gruber noted.

Another factor contributing to current conditions in the HMO industry was the restructuring of Maxicare, one of the largest publicly traded, multi-state HMO firms (*BI*, Sept. 5, 1988).

'I think the Maxicare situation has had a sobering effect on (national) HMOs,' says Ms. Gruber.

Maxicare, which in March of this year filed for protection from its creditors under Chapter 11 of the Federal Bankruptcy Act, began selling or closing many of its HMOs in mid-1988 to meet the demands of creditors (*BI*, March 27).

Maxicare has reduced its holdings to nine HMOs in seven states, from 37 HMOs in 25 states in 1987. Its enrollment has declined to about 900,000 members from 2 million in 1987, the study reports.

The company made two large acquisitions in 1986 in an effort to become a national system of health care delivery. Maxicare also developed a national accounts program for multistate employers that included standardized benefits packages, enrollment procedures and single billings, the study notes (*BI*, Aug. 4, 1986; July 21, 1986).

However, Maxicare soon began to suffer the effects of huge debt associated with the acquisitions, coupled with spiraling health care cost inflation and inadequate premiums.

"I think the Maxicare situation has had a sobering effect on HMOs that are national companies. There is a lesson to be learned here. First of all, HMOs are not taking on more than they can handle" in terms of acquisitions of other HMOs, said Ms. Gruber. And, "they have learned that health care cannot be delivered on a national, standardized basis. but rather it is a local or regional phenomenon."

The Maxicare restructuring increased employers' concerns about the financial health of HMOs in general, the study says. As a result, HMOs must concentrate on controlled growth, properly priced premiums and stronger financial bottom lines to improve employers' confidence in HMOs, the study says.

Meanwhile, the study found that enrollment growth in the second half of 1988 varied by type of HMO model and by state.

For example, open-ended HMOs —hybrid plans in which enrollees may use non-HMO providers but then must pay higher out-of-pocket costs—experienced a 27.8% increase in enrollment.

Enrollment in open-ended HMOs jumped to 616,565 between June 30, 1988, and Jan. 1, 1989, up 134,207 members from the first half of 1988.

And, a total of 70 HMOs now offer this hybrid product, up from 48 HMOs offering the product in June 1988.

Still, only 11.5% of all HMOs offer an open-ended product, the study notes.

In addition, the increase in open-ended HMO enrollment is mainly due to first-time reports by 26 new open-ended HMOs, rather than by growth in existing open-ended HMOs, the study says.

And, open-ended HMOs are not as prevalent in some large metropolitan areas such as Chicago and Los Angeles where traditional HMOs have flourished. Therefore, HMOs may be using this new product to expand into markets that either previously had low enrollment or markets that already are saturated with HMOs, the study says.

Group and network model HMOs reported the largest 1988 enrollment increases of all traditional types of HMOs. Each type reported gains of 300,000 new members, the study says.

Group model HMOs contract with independent, multispecialty physician groups. Network model HMOs contract with two or more large independent practice association, which contract with independent physicians or small single-specialty physician groups.

However, IPA models still enroll more than 42% of total HMO enrollees nationwide, the study adds.

Twenty-five IPA model HMOs closed in the second half of 1988, leaving a total of 387 IPAs as of Jan. 1, 1989, compared with 412 on June 30, 1988.

The number of group, network and staff model HMOs remained fairly constant during the period, the study notes.

Enrollment growth also varied by state in the second half of 1988, the study notes.

For example, HMOs in 31 states gained members. And, Massachusetts, New Jersey, New York, Pennsylvania, Maryland and California each reported enrollment gains of 50,000 or more. Growth in these states accounted for 93.5% of all new members.

Also, enrollment increased among 70% or more of the HMOs operating in Maryland, Massachusetts, New Jersey, New York and Pennsylvania.

According to the study, the top five states ranked by total HMO enrollees are: California, with 8.1 million enrollees; New York, with 2.5 million; Illinois, with 1.6 million; Massachusetts, with 1.4 million; and Michigan, with 1.4 million.

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Copies of "Interstudy Edge" for the second half of 1988 are available for $60 each. Annual subscriptions to "Interstudy Edge" are available for $225. For more information, contact Interstudy, 5715 Christmas Lake Road, P.O. Box 458, Excelsior, Minn. 55331-0458; 612-474-1176.

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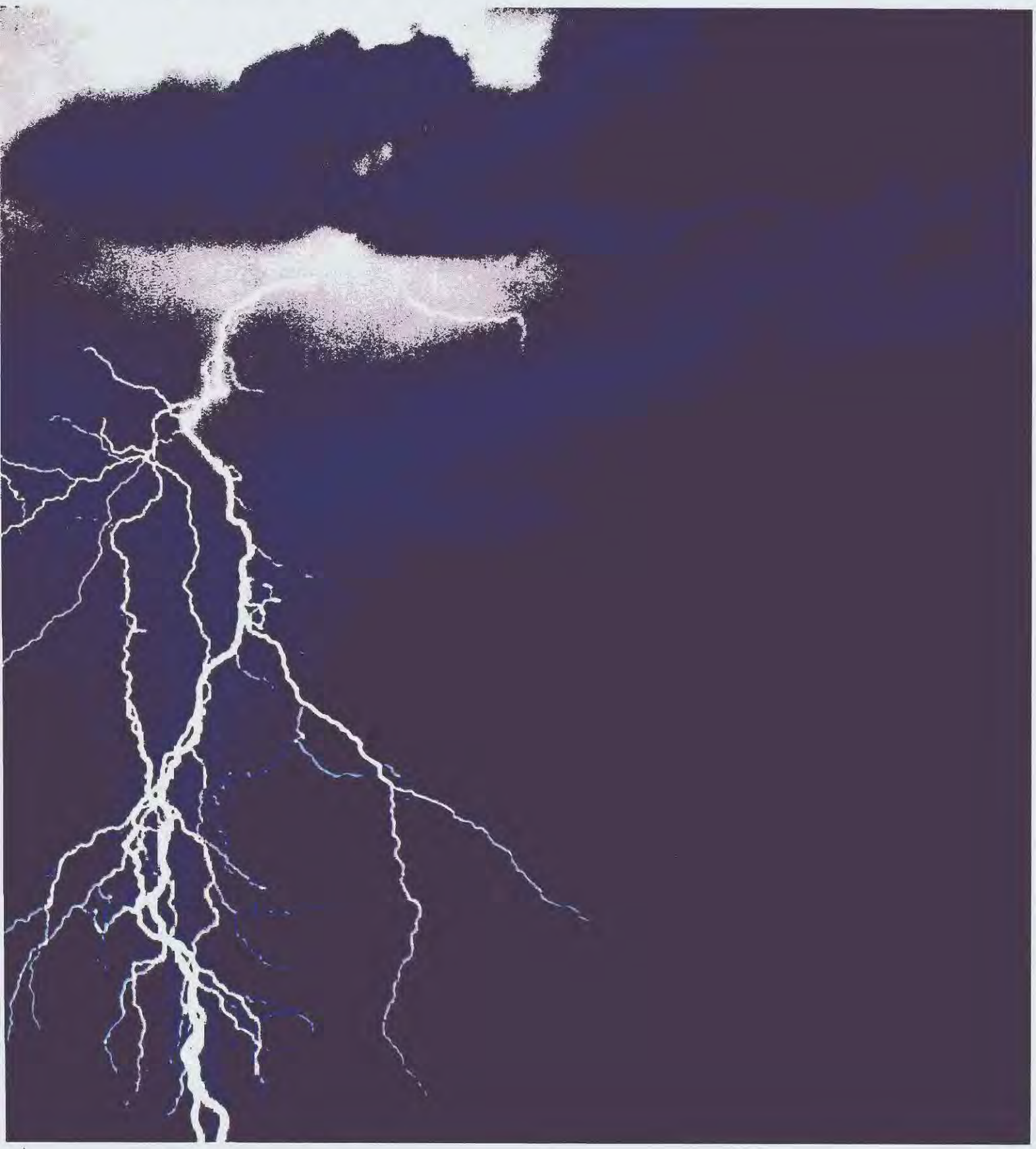

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Opinions

Communication is crucial

AT A TIME WHEN communication with policyholders and the public is more crucial than ever, insurance company executives are becoming increasingly more cautious about what they will say about how they do business or intend to do business.

That caution threatens to destroy the candid and productive discussion of important issues that will determine the future of the insurance business and how it services its policyholders.

The antitrust lawsuit filed by 19 state attorneys general in federal court against 31 insurance industry defendants and efforts to reform or repeal the McCarran-Ferguson Act are beginning to create an atmosphere of paranoia among insurance company executives that if they open their mouths at a meeting with colleagues, an antitrust violation may slip from their lips.

We, of course, do not condone any conspiracies among insurance companies to boycott, intimidate or coerce—actions that are not protected by the antitrust exemption afforded the insurance industry by the McCarran-Ferguson Act.

However, we do strongly encourage open and candid discussion of issues confronting the insurance industry and its policyholders, whether it be during committee meetings of the insurance industry trade associations, at public industry meetings or other public forums.

Only through open and candid discussions can problems be identified and solutions be proposed among insurance company executives and with their buying public. An informed insurance-selling and insurance-buying public makes the insurance marketplace function the most efficiently.

From what we have heard lately, however, insurance company executives are so concerned about what they should not be discussing that an informed insurance-selling and insurance-buying public is in danger.

We strongly encourage insurance company executives and their trade associations to exercise their rights to discuss issues as clearly defined by Supreme Court decisions and not to shut down communications among themselves and with the insurance-buying public because they are afraid of being accused of violating antitrust laws.

The Supreme Court, for example, has ruled in various cases that the right to petition the government for action allows the discussion of many topics that otherwise would not be permitted under antitrust laws.

Insurance industry regulation and operations are in the throes of the most important change since the 1940s, when the bases for current regulations and ratemaking were established. To be sure that what emerges is the best system for the future requires thoughtful and probing debate.

That cannot occur if insurance industry executives are gagged by overly cautious restrictions on what they discuss.

Letters

Documentation views spur strong opposition

To the editor: As a product liability lawyer who has handled more than 300 cases in the last 10 years, I must take strong exception to the comments of George W. Flynn, an attorney with the Minneapolis law firm Feagre & Benson, reported in "Needless Papers May Haunt Manufacturers" (*BI*, April 17).

Mr. Flynn is quoted as saying "you don't have to keep highly inflammatory letters like customer complaints," and apparently espoused this view as being appropriate in his remarks before the Assn. of Insurance & Risk Managers in Industry & Commerce.

Not only are Mr. Flynn's apparent views on this matter outrageous from the standpoint of what a company with an appropriate product safety stewardship program should be doing, but it also can be extraordinarily counterproductive in the defense of product liability suits.

There is a wealth of engineering literature, literally hundreds of thousands of documents in the public domain, that confirm that consumer complaints, field reports and lawsuits provide one of the best means for a manufacturer to obtain feedback as to potential product defects. The importance of these documents in designing for product safety is universally accepted, even by those expert witnesses who most often testify for defendants. Moreover, these documents are the foundation for future designs of products and for the determination by the engineering department of foreseeable uses and misuses.

A company's failure to adequately review such customer complaints, even those over a period of 10 to 20 years, can itself result in liability. But, more than that, Mr. Flynn's views represent neither a moral nor an ethical choice for manufacturers that have a duty to those who are using the products to design a product safely using all the available resources in choosing that design.

Not only are Mr. Flynn's views without merit from an ethical standpoint, but a company that destroys customer complaints, field reports and records of lawsuits potentially subjects itself to an even greater risk. In discovery, if it is found by the plaintiff's counsel that such documents are routinely destroyed rather than maintained, such action, combined with other evidence can itself form the basis for a claim for punitive damages for willful, wanton and reckless conduct on the part of the manufacturer.

Mr. Flynn's views, if correctly reported, indicate that he is advising companies that in fact do have knowledge of product dangers to destroy the evidence of such knowledge. It is precisely this kind of conduct that can itself lead to awards of punitive damages. Admittedly, a company would most likely not wish such information to be in the hands of plaintiffs counsel in a products liability lawsuit. But the only appropriate thing, from a business standpoint, is to maintain such documents and make them a part of the design review so that the defects can be eliminated from the product before such product causes injury.

Michael Garth Moore
Columbus, Ohio

* * *

To the editor: The unqualified statement in the article "Needless Papers May Haunt Manufacturers" is not only wrong but also indefensible.

Assuming that the reference to U.K. law was in fact to English law, it is quite clear that extensive procedures exist in both High Court litigation and arbitration for discovery including, in the Commercial Court, exchange of witness statements in lieu of evidence in chief.

The scope of discovery of documents may not be as wide-ranging as found in certain jurisdictions in the United States, but the English requirements are just as exacting. Indeed, if a document is not available or has been destroyed, a party must explain the circumstances as to how that document came to be missing or destroyed, and when. The suggestion that seems to be implicit in the article that defendants who are subject to English jurisdiction can destroy or hide documentation to suit their own wishes is just not correct.

The major difference between English and American discovery is on the question of depositions. Generally speaking, except in very limited and clear circum-

Continued on page 10

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

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Letters

Continued from page 8

stances, the English courts will not order deposition of witnesses. It is an open question as to which of the two systems of law have in fact correctly addressed this aspect of discovery.

David Farrington
Resident Partner
Lovell White Durant
New York

■ *George W. Flynn, a partner in the Minneapolis law firm of Feagre & Benson, responds: As the speaker at the AIRMIC conference in Cambridge, England, summarized in the article "Needless Papers May Haunt Manufacturers," I would like to clarify a few points I made in my speech and correct some misunderstandings the summary may reflect. I will also respond to the comments of attorneys Moore and Farrington.*

The predicate of my presentation was that documents are not helpful to the defense of product litigation. Companies create documents to address problems and to attempt to resolve them. As a result, all documents deal with problems in one way or another. Rarely does a company record state "Production was fine. No problems occurred. Everything is excellent."

The premise of Mr. Moore's criticism is that identifying documents as a hazard in product litigation is synonymous with abandoning post-sale product management or the use of product experience in subsequent design and development. That is not my position.

To the contrary, I said in my speech, which I have delivered on several occasions, that post-sale product management is imperative both legally and morally. In the United States, where the post-sale duty to warn has been accepted to a greater or lesser degree by most jurisdictions, a company is bound to monitor the field performance of its product and, if problems develop, to take appropriate remedial action—be that retrofit, inspection, additional warnings or recall. To fulfill that duty, a company must monitor the field performance of its products.

However, that monitoring does not convert to mindless and endless retention of every document generated by a company's people and its customers. Once a field problem has been identified and its resolution adapted, then further retention of the records and documents regarding that problem are not necessary for field management and performance.

At that point, the actual reporting documents regarding product information are no longer needed to continue product management. However, several manufacturers seem to think that all this type of material should be retained, not to assist in product management, which, if it serves that purpose, should qualify it for retention, but rather to assist in defense of product litigation or, worse, for no reason at all.

Because reports and documents that identify problems commonly portray or imply a serious hazard or risk of injury attributable to them, they are simply not helpful in product liability defense, nor are reports or memoranda complaining of the various vicissitudes of manufacturing life helpful. Such documents may be critical, rightly or wrongly, of one aspect or another of company policies or procedures and surface in litigation as a plaintiff's proof of corporate insensitivity or mismanagement. In general, for purposes of product liability litigation—again, as opposed to product management—the documents are not useful.

Both Messrs. Moore and Farrington make the legitimate point, which I also made at the AIRMIC presentation, that documents may not be selectively retained or destroyed. Rather, a uniform document retention policy must be established based on the company's need for the documents.

Proper field management and fulfillment of the post-sale duty to warn or recall are some of the considerations that dictate the period of time for which certain categories of documents should be retained. Therefore, I am not advocating the selective destruction of documents. Rather, I am urging that companies carefully consider the question and establish policies on document retention to reflect their needs.

I am further urging, contrary to Mr. Moore, that documents will not be helpful in trial. As Mr. Moore notes, the absence of documents may be a basis for a negative inference by the court and jury. However, the presence of these documents is an even more onerous basis from which negative, often erroneous, and unfair conclusions can be drawn.

A uniform document retention policy must be established based on the company's document needs.

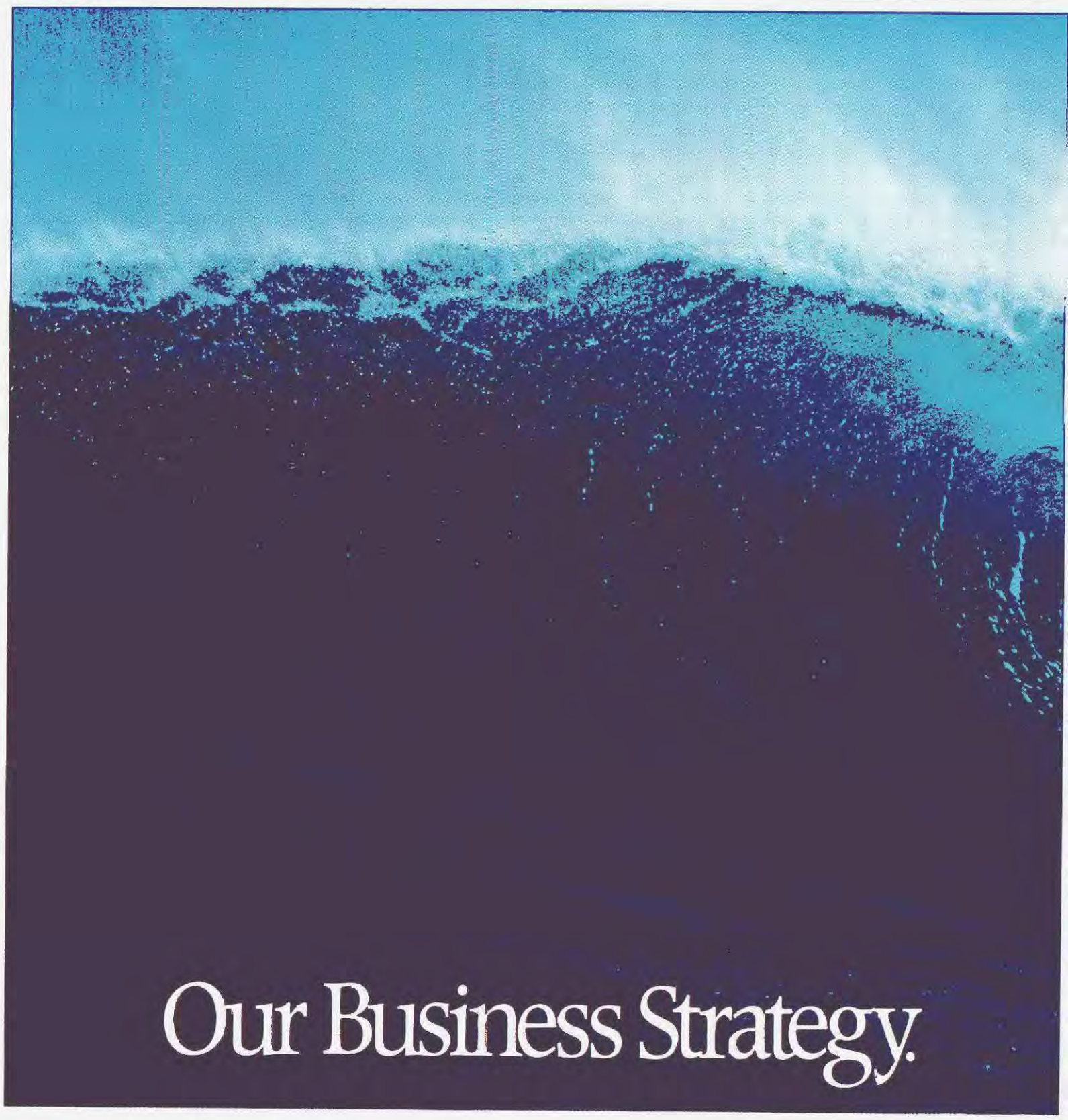
Again, the point of my presentation, which was not reflected in the comments reported in Business Insurance, *is that documents for product defense are much more harmful than helpful. They may, as Mr. Moore indicates, be needed for product management. To the extent that they serve that function, they should be kept for the uniform period of time they are potentially helpful, but they should not be kept for use by the company at litigation.*

Finally, while I am not an expert on U.K. law, I believe Mr. Farrington is correct that the English system does not provide for wholesale demands for broad classes of documents.

However, apparently the legal system in the United Kingdom provides that whatever lawyers deem to be relevant documents must be produced to the opposing party. The distinction between the English and American systems, which reflects a high degree of integrity in the English bar, is that the decision on what is relevant is left to the attorney for the defendant, rather than the extensive review of mass documents conducted by the plaintiff's attorney looking for what he might view as relevant.

Finally, it was reported that I stated that the European Community's definition of strict liability "...does not encompass a wholesale duty to warn customers of product dangers." Lest there be any confusion, it is my understanding that the proposed EC directive does call for warnings, if necessary, when the product is manufactured. The distinction between that directive and the practice in the United States is that the EC does not, at present, impose a post-sale duty to warn.

As I noted in my comments at the AIRMIC conference, I think any English manufacturer relies on that current difference at its peril. Clearly, if information comes to a manufacturer's attention after a product is sold—but while it is still in field use—that it is causing injuries or death because of some defect in the product, it is untenable to contend that the manufacturer can simply remain passive, hiding behind a contention that once a product is sold its duties are fulfilled. Therefore, I think it is predictable that the European system as ultimately adopted will include some provision for post-sale warning or other remedial conduct if the severity and frequency of the hazard compels it.



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At issue

Should retiree health care benefits be based on length of service?

Timothy J. Sutter
senior supervisor-benefits
United Van Lines Inc.,
Fenton, Mo.

Given the proposed FASB standards, employers will be most concerned with damage control. The use of an employee's years of service in either the calculation of the employer contribution or in the benefits offered are valid alternatives in the fight to minimize potential damages.

William Dodge
vp-insurance
Fuqua Industries Inc.,
Atlanta

It's fair because if, in fact, a pension a retiree receives is based on service, he ought to have the same reward by a lessening of his contribution to his medical coverage cost based on service.

Richard L. Clapp
vp-compensation/benefits
Gannett Co. Inc.,
Arlington, Va.

There should be a number of criteria employers should consider, and length of service is one factor. Other considerations would be cost sharing, plan design and competitiveness, business necessity and other workforce factors.

Ann E. Burke
manager-corporate employee benefits
Boehringer Ingelheim Corp.,
Ridgefield, Conn.

Companies will be forced to tie the retiree health care package to one or two key elements to be able to effectively manage the costs involved. Length of service and age at retirement should certainly be viewed as a means to control the number of retirees who will become eligible for the medical program. However, a closer look at retiree medical plan design is needed to minimize costs.

Compiled by Christine Woolsey

Around the states

Ohio bill calls for state-run health insurer

COLUMBUS, Ohio—A proposal in the Ohio Legislature would revolutionize health care in the state by creating a state-run program to provide all Ohio citizens with health insurance coverage.

H.B. 425, introduced last month by Rep. Robert Hagan, D-Youngstown, would create the Ohio Universal Health Insurance Plan, which is described in the bill as "a single, publicly financed statewide insurance program to provide comprehensive coverage for all necessary health care services" for all residents.

The plan would replace nearly all private health insurance coverage and also would provide protection for those currently uninsured.

Under the bill, which is now before a House subcommittee, the state would provide comprehensive major medical coverage, including substance abuse treatment, outpatient mental health services and prescription drug coverage, although medications would be subject to a $1 copayment.

Under the bill, insurers and employers could only offer Ohio citizens health care benefits that would not duplicate the state program's coverage. For example, such benefits as cosmetic surgery, basic nursing home care and medical examinations and reports prepared in connection with life insurance applications or litigation would be allowed.

The plan calls for creation of a trust fund, which would be financed by several new taxes, including an 8% payroll tax on employers, a 1% tax on an employee's gross salary, a 10% tax on both alcoholic beverage and cigarette sales, and a 2% tax on interest and dividend payments in excess of $1,000 per year.

The plan also would request that the federal government prepay to the state trust fund all federal health care moneys owed to Ohio residents, including Medicare funds, said Peter MacDowell, a legislative director of Ohio Citizen Action, a consumer group that helped draft the measure.

According to the proposal, an Ohio resident would obtain health care services from the physician of his choice. Independent health care providers would then bill the trust fund on a fee-for-service basis, although the amount charged could not exceed a statewide fee schedule that would be negotiated annually.

"Multispecialty provider organizations," like health maintenance organizations, would be reimbursed on a capitation basis under the plan.

Institutional providers, like hospitals, would be reimbursed for services based on an annually negotiated budget that is subject to plan officials' approval.

The bill, which, if enacted, would take effect Jan. 1 of next year, was promoted by the Northeast Ohio Coalition for National Health Care and Ohio Citizen Action.

The groups developed their proposal after an article in the New England Journal of Medicine and a recent nationwide poll both recommended creating state plans similar to health care plans in Canadian provinces, according to Libby Holman, Rep. Hagan's legislative aide.

Continued on next page

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Around the states

Continued from previous page

"No one predicts the bill will pass this session," said Ohio Citizen Action's Mr. MacDowell.

However, similar legislation will be adopted in Ohio within the next few years or in other states, he predicted.

—By Meg Fletcher

Work comp pool refunds

LANSING, Mich.—About 12,375 Michigan employers recently received $34 million in long-awaited premium refunds from the Accident Fund of Michigan, the state's largest workers compensation insurer.

The refunds, which were distributed from the fund's surplus, included $26 million in excess premiums that the fund had collected between 1976 and 1981 and $8 million in interest.

Distribution of the refunds, which were mailed May 8, had been stalled because of an ongoing legal battle between the Lansing-based fund and the state attorney general, who represents the Michigan Insurance Bureau.

The debate centers on whether the fund is a private or state-controlled insurance company. State officials contend the fund is a state agency under the Insurance Department's direct control, while the fund maintains it is a private insurer, capable of setting its own rates under the state's file-and-use competitive rating law.

The state's position was upheld in December by the Michigan Court of Appeals and by a state Circuit Court decision before that. But the fund has asked the Michigan Supreme Court to review the appellate court's decision.

State officials had balked at distributing the $34 million unless the fund dropped its fight to be independent, said D.A. D'Annunzio, deputy insurance commissioner.

State officials were worried that if the fund were declared a private agency, it would be liable for federal and state taxes that conceivably could wipe out the fund's $185 million surplus, he explained. Distributing the refunds would deplete the surplus available to meet this potential tax liability, officials had feared.

To obtain release of the money, the fund launched a public relations offensive in April. It sent more than 12,000 employers photocopies of their prepared refund checks and urged them to contact legislators and lobby for passage of a House bill that would require the state to release money for the checks.

Shortly thereafter, state officials determined that there was sufficient money to pay the refunds and still meet the fund's potential tax liability, Mr. D'Annunzio said.

"We want to be able to give the money back to the businesses now," he said. "It seemed unfair for business to be caught in the middle.'

The fund's surplus stands at about $150 million after the refund, Mr. D'Annunzio noted.

Frank M. Feeley, the fund's executive vp and acting chief executive officer, said the distribution of the premium refunds to the fund's employer members "did not come about easily."

—By Meg Fletcher

Ohio rehab services

COLUMBUS, Ohio—The Ohio Industrial Commission now requires some disabled workers to undergo evaluations to determine whether vocational rehabilitation services will help them return to work.

Under the program, which was launched this month, injured workers receiving temporary total benefits will undergo an evaluation between three and nine months after their injuries, depending on the severity of their conditions, said Bruce Growick, director of the OIC's rehabilitation division.

According to a report issued by the state last year, 400,000 Ohio workers were injured on the job in 1987, but only 100,000 of those were off work seven days or more. Of those, 90,000 workers returned to work during the first three months, but 10,000 workers were off work 90 days or more, Mr. Growick said.

The OIC's new evaluation program targets those 10,000 workers, he added.

"The earlier the intervention, the more likely we can get them back to work," he said. If intervention is delayed, recovering workers may develop problems like depression and adjust their lifestyle to living on workers compensation payments, which are set at two-thirds of their weekly salary up to $400 per week, tax-free.

Workers who are off work for nine months to one year begin to perceive financial disincentives to return to work, Mr. Growick added.

The mandatory evaluation will consist of OIC case workers—who operate from state-run centers in Columbus, Cleveland and 12 field offices throughout the state—contacting an injured worker and reviewing his or her situation, Mr. Growick explained. Consultation with the worker's physician will be arranged as needed, he said.

A worker who does not participate in the evaluation may jeopardize his workers comp benefits, Mr. Growick said.

If it is determined that an injured worker could benefit from the state's vocational rehabilitation program, he or she will be referred to a state-run center for help, he said. Although the evaluation is mandatory, an injured worker's participation in any vocational rehabilitation program is totally voluntary, Mr. Growick said.

Employers support the program because they "are interested in getting workers off the temporary total rolls and back to work," Mr. Growick said.

The program is also expected to help the state take advantage of its underutilized rehabilitation centers. For example, the 5-year-old, $35 million J. Leonard Camera Industrial Rehabilitation Center in Columbus has operated at about 60% of capacity for the past two years. And, the $70 million W.O. Walker Industrial Rehabilitation Center in Cleveland was completed last year and is expected to open July 1.

—By Meg Fletcher

Missouri regulator

JEFFERSON CITY, Mo.—Missouri Insurance Director William A. Bennett resigned May 22, approximately three months after taking the post (*BI*, March 6).

Deputy Director Larry Call will step in as acting director, as he did after the October 1988 resignation of Mr. Bennett's predecessor, Lewis Crist (*BI*, Nov. 14, 1988).

Mr. Bennett, 49, said "personal family reasons" prompted his decision.

He plans to return to the employee benefits division of Aetna Life Insurance Co. in St. Louis as a senior account executive.

—By Meg Fletcher

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Insurance 'war' slows progress: Lawmaker

By LINDA J. COLLINS

CHICAGO—Legislative and consumer assaults on the insurance industry throughout the 1980s constitute a war fought on several fronts, says New York state Sen. John R. Dunne.

And, in this struggle, insurers spread their resources "too thinly over too many minor skirmishes," Sen. Dunne, R-Garden City, told attendees at a May 17 symposium in Chicago sponsored by Standard & Poor's Insurance Rating Services.

"On one front, there is McCarran-Ferguson, a conflict characterized by one veteran insurer as having started the very day it was enacted almost a half-century ago," he said, referring to the 1945 federal act that grants insurers limited immunity from antitrust laws and gives states primary responsibility for regulating the insurance industry.

"On another, there is the antitrust litigation, with insurers and attorneys general at a standoff (*BI*, Jan. 9).

"And on. . .the Western front, there is Proposition 103, which consumed an extraordinary amount of resources and constituted an industry defeat," Sen. Dunne said in reference to the controversial California law requiring insurers, among other things, to roll back most property/casualty insurance "charges" to 20% below November 1987 levels (*BI*, Nov. 14, 1988).

Sen. Dunne

The distractions posed by those skirmishes kept insurers from focusing on improving "the business of insurance and reinforcing policyholder confidence in their insurance product," asserts Sen. Dunne, who is ranking majority member of the New York Senate Insurance Committee.

And while insurers spent considerable time and energy on those issues without yielding "any significant public policy breakthroughs, more serious fundamental problems arose on other fronts," Sen. Dunne noted.

Those latter problems—"specifically (related to) insurer solvency, reinsurance regulation, alternative market mechanisms and affordable health insurance—will dictate the strategy of the next decade," he predicted.

Of those problems, Sen. Dunne characterized insurer insolvencies as the most onerous.

"There is nothing, in my judgment, that threatens the credibility of the insurance industry as much as the specter of insurer insolvency and the attendant issue of the sufficiency of the states' guaranty funds" to handle those insolvencies, Sen. Dunne said.

In the past four years, more than 70 insurers have been placed in liquidation, Sen. Dunne noted. And, "others are certainly perched precariously close to insolvency," he added.

"I believe the agenda for the '90s must lead with the insolvency issue, and changing the way we address it must be our highest priority," he stressed.

In his remarks, Sen. Dunne said he questions the effectiveness of the various existing state guaranty funds in handling insurer insolvencies.

"The guaranty fund system—now a patchwork of pre- and post-assessment funds covering both personal and commercial lines, as well as separate funds for life underwriters—needs to be revamped, and it must be achieved, in my judgment, without further delay," Sen. Dunne stressed.

He cited recent emergency legislation restructuring Maine's guaranty funds as a good example of the problems and possible solutions.

In addition to increasing insurers' maximum assessments by Maine's three property/casualty guaranty funds to 2% from 1% of annual direct net written premiums, the legislation established a limited prefunding mechanism for all six of Maine's guaranty funds to provide immediate funds to pay claims in the event of an insurer insolvency (*BI*, May 8).

"I believe that we have to move toward preassessment funds because the funds have to be there to (enable) the liquidator to go in and meet those initial obligations," he said. "I think the Maine legislation provides a good balance."

But Sen. Dunne pointed out that the preassessment portion of Maine's emergency legislation was limited in scope, "in response to industry fears that a preassessment fund would be subjected to. . .legislative larceny such as we practiced in New York, when revenue-starved officials raided the fund's surplus in order to balance the state budget."

His remarks were in reference to the New York Legislature's appropriation of $87 million from the state's property/casualty guaranty fund earlier this decade (*BI*, Jan. 23; May 9, 1988).

Prior to passage of Maine's emergency legislation, New York was the only state to prefund its guaranty fund.

"I have been trying to get written into our state constitution a prohibition against the raiding of the funds which we have witnessed in New York," Sen. Dunne said.

Sen. Dunne said he hopes that the National Assn. of Insurance Commissioners will develop model legislation to address the inequities between various state guaranty funds and develop a more consistent response to insolvencies on a state-by-state basis.

According to Sen. Dunne, "another nagging dispute is if guaranty funds should cover all lines of insurance or protect only certain classes of policies and policyholders."

He explained that unlike in the 1970s, when personal lines problems "put a serious strain on property/casualty funds," in "this current decade insolvencies in commercial lines have significantly drained guaranty funds."

Depletions of state guaranty funds from the rash of insurer insolvencies in recent years has "led some (people) to call for total removal of commercial risks from guaranty fund protection," Sen. Dunne said.

However, in his opinion, that "would be imprudent, because not all commercial insurance buyers are sophisticated insurance consumers, nor are they all capable of absorbing high-limit losses in the event of an insolvency."

Continued on next page

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Industry battles

Continued from previous page

"I suggest that a more balanced approach would be to segregate guaranty funds along personal and commercial lines, which would obviate the inevitable inequities of each line subsidizing the other," he said. More specifically, it would keep personal lines policyholders from having to bear the burden of commercial lines insolvencies, he noted.

The senator stressed that he hopes "the tendency to let insurers dig their own hole, to have healthy insurers skim off the good business and then let the insolvency go through litigation will not be tolerated much longer, because it is a very expensive way of meeting a goal readily achievable through natural business processes such as mergers and acquisitions."

"Waiting for a company to be declared insolvent and be run through the liquidation process and satisfy claims through the guaranty fund mechanism is not only expensive in real dollar terms and costly in terms of regulatory resources, it is also the creator of a very negative perception of the industry which tends to diminish public policyholder confidence," Sen. Dunne warned.

The specter of unrecoverable reinsurance also looms heavily over the insurance industry and may serve to drive some smaller insurers into insolvency, the senator observed.

The current regulatory philosophy is to regulate reinsurance practices by regulating the ceding company, Sen. Dunne said. That policy, he said, should be re-examined.

He noted that the National Assn. of Insurance Commissioners, in close cooperation with the Reinsurance Assn. of America, "is currently amending its forms and regulations to provide a more accurate evaluation of reinsurance assets and liabilities of ceding insurers."

This effort includes the recent approval of NAIC regulations that, beginning with 1990 annual statements reporting on 1989 operations, ceding insurers must write off a percentage of undisputed overdue reinsurance against their capital and surplus (*BI*, Dec. 26, 1988; Oct. 31, 1988).

However, Sen. Dunne said the measures don't go far enough and "must be complemented by a commitment from state lawmakers to understand the role of reinsurers."

As insolvencies wear away at guaranty funds, dramatic premium pricing swings erode the insurance industry's credibility among policyholders and regulators, he added, cautioning that "if insurers hope to survive in the long-run, then they also need to rethink the criteria for premium pricing decisions."

For example, Sen. Dunne noted, while it is perfectly acceptable to incorporate such short-term pricing strategies as interest rate fluctuations or bond yields into their ratemaking decisions, those strategies "cannot replace strict adherence to underwriting principles" and should not be relied upon too heavily.

When insurers let these short-term strategies override long-term underwriting concerns, consumers and legislators are forced to take the offensive, Sen. Dunne said.

That is what prompted the consumer revolt that brought forth Proposition 103, he argued, adding that insurers lost that battle because their strategy was misdirected.

"Price-sensitive initiatives, such as Prop. 103 and others now being considered (in other states), must be challenged head-on—not by stonewalling, but by educating the public, legislators and regulators," he said.

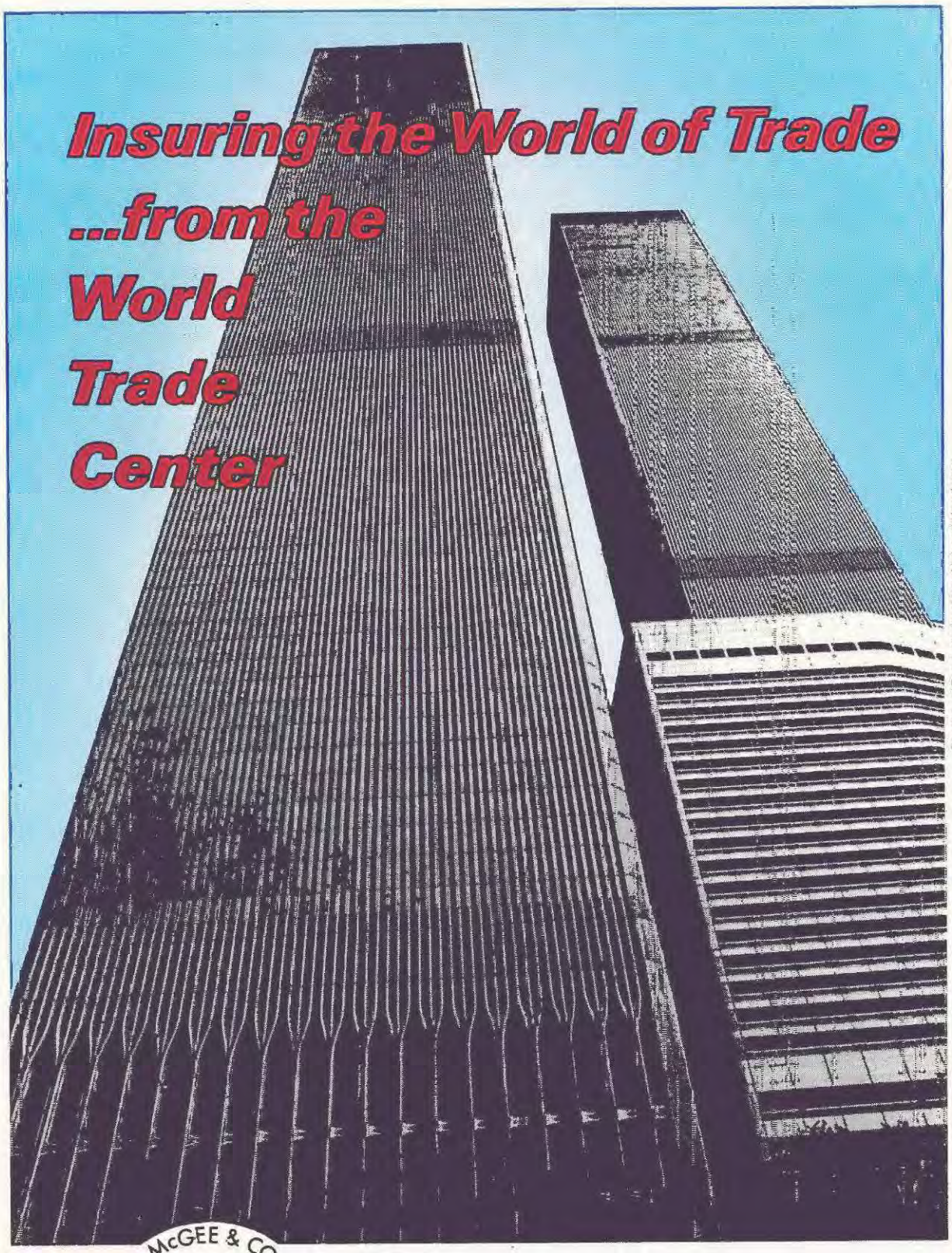
Sen. Dunne said he does not view initiatives like Proposition 103 or similar legislative endeavors as solutions to the insurance industry's problems. "Insurance is not a short-term business and its processes cannot be dictated by the simplistic short-term perspectives that inspire such referendums," he said.

Although current attention appears to be focused on traditional insurance mechanisms, Sen. Dunne predicts that the next decade "will require a monitoring of the condition of alternative markets" as well.

"It is the success of the non-traditional mechanisms that may determine the insurance industry's tolerance for market cycles," he said.

Another critical issue "that could prove to be the Waterloo for insurers, reinsurers and alternative markets, is the unchecked spiral in health insurance costs. Increases of 20%, 25% and 30% each year simply cannot be sustained by the market or by the public that ultimately pays the bill," Sen. Dunne stressed.

Not only do these increases affect individual consumers and employers sponsoring group health care plans, they also have been a major contributor to rising costs for some lines of property/casualty insurance, he said, citing the medical care cost component in automobile insurance as an example. ■



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Brokers must scrutinize insurer books: Panel

By LINDA J. COLLINS

CHICAGO—Careful scrutiny of insurers' and reinsurers' financial condition is an essential task for brokers as intense competition continues in the commercial property/casualty insurance marketplace.

Brokers and reinsurers speaking at a symposium sponsored by Standard & Poor's Corp.'s Insurance Rating Services May 17 in Chicago suggested ways to measure the financial security of insurers and reinsurers.

"The outlook for (the property/casualty marketplace in) 1989 is for a continuation of increased capacity and low (premium) costs," predicted Marjorie Horwitz, vp of Marsh & McLennan Worldwide in New York, which provides global insurance marketing and brokerage support resources to the worldwide brokerage operations of Marsh & McLennan Cos. Inc.

"Even without some major catastrophe, it is expected that by the fourth quarter of 1989, operating losses—not underwriting losses—can easily start to appear on insurers' financial statements. In other words, underwriting results should deteriorate significantly in 1989," Ms. Horwitz noted (see story, page 1).

"Deteriorating underwriting conditions provide less funds for investments, and therefore investment income should also start to slow down. Cash flow generated by underwriting operations has been declining, and this decline is expected to continue," she added.

Because of these factors, insurer "results will continue to get worse before they get better," Ms. Horwitz stressed.

Furthermore, "in addition to major problems of underreserving, there are questions of uncollectible reinsurance and the anticipated increased costs" for insurers created by the Tax Reform Act of 1986, she noted.

And, insurer annual statements are also reflecting the "tremendous costs incurred by carriers for insolvency fund assessments," Ms. Horwitz explained.

In a nutshell, the "current conditions in the marketplace certainly have raised the issue of solvency of insurance companies," she pointed out.

Ms. Horwitz suggested that to avoid placing their clients' business with "the problem companies that will continue to plague the insurance industry," brokers should "communicate with people in the marketplace, with brokers, agents, risk managers and purchasers of all types of insurance" to help identify problem insurers.

And, in addition to getting feedback from outside their operations, she said brokers need to examine the following criteria before selecting insurers:

• Who are the insurer's senior officers? What is the length of time they have been with the company? What is their previous background?

For example, longevity of an insurer's top officers, either within their present company or within the insurance industry, is one indication that its managers understand the insurance business, Ms. Horwitz explained.

• Has the insurer's underwriting philosophy or underwriting procedures changed recently? Or, has it suddenly shown a tremendous increase in premium volume from one year to the next?

"This could be the beginning of a cash-flow problem. A company may very well be writing more now so that its losses and expenses can be paid," Ms. Horwitz noted.

"In today's environment, when we see large premium increases from companies that state they won't cut their rates, we really have to look at the credibility of management," she added.

• Does the insurer do business solely through managing general agents or through a network of agent or broker intermediaries? Who are its MGAs and what is their binding authority? Is its list of MGAs suddenly growing or changing?

MGAs that have long-standing relationships with insurers are well-versed in their underwriting criteria, but if an insurer suddenly expands its MGA list, the new MGAs might not be as careful in their selection of business, which can generate huge losses, Ms. Horwitz pointed out.

• Is there a change in the insurer's mix of business? If so, is it now writing lines of business that require a greater amount of expertise, like medical malpractice insurance? Does the insurer have the expertise to write that business?

• What percentage of the insurer's gross written premiums are retained and how much is it ceding to reinsurers? What is the quality of its reinsurance? What percentage of the insurer's incurred-but-not-reported losses are reinsured by companies that are already in financial trouble?

• What is the quality of the insurer's policyholder surplus? Is it liquid or non-liquid? For example, Ms. Horwitz asked, if the insurer lists real estate among its assets, can that real estate be sold at its carrying value?

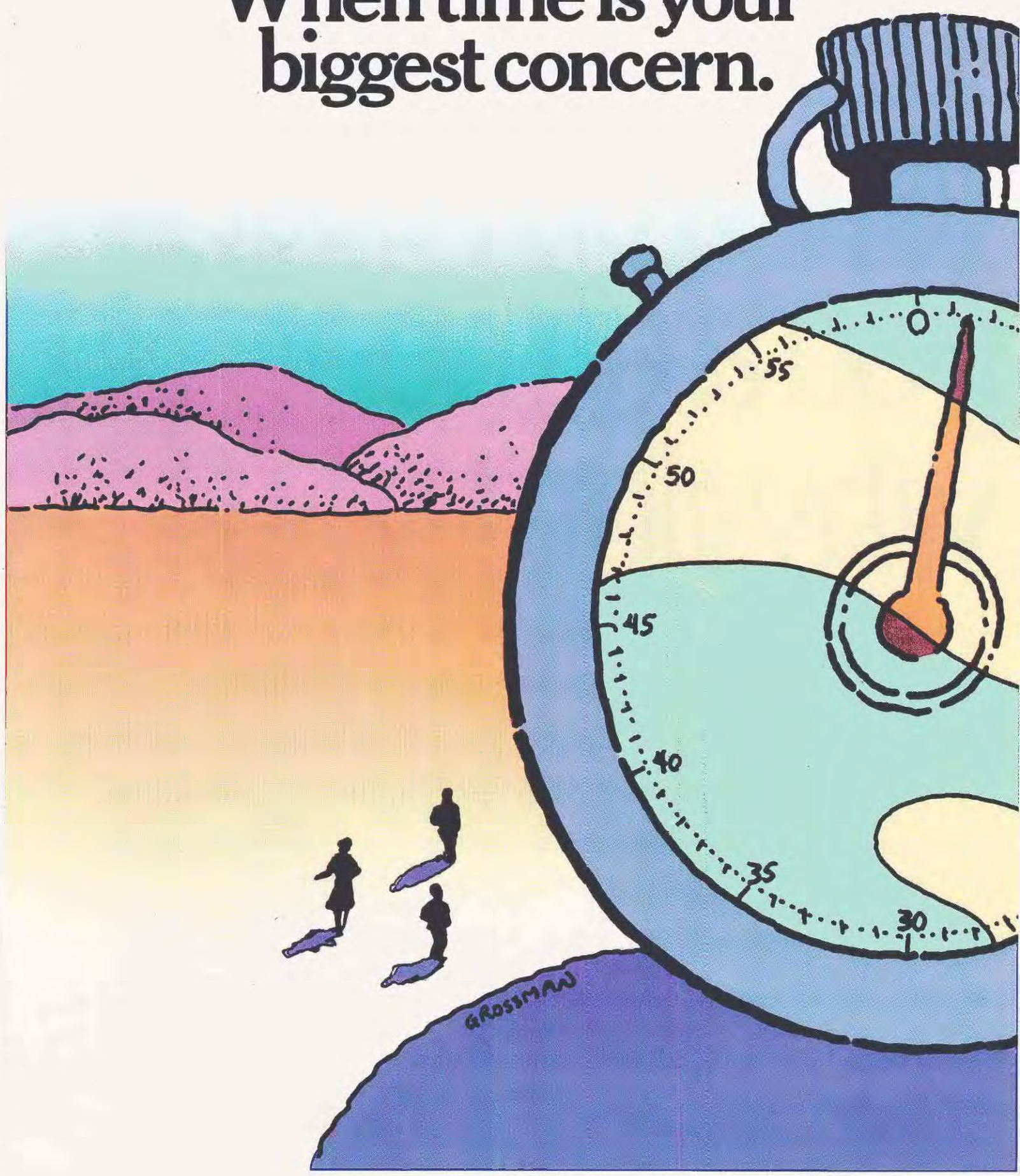
• Has the integrity of the company's surplus and investments changed recently? Is the portfolio of assets in high-risk type investments?

• How efficient is the insurer's data processing system?

• Do loss portfolio transfers disguise the actual financial condition

Continued on next page

When time is your biggest concern.



Continued from previous page
of the company?

- Has the insurer discounted its loss reserves in the past? Is it experiencing poor loss development? What is its ratio of net premiums written to surplus? What is its ratio of gross premiums written to surplus?
- What will the insurer's tax liabilities be under the Tax Reform Act of 1986?

Marshall Pinnix, senior financial analyst for Alexander & Alexander Inc. in Owings Mills, Md., said that in assessing an insurer's stability, he finds that the "three L's"—leverage, loss development and liquidity—are the most important indicators of its financial condition.

In assessing an insurer's stability, the 'three L's'—leverage, loss development and liquidity—are the most important indicators of its financial condition, says Marshall Pinnix, senior financial analyst for Alexander & Alexander Inc.

It may not be possible for the insurer to liquidate some of its assets at their carrying value in the case of distress, he said. And "loss reserves often have to be raised because of the past year's loss development. Either or both of those things working together can squeeze that surplus," Mr. Pinnix explained.

"What you want to look at is how much squeezing can it take," he added.

And the insurer's policyholder surplus should also "be reduced by any equity investments in its unconsolidated affiliates," Mr. Pinnix stressed.

A better way to examine this is to look at the insurance group's consolidated statement, he noted. "If you leave their investment in other property/casualty companies (that are affiliates) in their assets, and therefore, in their surplus, you're putting that (value) in the denominator, but you're not putting their premiums written, total liability and reinsurance leverage in the numerator, so you are understating their leverage," Mr. Pinnix explained.

Gross leverage is calculated by adding the insurer's net premiums written to surplus, reinsurance leverage and total liabilities to surplus, he said.

According to Mr. Pinnix, an insurer's reinsurance leverage is calculated by adding:

- Premiums ceded during the year to non-affiliates.;
- Reinsurance recoverables and amount of reinsurance ceded under its incurred-but-not-reported losses.

That sum is then divided by policyholder surplus.

In checking an insurer's loss development, the most recent year's loss development should be compared with that of several preceding years to see if there has been a significant increase, Mr. Pinnix suggested.

The insurer's liquidity can be assessed by dividing its liabilities by its liquid assets, excluding its investments in affiliates, he said.

But while leverage, loss development and liquidity are the most important indicators of the insurer's financial shape, "it's also important to review the quality of the assets, including the stocks and bonds," and to examine results of insurer's Insurance Regulatory Information System tests administered by the National Assn. of Insurance Commissioners, Mr. Pinnix noted.

Robert A. Bailey, senior vp of reinsurance intermediary E.W. Blanch Co. in Minneapolis, pointed out that while reinsurance brokers do monitor the financial stability of reinsurers with which their clients cede business, "a (reinsurance) broker's role is not to select reinsurance for the ceding companies or evaluate security for the ceding companies."

"The broker's role is to provide information about price, availability, service and security—timely information," Mr. Bailey explained.

The ceding company must weigh the trade-off between the risk and the benefits based on its own priorities, he said. "For some clients, security comes last, for some it comes first, and for some it comes in the middle," Mr. Bailey observed.

And, sometimes the reinsurer with the best security is the worst in price, availability and service, Mr. Bailey acknowledged. "It's a question of risk in relation to benefits."

While there "is no end to the data that can be compiled" to evaluate a reinsurer's security, "the three criteria most commonly used in the marketplace by ceding companies" are size, rating and ownership, Mr. Bailey noted.

Size is an important consideration, since "in the U.S., the last 50 years, the largest insolvency we have had was the Mission (Insurance) Group, which at its peak was the 53rd largest insurance group in this country, based on premium volume," Mr. Bailey stressed.

"The top 50 groups in the U.S. which write 75% of the market share in this country have not had any insolvencies in the last 50 years," he observed.

"That means that the 400 to 500 insolvencies that have occurred in the U.S. have all been concentrated" among the smaller companies that comprise the remaining 25% of the marketplace, Mr. Bailey pointed out.

The second criteria to evaluate is the company's financial rating, which he said can be checked through any of three rating services: Oldwick, N.J.-based A.M. Best Co. Inc.; Braintree, Mass.-based ISI Systems Inc.; or New York-based Standard & Poor's.

The third criteria to examine in evaluating an insurer's financial condition is its ownership, Mr. Bailey said.

The insolvency rate among companies with "an ownership and management that has been around long enough to demonstrate its expertise, commitment and to earn. . .the confidence of the mar-

Continued on next page

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Insurer solvency

Continued from previous page
ketplace" is much smaller than for companies with less-seasoned people in charge, Mr. Bailey stressed.

Unfortunately, some ceding companies needlessly go to great lengths when evaluating their reinsurer security, he observed.

"The problem (with that) is that accuracy is not the most important ingredient for success in evaluating security," Mr. Bailey contends.

"The most important ingredient is the priority the buyer assigns to security," he explained, adding that complexity can confuse the issue because it "is often used to justify whatever markets are selected based upon some other criteria, like price."

"In the face of commercial pressures, such as availability and price, complexity can be counterproductive. It can override the purpose of the security program," Mr. Bailey noted.

'If priority is high, good security is easy to achieve (using) the simplest of tools, like size, rating and ownership,' says Robert A. Bailey, of E.W. Blanch Co.

"If priority is high, good security is easy to achieve (using) the simplest of tools, like size, rating and ownership," Mr. Bailey concluded.

Also participating on the panel was John Iten, assistant vp of Standard & Poor's in New York. The panel was moderated by Standard & Poor's Senior Vp Alan Levin. ■

Products & services

Financial institution policy covers pollution legal costs

A new insurance product covers the legal expenses of financial institutions involved in litigation stemming from pollution and/or contamination of property acquired through foreclosure or held in trusts.

The Bankers Environmental Legal Expense Reimbursement Insurance program is underwritten by Lloyd's of London syndicates and brokered by Los Angeles-based NAS Insurance Services Inc.

The policy, which covers court costs and expert witness and attorneys' fees, has up to a $1 million limit, said NAS President Maurice Sidy. However, the policy does not respond to damage awards.

The policy is written on a claims-made form and currently is available in all states except New York.

Annual premiums, which range from $3,000 to $17,500, are based on the institution's size, number of mortgages, property in trusts and residential/commercial foreclosure ratios, according to Mr. Sidy.

Deductibles, which vary according to the limits purchased, range from $5,000 per claim on a $50,000 policy up to a $25,000 per claim deductible on a $1 million policy. In addition, policyholders are responsible for a 10% copayment per claim.

For more information, contact Maurice Sidy, NAS Insurance Services Inc., 1800 Avenue of the Stars, Suite 410, Los Angeles, Calif. 90067; 213-277-2112.

BC/BS long-term care

Blue Cross & Blue Shield of Rochester, N.Y., has introduced three new long-term care policies for groups and individuals in New York state.

Under the BC/BS long-term care plan, policyholders can select from among three coverage options:

- Care Directions I, which covers 75% of costs for nursing home care, hospital alternate care, adult day care, home care and respite care.
- Care Directions II, which is an indemnity program that pays $100 per day for nursing home care and hospital alternate care and $50 per day for adult day care, home care and respite care with inflation protection at 5% annually for 20 years.
- Care Directions III, which combines the $100-per-day coverage for nursing home care and hospital alternate care with 75% coverage for home care and respite care with inflation protection at 5% annually for 20 years.

"With a wide array of affordable products available, consumers can now select the type of long-term care coverage that best suits their needs and budgets, said Howard Berman, president of the local Blue Cross & Blue Shield plan.

All Care Directions policies

Continued on page 20

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Products & services

Continued from page 18

cover skilled, intermediate, custodial and respite care, as well as the rental or purchase of durable medical equipment, which can include the rental or purchase of an emergency alert system to contact a monitoring center in case of emergency.

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For example, a 50-year-old employee would pay $30.16 per month for Care Directions I group coverage, while a 60-year-old employee would pay $52.60 for the same policy.

Individual rates are approximately 10% higher than group rates.

Group long-term care policies are available to active employees between the ages of 21 and 85.

Coverage at the group rate also can be obtained for spouses and relatives of active employees.

Premiums for groups of active employees are collected through automatic payroll deduction, while BC/BS will directly bill eligible family members of retired or inactive employees.

For more information, contact Phil Puchalski, Blue Cross & Blue Shield of Rochester, Gateway Centre, 150 E. Main St., Rochester, N.Y. 14647; 716-238-4367.

Coverage history

Tillinghast offers software that helps a risk manager at a company that has merged or been acquired or faces long-tail liability claims develop a historical picture of the company's insurance program.

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"The new program helps organizations orchestrate risk management by producing a coverage profile that is complete enough to answer their claims exposure questions in a timely manner," Mr. Dorn said.

The software also is useful for risk managers confronted with long-tail liability claims such as those in the pharmaceutical, transportation, chemical and manufacturing industries, according to Mr. Dorn.

The software includes:

- Reports with exhibits detailing schedules of coverage.
- Attachment layer analysis summaries, which show the different layers of coverage.
- Quota-sharing participation reviews.

The software package, which includes all required programs, onsite training and consulting time and data abstract collection forms, costs $9,995.

Updates and telephone support are available for an annual maintenance fee of $900.

For more information, contact Mark E. Dorn, Tillinghast/RISKMASTER, 33063 Schoolcraft Road, Livonia, Mich. 48150; 313-261-4440.

Books & videos

A guide to **alternative dispute resolution** has been published by ASFE/The Assn. of Engineering Firms Practicing in the Geosciences. The 134-page publication, titled "ADR: Alternative Dispute Resolution for the Construction Industry," discusses more than 25 separate alternative dispute resolution procedures and provides detailed contract language and implementation instructions in 18 appendixes. More than 40 non-profit and commercial providers of ADR services also are identified. The publication is available for $65 per copy from ASFE/The Assn. of Engineering Firms Practicing in the Geosciences, 8811 Colesville Road, Suite G106, Silver Spring, Md. 20910. ■

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Big quake could ruin economy: Stewart

By MARK A. HOFMANN

HONOLULU—The shockwaves from a major earthquake would reverberate throughout the U.S. economy, causing the insurance industry to shudder for years, a prominent New York economist predicts.

"The crisis of availability and prices in liability insurance a few years ago would be a minor event compared with the crisis created by a major earthquake," said Barbara D. Stewart, president of New York-based Stewart Economics Inc.

And, "without insurance, many entities would have to bear their own risks or curtail their activities. The economic and social costs as well as the uncertainties would be enormous," Ms. Stewart said during the Society of Chartered Property & Casualty Underwriters' first international conference on earthquakes in Honolulu earlier this month.

Because of urbanization and industrialization, the United States currently is more vulnerable to earthquakes than ever before, she pointed out.

Significant property and population concentrations along the West Coast's San Andreas Fault and the New Madrid Fault in the Mississippi Valley, as well as in other earthquake-prone areas such as Washington state's Puget Sound, have greatly increased the likelihood that damage from a quake could reach previously unheard-of proportions, Ms. Stewart said.

For example, property losses alone in Southern California could reach $70 billion in the wake of a major earthquake, while a quake along the New Madrid Fault could cause $52 billion in property damage, she estimated.

In addition, a Southern California quake could cause 10,000 deaths, while fatalities from a New Madrid quake could reach 5,000, she said.

"Earthquake claims could wipe out half of the (insurance) industry's capital," which she estimated at about $120 billion.

And, Ms. Stewart warned that her examples might be optimistic.

"These estimates could easily understate actual losses. They do not cover the worst imaginable, but perfectly plausible, scenarios, such as an earthquake-induced nuclear disaster, escape of toxic substances, dam failures or firestorms," Ms. Stewart said.

And, given the interlocking nature of the U.S. economy, there is no way that the financial devastation from a major earthquake could be confined to the region in which the quake struck, Ms. Stewart pointed out.

"Lost production, employment and income for the immediate victims of the earthquake would be only the first round of economic damage," she said.

"The next round would be disruption to people and businesses that suffered no physical damage but depended on those who did. In addition, everyone would suffer from higher prices that almost certainly would result from shortages after the earthquake," Ms. Stewart predicted.

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She noted that indirect losses, such as lost wages and business interruption, would not be totally compensated by government or private insurance. As a result, some businesses might never reopen, and some customers of damaged enterprises might not be able to return to their earthquake-damaged suppliers, Ms. Stewart said.

Indirect damage would then spread quickly from the earthquake zone, Ms. Stewart pointed out. For example, if a California quake temporarily halted the manufacture of semiconductors, the production of computers, telecommunications equipment, consumer electronics and other goods would be harmed throughout the country, she said.

In another example, an earthquake in the Puget Sound could shut down Seattle's port facilities, disrupting U.S. trade with Asia, she observed.

And, because major gas and petroleum pipelines crisscross the New Madrid earthquake zone, energy supplies to the Midwest and East Coast could be cut off if a major earthquake occurred along that fault, she said.

Financial services would be harmed as well, Ms. Stewart noted. For example, an earthquake could knock out banks' electronic data processing systems, causing chaos by knocking out routine functions such as check clearing, payroll processing and electronic funds transfers.

"Loan defaults would be another problem for banks after the earthquake. Following the 1971 San Fernando, Calif., earthquake, many borrowers—who had little equity in their homes and had no earthquake insurance to cover their losses—defaulted on their mortgages," Ms. Stewart said.

Uninsured and underinsured businesses also would be forced to default on their loans, and bank failures would inevitably follow, she said.

The securities industry also would be shaken by a major quake, she said. Stock and bond prices would plunge because the assets underlying the securities would be impaired by the quake, and the resulting uncertainty would rock the financial markets, she said.

During such chaos, the U.S. insurance industry would be hard-pressed to respond to the situation, Ms. Stewart said.

"The private insurance system is not prepared to respond on its own to a great earthquake and continue to function normally. What it would have to do to raise the money and to keep sound books of account would send a second order of economic aftershocks around the country," she said.

To generate the cash needed to pay claims, insurers would "have to dump stocks and bonds onto the market all at once," Ms. Stewart said. "Massive sales would depress prices in markets that would already be in turmoil due to uncertainties created by the earthquake."

Municipal bonds would bear the brunt of the sell-off because they make up the largest proportion of insurers' assets and because the bonds are not traded often enough to absorb a large volume of sales, she said. As a result, municipalities thousands of miles from the earthquake would have to postpone spending and slash services, Ms. Stewart said.

And, as claims started to pour in, financially pressed insur-

Continued on next page

Protection . . .

More data required to gauge earthquake risks: Reinsurers

By MARK A. HOFMANN

HONOLULU—The property/casualty insurance industry needs more and better data to identify and measure earthquake exposures, a panel of international reinsurance executives agree.

To better understand the extent of probable maximum losses from earthquakes, "the industry—including insurance companies, reinsurers and regulators—should consider developing a standard countrywide—and by extension—a worldwide zoning system," said Jean F. Webb, vp of Newark, N.J.-based Prudential Reinsurance Co.

Mr. Webb was a participant in a panel discussion addressing "Assessing Earthquake Reinsurance Capacity Worldwide" at an international conference on earthquakes in Honolulu earlier this month. The conference was sponsored by the Malvern, Pa.-based Society of Chartered Property & Casualty Underwriters.

In addition to gathering more information on earthquake exposures, "Reinsurers must pool their worldwide resources to provide the enormous capacity necessary to reinsure very large natural disasters," said John P. Phelan, president of Toronto-based Munich Reinsurance Co. of Canada.

"To do so effectively, they should be permitted the free and rapid transfer of funds from one territory to another to meet those obligations wherever they may occur. It is only with this kind of freedom that worldwide capacity can be made available to each market even when its exposure to very large losses may be disproportionately high relative to the size of its insurance market," he said.

"The global balance of our portfolios would enable the commitment of far greater resources than would otherwise be prudent," said Mr. Phelan.

Obtaining the type of information needed for such a coordinated

Continued on next page

Earthquakes' economic costs

Continued from previous page

ers would begin becoming insolvent, she said.

"Insolvent insurers would include large, diversified national companies," Ms. Stewart noted.

In addition, "not just earthquake claims might not get paid, but also other types of claims—automobile, workers compensation, fire and others—all over the country," she said.

State guaranty funds would not be able to respond immediately, and the payments they would be forced to make might stretch out for years, she said.

And, the crippled insurance industry would not be able to accept new risks, because as much as half of its surplus would have been wiped out by a single disaster.

"Less capital to support risk taking would lead to shortages and higher prices of insurance of all kinds—regardless of location," Ms. Stewart said.

The government would certainly act in the wake of a major earthquake, she said. But, Ms. Stewart observed: "The big question is 'How?' "

She speculated that the government might suspend some mandatory insurance requirements or limit tort recoveries to ease the situation. "It's conceivable that insurers could be required to support more risk taking with greatly reduced capital," she said.

"We just don't know what sort of policy responses will be forthcoming," she said. ■

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Earthquake data

Continued from previous page
global response requires data-gathering that transcends national borders, panelists said.

Ake Munkhammar, vp and manager of the underwriting control function for Skandia International Insurance Corp. in Stockholm, Sweden, noted the insurer-supported Catastrophe Risk Evaluating and Standardising Target Accumulations—or CRESTA—study group as an example of the type of information gathering that insurers and reinsurers worldwide must consider.

The informal study group, which is supported by a group of about 40 primarily European and Latin American insurers and reinsurers, provides its members with information sheets regarding a country's earthquake history, past losses and loss potential.

CRESTA's information gathering is "far from ideal, but it is an encouraging first step," Mr. Munkhammar commented.

Mr. Munkhammar said CRESTA came into being in the 1970s as a result of earthquakes in Nicaragua and Guatemala.

The effort is still limited, he said, noting that U.S. insurers and reinsurers do not participate in the informal group.

In addressing insurers' earthquake data collection problems, Mr. Munkhammar also noted that recorded history only extends back 5,000 years, which is a very short time in terms of geological movement. And, that record is not evenly applied to the entire world.

Munich Re of Canada's Mr. Phelan used his country's history as an example of just how incomplete the earthquake record can be.

Canada has had "relatively mild seismic activity" throughout its history, Mr. Phelan said.

"The fact is that none of the Canadian earthquakes thus far has caused serious economic loss. That happy experience has led to the incorrect, but all too comfortable, assumption that we shall also be spared economic devastation in the future," Mr. Phelan said.

"In addition, the short recorded history of our country—only about 200 years for the western part—means that much of the evidence concerning the threat of serious earthquakes is circumstantial," he added.

Because Canadian earthquakes occur infrequently and because of what Mr. Phelan called a "seeing-is-believing" attitude, "there is a strong tendency to postpone the management of those dangers and even to deny that they exist," he said.

To help determine the extent of Canada's earthquake exposure and to estimate probable maximum losses, Munich Re of Canada has divided the nation into three types of earthquake exposure zones, Mr. Phelan said. The zones are then broken down into earthquake loss accumulation zones, which are "those areas likely to be affected by earthquakes of predetermined epicenter and magnitude," he said.

These zones are broken down further into "accumulation assessment zones" based on the first three digits of the Canadian postal code. This allows the monitoring of relatively small geographic units, Mr. Phelan said.

Such detailed information itself is not enough to allow insurers to meet the demands of a major earthquake, Mr. Phelan said.

"Can the Canadian property and casualty insurance industry afford an earthquake loss in the billions—if not tens of billions—of dollars?" he asked. "The answer is a resounding, unequivocal no."

In addition, the Canadian government would not be able to absorb underinsured or uninsured losses stemming from the quake, he said.

'Can the Canadian property and casualty insurance industry afford an earthquake loss in the billions—if not tens of billions—of dollars?' asks Mr. Phelan of Munich Re of Canada. 'The answer is a resounding, unequivocal no.'

What is needed is "a new and much more enlightened approach, involving closer cooperation between government and industry," Mr. Phelan said. Laws allowing the accumulation of tax-deductible contingency reserves should be part of this cooperation, he said.

Skandia's Mr. Munkhammar said that insurers and reinsurers should be allowed to set aside both earthquake insurance premiums and a portion of other property insurance premiums to prefund the losses stemming from a quake.

"In many countries like the United States, the insurance industry is not allowed to fund these reserves. Instead, (premiums) show up as profit and are taxed accordingly," he said.

Prudential Re's Mr. Webb also pointed to taxation as one of the reasons the market for catastrophic property coverage is not large.

"In theory, premiums should be divisible into two segments," he explained. "One part of the premium should be for 'normal' losses, and if the expected losses do not occur, profit results. The premiums for rare accumulation occurrences such as earthquakes should not be considered profit in a year when no earthquake occurs, but should be set aside as a reserve against future losses.

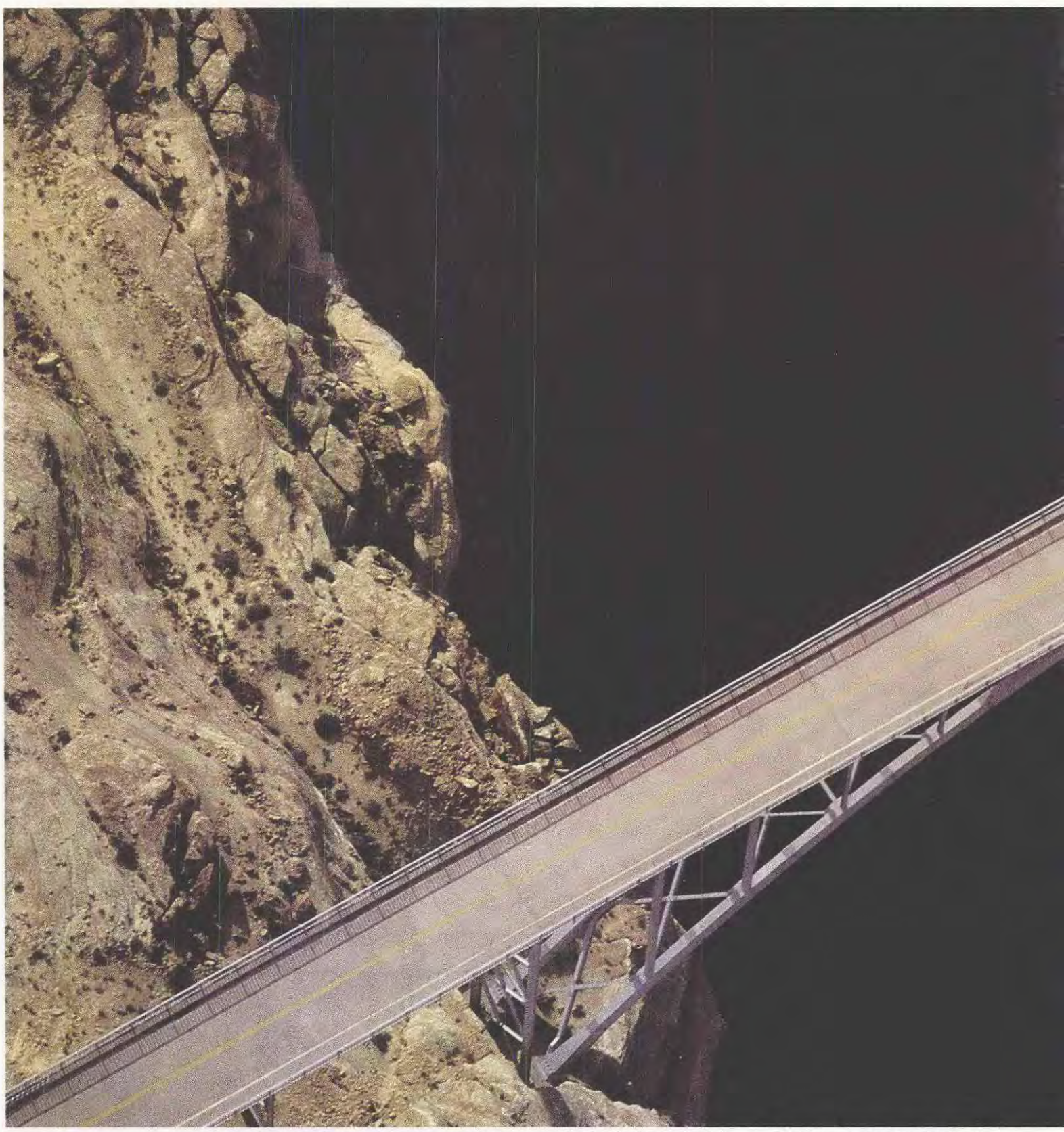
"U.S. tax laws, however, do not permit us to establish pretax reserves for future losses, so the premium, which the policyholder may already consider excessive, has to be loaded for the taxes that will be incurred in most years," Mr. Webb said.

Mr. Munkhammar said that he hopes the insurance industry-backed "Earthquake Project" proposal, under which the U.S. government would reinsure earthquake risks, becomes law (*BI,* Oct. 24, 1988).

But no matter what happens, "Not until we are able to measure the risk reasonably well, to rate the risk reasonably well and to create the necessary funds, will there be enough capacity available and will the earthquake peril become truly insurable," Mr. Munkhammar said.

Henry J. O'Shea, president of Westwood, N.J.-based Ashford Reinsurance Intermediaries Corp., moderated the session. ■

Between the lender's risk and the lender's reward



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Time fails to douse quake fire threat: Expert

By MARK A. HOFMANN

HONOLULU—Fire departments might be just as helpless in the face of an earthquake-induced fire today as they were in 1906 during the San Francisco quake, says a structural engineer.

But, fires caused by earthquakes can be controlled if the correct precautions are taken, said Charles Scawthorn, vp-design and analysis division of San Francisco-based EQE Engineering Inc., a consulting firm specializing in earthquake engineering.

Fires following quakes present a complex safety problem that must be addressed from several perspectives involving risk management, engineering, firefighting and public safety concerns, Mr. Scawthorn told attendees of "Comprehending Earthquake Conflagration," a seminar at the Malvern, Pa.-based Society of Chartered Property and Casualty Underwriters' international earthquake conference in Honolulu earlier this month.

Despite technological advances, many of the weaknesses in firefighting remain unchanged since the turn of the century, he said.

"Water supplies today are in many ways just as vulnerable as they were in 1906," said Mr. Scawthorn.

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To illustrate the extent of the problem, he pointed out that serious fires have followed several more recent California earthquakes, including those that struck Long Beach in 1933, Kern County in 1952, the San Fernando Valley in 1971 and Coalinga in 1983.

Typically, breaks in natural gas and electric lines cause outbreaks of simultaneous blazes throughout the quake-affected area.

The speed with which simultaneous fires can ravage an area should not be underestimated, Mr. Scawthorn noted.

For example, the first fires stemming from the 1906 San Francisco quake began around 5:15 a.m., April 18, shortly after the quake struck. Within three hours of the first few isolated outbreaks of fire, entire city blocks had burned to the ground.

One of the major reasons that multiple simultaneous fires are difficult to contain is that the manpower necessary to battle the blazes is simply unavailable, Mr. Scawthorn said. Local fire departments do not have an infinite number of firefighters, and firefighters from neighboring unaffected areas may need to be called in, he said.

However, getting the additional personnel to the burning area is no easy task, because earthquakes are accompanied by communication breakdowns, he added.

"There will be an extended period of (fire) reporting," Mr. Scawthorn said. For example, the quake may cut telephone lines, he said. But even if telephone lines remain intact, the system may be overloaded with calls as anxious people try to reach their families and emergency services.

Once there is an awareness that fires have broken out, firefighter response is dependent on the survival of fire departments and equipment. Fire stations themselves are often poorly constructed with weak first floors and are extremely vulnerable to earthquake damage, he said.

Because of structural damage to firehouses in a major quake, a city could lose a significant amount of its firefighting capability even before the first blazes flare, he said.

When the firefighters do reach the fire, water may not be available, Mr. Scawthorn said. Water mains are among the first casualties of an earthquake, he said, noting that broken mains throughout the downtown area crippled firefighting efforts during the 1906 San Francisco earthquake.

Even the best pumping equipment in the world does no good if there's no water to pump, he pointed out.

He also noted that fire engines have limited pumping capacity even if they have unlimited water to draw upon. The typical fire engine can pump 1,200 gallons to 1,500 gallons of water per minute, Mr. Scawthorn said. That capacity is roughly the same as that of 1906 fire engines. But the capacity of each hand line operated by two firefighters, is only about 250 gallons per minute. Because fire engines rarely carry more than a half-dozen firefighters—who can man only three hand lines—their effective output per minute rarely approaches their capacity, Mr. Scawthorn said.

In a downtown area, this can be extremely critical, he said. If a high-rise building catches fire, the fire can spread from high rise to high rise beyond the reach of high-pressure water hoses, and thus cause tremendous amounts of property damage very quickly, he said.

In addition, firefighters' priority is not to save property, he noted. Instead, their priority is to save lives.

Despite the complexity of dealing with earthquake-induced fires and the potential for very large losses, the problems can be mitigated somewhat.

Upgrading of building construction techniques for fire stations and other emergency service centers is an essential factor in assuring the post-quake survival of firefighting capabilities, Mr. Scawthorn said.

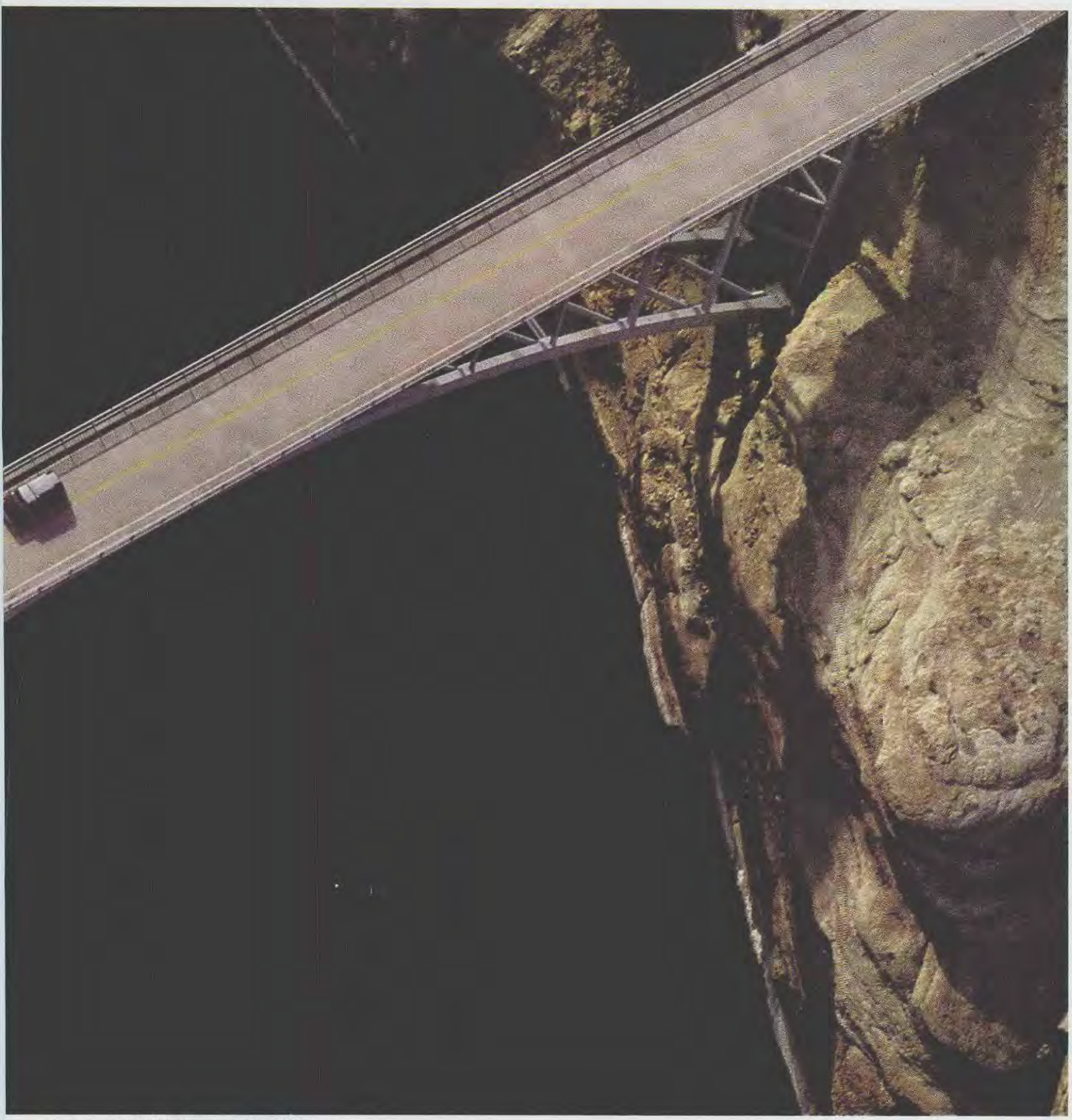
Earthquake-resistant communications networks and bolstered water lines must also be put in place if the effects of a major quake are to be mitigated, he said.

Better training for firefighters, specifically, and more public education on the fire dangers presented by earthquakes in general could also help reduce the degree of property damage, injury and loss of life resulting from a quake, said Mr. Scawthorn.

In addition, companies can better brace their storage racks containing flammable materials to decrease the chances of ignition following a quake, he said.

Petroleum and other combustible liquids need to be stored properly to minimize the possibility of fire, Mr. Scawthorn said. ■

is a perilous gap.



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RUNNING AMOK

Employers losing control of EAP costs, management

By Dr. Walter E. Afield

EMPLOYEE ASSISTANCE programs in American business and industry have become enemies of health care cost containment, causing costs to go *up*, not down.

Mental health care costs have become a nightmare for employers. CEOs are being taken for a ride. The EAP system, originally an excellent idea, has gotten out of control and is generating a crisis that employers don't understand and, therefore, can't curb. Not only do EAP procedures frequently border on the unethical, they are costing a fortune in dollars, lost productivity, individual self-esteem and sidetracked careers.

The winners in this shady game, too often, are the large hospital chains and quasi-trained EAP counselors who are paid or influenced by hospitals. The losers are corporate CEOs, insurance companies, policyholders and, ultimately, American workers whose mental health benefits are insured but are far from managed or protected.

A significant problem with the system is this: EAP counselors are often low-level folks in the corporate pecking order. Though they may hold master's degrees in counseling or rehabilitation, they are often naive and inexperienced in business and business politics. As such, they're prime candidates for lobbying by the national hospital chains. In fact, it is common, though not widely known, that bounties (often $150 a head) are paid to EAP counselors for every admission they secure.

Another standard ploy is offering a "consultancy" to an EAP counselor who is in a position to refer patients. He or she will be offered so much per hour for, say, 12 hours a week, to act as a "consultant" to the hospital. The implication, however, is that they don't really have to show up or produce anything other than a consistent stream of referrals to fill hospital beds. Like the common practice of lobbying senators and congressmen, this may not be illegal but it strikes me as unethical and immoral.

The history of employee assistance programs has been intertwined with alcohol abuse treatment and with Alcoholics Anonymous. The first EAPs were OAPs—Occupational Alcoholism Programs—started by large companies in the early 1940s. The modern EAP was born when, in the early 1960s, the concept was expanded to provide treatment for "other living problems" such as marriage, family and financial difficulties.

As EAPs developed, however, they set themselves up for abuse. Early programs were designed to be in-house and confidential. Mindful of the fact that the average employee with an alcohol problem, for example, is a skilled worker with 10 years' tenure, they did everything possible to keep valued workers on the job while helping solve the problem. As the idea caught on, however, each industry developed its own purpose, programs and pitfalls.

A major brewery, for instance, had a specific problem with alcoholism; encouraged, one would suspect, by the free taps available to workers on break. When an effort was made to remove the taps to discourage drinking on the job, the unions put pressure on management to keep the taps flowing.

Law enforcement agencies, on the other hand, had a very different situation. Their EAPs were designed to weed out questionable or psychologically unstable officers. When a cop shot someone, was it safe to allow him to continue to carry a gun?

The military's Human Reliability Program had a similar mission. They used psychiatrists as hatchet men to "safeguard the nation" by getting rid of unstable personnel who had anything to do with nuclear weapons.

Speaking out

The broad brush approach to dealing with employee problems has evolved in the 1980s into the Employee Enhancement Program, with its preventive, holistic health focus. Workers are offered help with stress management, smoking, overeating, overworking, fitness and other physical and mental health, as well as lifestyle issues.

Today, there are thousands of EAP programs in existence. One source indicates that 60% of all Fortune 500 companies have an EAP. A recent survey indicated that more than half of the responding companies have an EAP.

Given estimates that troubled employees cost industry a staggering $50 billion last year, there's no doubt that a procedure is needed for identifying and helping employees with problems; both for their own good and that of their employers. Employee problems at home become employee problems at work, with a domino effect involving higher costs—accidents, workers compensation claims, litigation, personnel problems, turnover and increased use of medical benefits—and lower productivity—conflicts with supervisors and co-workers, absenteeism, tardiness, poor work quality and morale problems.

These days, EAPs are either handled in-house or contracted out but most of them are still geared to ferreting out problem employees and referring them on for help, often *after* the crisis has passed. In order to justify their existence, EAPs often go looking for problems, their jobs expanding to fit their needs. EAPs have evolved into employee advocates and union backers. This is especially true in school systems and big cities, where employees traditionally have been high users of mental health services. Employees and EAP counselors seem to regard not being approved for coverage of a 30-day hospital treatment program by an insurance company as a violation of their union rights.

EAP counselors who run these programs are sometimes recovered alcoholics or drug addicts who believe an inpatient treatment program is the only way to go because it's worked for them. In reality, evidence points to *outpatient* treatment as far more effective and cost efficient. A recent article in the New England Journal of Medicine cites statistics supporting that point of view.

Confining a chemically dependent employee (verification of this is often shaky, but that's another issue) to a 30-day inpatient program, though it may seem to solve the immediate program, too often hurts everyone involved. The employer loses the worker's productivity while he's off the job and usually must not only pay for his treatment but for a replacement.

The employee, though, often sustains more profound and far-reaching damage. His personnel record may always show he's been hospitalized for substance abuse. He may be a "marked man," ineligible for promotions, shunned by other employers, unable to qualify for future insurance benefits, precluded from running for public office, etc. He may also lose face with his family and friends and, if he fails to remain abstinent after his release from a structured program, he is doubly humiliated. When that happens, his employer continues to suffer as well.

A related factor is that mental health care delivery is often based largely on the financial needs of the institution rather than the best interests of the patient, especially when bed census is down. Lengths of stay just match insurance benefit time frames and "miraculous" cures occur routinely as patients near the end of their allotted inpatient coverage.

Group health insurance premiums are skyrocketing as everyone is painfully aware, and mental health care costs are increasing at an even faster rate. They now represent as much as 32% of the total cost of employee health care programs, up 100% in the past five years. Stress-related disability claims increased an average of 85% annually between 1980 and 1988.

Substance abuse, still the mainstay of EAPs, is also increasing at an alarming rate. Business and government spent approximately $65 billion last year on the problem. Compare that to the $145 billion *total* profits for all U.S. corporations.

But that's not all. Employees with mental health problems are far more likely to require other medical services. They're four times more likely to have digestive problems, 6½ times more susceptible to endocrine, nutritional and metabolic disorders, and 4½ times as likely to have accidents requiring treatment. This all represents a significant "crossover" effect that adds substantially to an employer's other health benefit costs, an opportunity far from lost on the often misdirected employee assistance system.

In spite of a runaway situation, incredibly very few companies know exactly how much they are spending on mental health care. Without retrievable data, business decision-makers are operating in the dark. From huge employers to small companies, all over the country business bottom lines are suffering the damaging—and damning—effects of confusion and ignorance.

The EAP issue is a Pandora's box, but few CEOs are willing to look inside and consider that their EAP may be *costing* them—rather than saving them—money.

I'm in favor of scrapping the EAP system and starting over. Employers need to take a long, hard look at their EAPs and the folks who run them. The current health care cost crisis is well known, but what isn't as well known is the critical part mental health benefit abuses play on the game.

EAPs desperately need to go back to the drawing boards. A reworked blueprint should incorporate the managed care concept, with closely monitored treatment, case management, claims review, payment authorization and service delivery by top-notch professionals free of under-the-table reciprocity. (Managed care alone can result in documented savings of 25% to as much as 90%.) Senior management must be more involved instead of abdicating responsibility to corporate counselors.

A new system would start with a careful analysis of a company's mental health insurance picture. How many employees have been seen, with what problems, where, when, for how long and by whom? How much did it cost? How effective has their treatment been? Who, if anyone, is monitoring the mental health services delivered to employees? Are EAP counselors involved in a "you scratch my back and I'll scratch yours" arrangement with any hospital, facility or treatment professional?

Only when these changes are made will everyone win—American business, insurance companies, mental health professionals and, best of all, the troubled employee the system was designed for in the first place.

Dr. Walter E. Afield founded and heads Mental Health Providers Inc., a national managed mental health care firm in Tampa, Fla. Dr. Afield also founded and heads the Neuropsychiatric Institute in Tampa, a multidisciplinary mental health facility.

Continental creates specialty coverage unit

The special operations group of Continental Corp. of New York has created a new unit to offer excess and specialty liability coverages.

The new division, Continental Excess & Select, will offer excess, umbrella and specialty liability programs to industries and professionals such as railroads, corporate directors and officers, lawyers and accountants.

The new unit, which will be based in New York, consolidates the capabilities of certain Continental subsidiaries under the Excess & Select division, including: Harbor Insurance Co., Pacific Insurance Co. and East River Insurance Co. Ltd.

Bryan Reid, who will maintain his position as executive vp with Harbor Insurance Co., has been named president of Continental Excess & Select.

For more information, contact Mr. Reid at 180 Maiden Lane, New York, N.Y. 10038; 212-440-3690.

Markets

Benefits consultant

An employee benefits consulting firm has opened its doors in Fort Worth, Texas.

EBCON Co., founded by Thomas W. Freeman and Charles A. Gengler Jr., will assist employers with designing, funding and managing benefit packages.

Prior to forming EBCON, Mr. Freeman was a vp in the Dallas office of A. Foster Higgins & Co. Inc. of New York, a subsidiary of Johnson & Higgins.

Mr. Freeman also was a member of the Johnson & Higgins Task Force for Flexible Benefits.

In addition to EBCON, Mr. Gengler owns Forth Worth-based C. Gengler & Co., an international property/casualty insurance brokerage.

For more information, contact Mr. Freeman at 306 W. Seventh, Suite 400, Fort Worth, Texas 76102; 817-870-1596.

NWNL adds 3 PPOs

Minneapolis-based Northwestern National Life Insurance Co. is adding three new preferred provider organizations to its national network of providers.

The additional networks will enable residents of Atlanta, Milwaukee and Reno/Las Vegas, Nev., to participate in NWNL's PPO network.

In Atlanta, NWNL has contracted with SouthCare Medical Alliance, an Atlanta-based PPO that includes a network of more than 1,350 physicians and 11 hospitals. Utilization review services also are provided by the Atlanta Healthcare Alliance's utilization management program.

NWNL Group's new Milwaukee PPO network is Associates for Health Care Inc., which includes a network of 500 physicians and 13 hospitals.

Residents of Reno/Las Vegas, Nev., and the surrounding counties will be able to join Preferred Healthcare Network Inc. Preferred Healthcare Network includes a network of 500 physicians and 12 hospitals.

For information on the Atlanta PPO, contact Bill Mulkeen, Regional Manager, NWNL Group, 47 Perimeter Center E., Suite 103, Atlanta, Ga. 30346; 404-396-0788.

For information about the Milwaukee PPO, contact Barry Carlson, Senior Field Representative, NWNL Group, 3 First National Plaza, Suite 2710, Chicago, Ill. 60602; 312-346-0145.

For information about the Reno/Las Vegas, Nev., PPO, contact Paul Gulstrand, Regional Manager, NWNL Group, 1 Montgomery St., Suite 1350, San Francisco, Calif. 90104; 415-421-4252.

Baloise acquisition

The Baloise Insurance Co. Ltd. of Basel, Switzerland, has completed its acquisition of Providence, R.I.-based The PW Group, formerly The Providence Washington Insurance Group.

The acquisition marks Baloise's entrance into the U.S. commercial property/casualty insurance market.

Baloise has underwritten ocean and inland marine coverages in North America since 1978 through underwriting manager Wm. H. McGee & Co. Inc. of New York.

Financial terms of the agreement to purchase PW Group, which was reached in December 1988, were not disclosed.

Baloise Insurance Co. is composed of various life, property and casualty companies throughout Europe, Asia, Africa and South America. Its most important lines of business include liability, property, marine and reinsurance coverages.

Baloise acquired The PW Group from P.W. Investors Inc. The PW Group provides both standard and surplus lines insurance products.

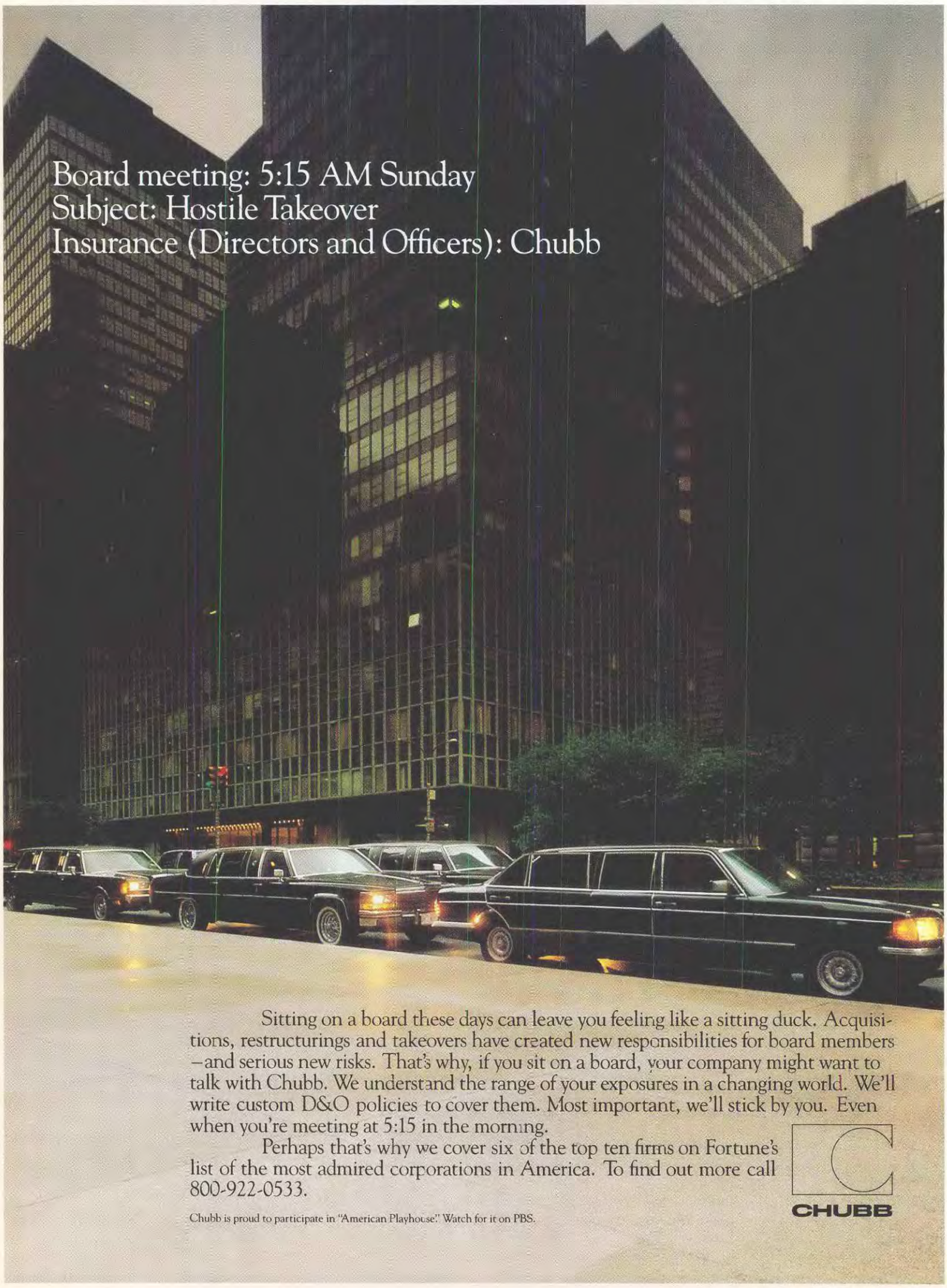
Baloise reported gross written premiums of $2.8 billion in 1988.

The PW Group reported 1988 net written premiums of $138.1 million and net income of $15.3 million.

New Offices

New York-based **Corroon & Black Corp.**'s Baltimore office, **Corroon & Black/Stump, Harvey & Cook Inc.**, has merged with **Herget Risk Management Inc.** of Baltimore.

In addition, Corroon & Black Corp. has acquired broker **Noyes Services** of Media, Pa. ■



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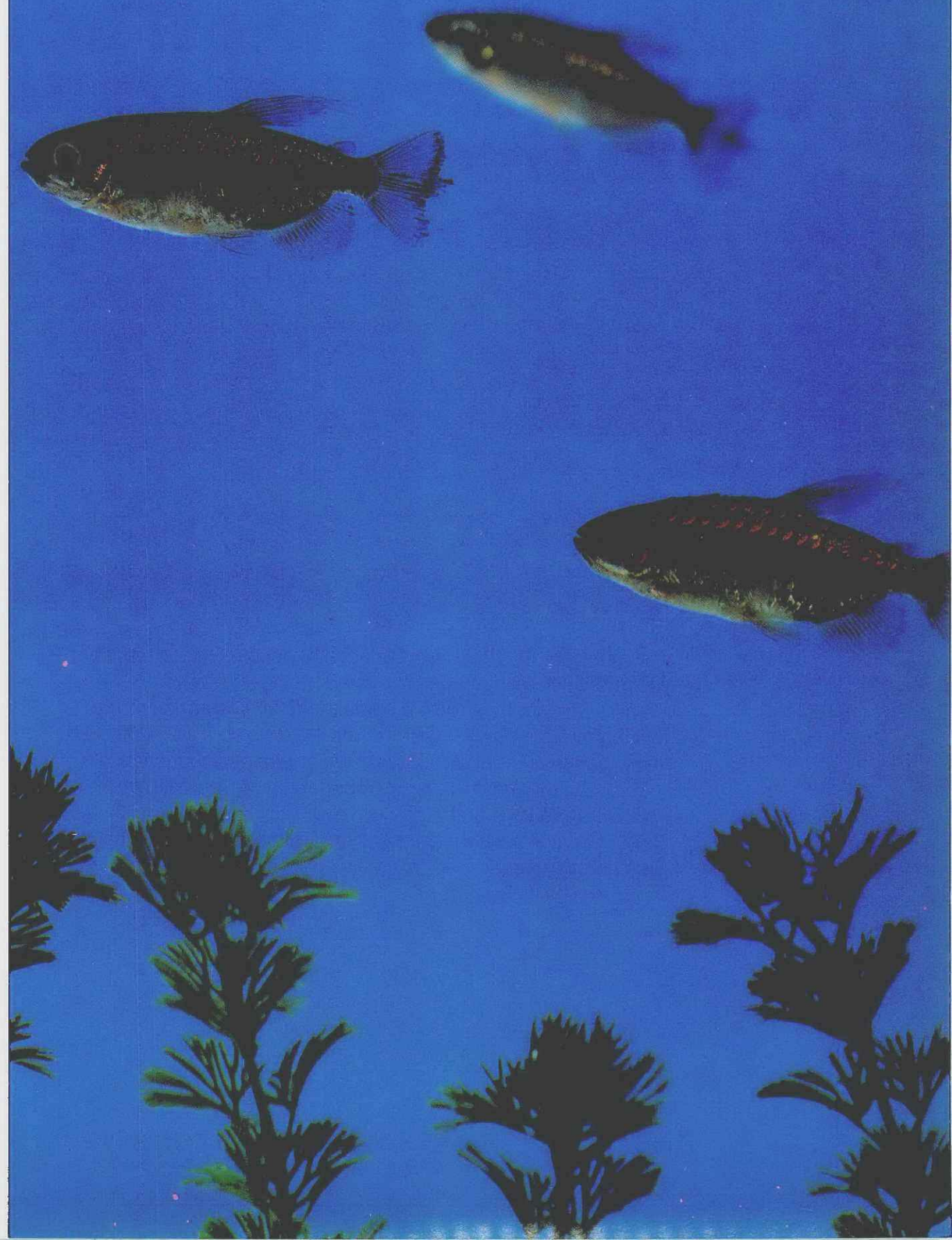

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Joseph W. Brown Jr. named president of Fireman's Fund

Comings & goings: industry

Joseph W. Brown Jr. has been named president of Fireman's Fund Insurance Co. of Novato, Calif., a subsidiary of Fireman's Fund Corp.

He most recently was vice chairman of the property/casualty insurer.

Mr. Brown, 40, joined Fireman's Fund in 1974 in the actuarial department, was appointed vp in 1981 and two years later was promoted to senior vp-corporate/agency interface and ceded reinsurance. He was named executive vp in 1983 and appointed chief financial officer in 1984.

Mr. Brown succeeds **William M. McCormick**, who resigned as chairman, chief executive officer and president last month (*BI*, May 1).

In other insurer changes:

American International Group Inc. of New York announced a series of executive promotions: **Thomas R. Tizzio** to vice chairman-domestic general; **Houghton Freeman** to vice chairman-foreign general; **John J. Roberts** to vice chairman-external affairs; **Ernest E. Stempel** to vice chairman-life; and **Edward E. Matthews** to vice chairman-finance.

AIG also announced several appointments within its international operations. **James E. Smith** named president of American International Underwriters. **Nicholas C. Walsh** succeeds Mr. Smith as president of the U.K. Ireland division of AIU. Also, **R. Kendall Nottingham** appointed chairman of American Life Insurance Co. And **Brian Dupperreault** succeeds Mr. Nottingham as senior AIG officer for Japan and Korea.

David B. Mathis named to the newly created position of executive vp of Kemper Corp. of Long Grove, Ill. Mr. Mathis will continue as chairman and chief executive officer of subsidiary Kemper Reinsurance Co.

E.L. Cox named chairman and will continue serving as chief executive officer of Amerisure Cos. of Detroit. Succeeding Mr. Cox as president is **J. John Wortman**, previously president of American Mutual Insurance Co. of Boston in Wakefield, Mass.

Melville P. Windle promoted to president and chief operating officer of 20th Century Industries Inc. and its two insurer subsidiaries, 20th Century Insurance Co. and 21st Century Casualty Co., all of Woodland Hills, Calif. Mr. Windle succeeds **Neil H. Ashley**, who will retire at the end of June.

Also at 20th Century Industries, **Richard A. Dinon** promoted to group vp, effective July 1.

Agents/brokers

Natalie Wasserman, executive director of the Public Risk Management Assn. since July 1979, will join Alexander & Alexander Inc. in July as a member of a national marketing group for public entities. She will be based in Washington, D.C.

R. Dennis Windsor promoted to president-employee benefits sales of Andreini & Co. of San Mateo, Calif.

William J. O'Brien Jr. joined Rollins Burdick Hunter of Florida Inc. as senior vp.

Reinsurance

Robert T. Mobyed named manager of the Chicago office of Thomas A. Greene & Co. Inc., a reinsurance brokerage unit of Alexander & Alexander Services Inc.

Bruce P. Reich joined Atrium Corp. of New York as vp. The reinsurance intermediary is wholly owned by North American Reinsurance Corp. Most recently, Mr. Reich was a vp with American Re-Insurance Co.

Thomas S. Case appointed executive vp and chief underwriting officer of Employers Reinsurance Corp. of Overland Park, Kan.

Also at Employers Re, **W. Mick Taylor** promoted to senior vp and chief administrative officer.

Excess/surplus

Douglas Boyce, Richard Easton and **Robert S. Moroney** promoted to vps of Interstate Insurance Group of Chicago.

Richard Nahas promoted to executive vp-northern division of Sherwood Insurance Services of San Francisco.

Charles E. Alegria joined Trinity E&S Insurance Services Inc. of San Rafael, Calif., as vp/Northern California manager. Prior to joining the excess/surplus lines broker, Mr. Alegria was an account executive-special accounts with Cambridge General Agency. ■

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Gulf Oil hires firm to handle runoff of Insco claims onshore

Bermuda

By ROGER SCOTTON

HAMILTON, Bermuda—Insco Ltd., a Bermuda-based captive insurer that has been running off its business since 1984, is moving its claims administration activities onshore, where they will be handled by an outside firm.

Insco, a Gulf Oil Corp. captive that once was Bermuda's fourth-largest captive, stopped writing new business five years ago after suffering unprecedented losses in 1983 on its book of unrelated business (*BI*, Nov. 26, 1984).

Insco, which plans to complete the move onshore by next March, says a runoff specialist will handle the claims administration, but it has not revealed the company's name.

The decision came after the company's May 15 general meeting, which was attended by representatives of Insco's immediate parent, Bermuda-based Bermaco Insurance Co. Ltd., a subsidiary of Chevron Corp. Chevron acquired Gulf in 1984.

The decision reflects the geographic weighting of the business being run off and its "increasingly legalistic content," said Insco President Paul Booth. "The non-related book is made up largely of North American casualty business, and it was felt to be more appropriate to handle claims from the U.S.," he added.

"Another factor is that it is getting more and more legalistic and that onshore, the U.S. offers the best forum for us to continue the (run-off) process started in Bermuda," he said.

Mr. Booth declined to reveal details of the business being run off, except to say that actuarial projections indicate "payouts continuing into the next century."

The claims administration work represents "the guts of our operation" involving 28 of Insco's 40 employees, Mr. Booth said. But, not all 28 positions will be eliminated by hiring an outside firm, he noted.

Meanwhile, accounting and investment activities will continue to be handled from Bermuda, Mr. Booth noted. "We're still running a $200 million investment portfolio, which is going to be remaining with the company here in Bermuda," he said.

Gulf closed Insco's doors Nov. 16, 1984, and the captive has produced no public financial statements since.

Adverse underwriting conditions were not the only factors behind the company's poor performance in 1983, when it produced a net loss of $16.1 million, according to former Insco President Leslie Dew. In that year's annual report, he notes that Gulf Oil had decided in May that year to assume the first $25 million of its marine and property risks previously ceded to Insco (*BI*, June 6, 1983). This reduced the captive's premium income by $16.5 million.

Mentor retrial motion

An underwriting manager and other defendants found innocent of fraud charges filed by Mentor Insurance Ltd. liquidators are asking a federal court to deny the liquidators' request for a rehearing.

The defendants contend in a memorandum filed with the U.S. District Court for the Western District of Missouri that the liquidators' motion should be denied on the grounds that they have raised "no point of error that would support granting a new trial in this case."

Mentor liquidators Michael Arnold and Charles Kempe filed their motion after a federal court jury found defendants World American Underwriters, an underwriting manager; James R. Wining, former president of WAU; and Kansas City, Mo.-based broker Financial Guardian Group Inc., WAU's parent, innocent of fraud and breach of contract charges filed by the liquidators.

The liquidators, both partners at accountant Arthur Young & Co., claim the federal jury had received "improper communications" from the court clerk prior to returning not guilty verdicts (*BI*, May 1).

The Mentor liquidators' suit sought $40 million in punitive and actual damages in connection with a reinsurance contract covering the liability risks of Wal-Mart Stores Inc. The complaint said the defendants acted as agents for Mentor in underwriting and managing the contract from 1981 until it was canceled in 1983.

The suit contends that Mr. Wining had misrepresented the Wal-Mart business to Mentor and that the FG Group was liable for his actions. Mentor suffered losses of about $10 million over the duration of the reinsurance contract, the suit says.

However, the federal jury ruled on March 24 that Mentor was 100% at fault for the losses.

In their retrial motion, the liquidators claim that the court's law clerk led the jury to erroneously interpret court instructions intended to

Continued on next page

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help them determine the degree of each party's liability. The liquidators base their motion on sworn statements obtained from two of the jurors, including the foreman.

In addition, the liquidators say that the court's written instructions to the jury also contained an error regarding the statute of limitations that further added to the jury's confusion.

The liquidators argue that the verdicts went against the weight of the evidence and should be set aside.

But, in a court memorandum, the defendants contend that the jurors' sworn statements cannot be considered by the court because they are in breach of evidence rules.

According to the document, the two jurors' statements are "incompetent" and should not be considered by the court. "Both the court's express written instructions to the jury and the federal rules of evidence prohibit plaintiffs from attempting to impeach the jury's verdict through the statements of the jurors Morgan and Cox," the defendants' memorandum says.

Federal rules of evidence also place strict limitations on post-verdict juror testimony, the defendants say. The memo also says the jury was told by the court not to talk about anything that happened in the jury room when they spoke tc lawyers conducting a routine case review after the verdicts were returned.

"The court's instructions and the federal rules of evidence preclude jurors Morgan and Cox from testifying as to the purported confusion which existed in the jury room or anything regarding their mental processes in arriving at the verdict in this case," the memo said. "As a result, most, if not all, of the sworn statements of Morgan and Cox must be disregarded by the court."

"The verdicts are fully supported by evidence, and these defendants respectfully urge the plaintiffs' motion for a new trial should be overruled on each and every point raised," the defendants conclude. ■

Employer liability

Continued from page 3
ligent acts of HMO or PPO physicians or other medical or non-medical personnel with which the employer has contracted.

- Breach of contract for failing to provide certain medical benefits included in the company's employee benefit plan.

This type of legal action usually is brought when an employee believes that he or she has received less than what was promised by the company, Mr. Mattingly explained.

To prevent such exposures, he advised employers to read their provider contracts carefully and be aware of exactly what promises they are making to employees.

For example, he said employers should make sure that when they promise medically necessary care, that they have clarified what either the provider or utilization review firm defines as medically necessary.

- Breach of patient confidentiality for disclosing information about the employee's medical history without his or her permission.

Mr. Mattingly advised employers to stipulate in their provider contracts exactly who will have access to employee medical records.

"Look at your release forms and make sure that they are broad enough to cover you from exposure" in case information is disclosed to a third party and the employee sues for breach of confidentiality.

However, the situation is different if the employee's negligence claim is pre-empted by ERISA, Mr. Mattingly said.

In those cases, the employer—in its capacity as the fiduciary of the health care plan—can be held jointly and severally liable for damages caused by the provider, he said.

"Although the newest source of liability is ERISA, it is not as big a threat as it appears and can be protected against," he said.

For example, ERISA permits employers to delegate fiduciary liability to others, he said.

"Employers should identify providers as fiduciaries in their contracts so that they can pass liability for health care responsibility of employees to them," he advised. "It is a procedural step that should not be overlooked. If you do it properly and jump through the proper hoops, then you will only be left with the responsibility for choosing the provider and not for their mistakes," he said.

He suggested that employers use a "wrap around" contract that includes all of the company's medical health care programs and assigns responsibilities to all of the providers.

However, if employers fail to delegate responsibility to the providers and ERISA pre-empts the employee's claim, joint and several liability can be imposed, leaving both the employer and provider sharing the liability for damages suffered by the employee. ■

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Drug plan cutbacks may prove costly

By KARI BERMAN

MINNEAPOLIS—Employers that eliminate their prescription drug plans to reduce health care costs may be causing more harm than good, a representative of the pharmaceutical industry says.

"The prescription drug plan should be viewed not as an expense but as a means to help reduce overall treatment costs," said Richard A. Levy, vp of scientific affairs at the National Pharmaceutical Council in Reston, Va.

If implemented properly, prescription drug plans can help control health care costs by allowing an employee to obtain pharmaceutical drugs he may not be able to afford without the plan that could reduce the possibility of more expensive medical treatment later, Mr. Levy said at the National Assn. of Employers on Health Care Action's National Health Management Conference in Minneapolis on May 18-19.

For example, employees suffering from chronic back pain, headaches or arthritis but not enrolled in prescription drug plans take aspirin because it is inexpensive, he said.

But, if an employee takes 12 to 14 aspirin tablets daily, it would cost an employer more to pay for treatment of an ulcer that may result from aspirin's damaging effect on the stomach lining than it would have cost to cover slightly more expensive, non-steroidal anti-inflammatory prescription drugs under a prescription drug plan, he said.

"Sometimes the cheaper drug isn't really cheaper. Aspirin may be cheaper initially but not necessarily in the end. Employee benefit managers should be aware of drugs that can save costs in the aggregate," Mr. Levy said.

He also said use of prescription drugs can improve productivity among employees who suffer from chronic pain.

"In 1987, chronic pain was a major cause of the 500 million lost work days which cost employers $35 million. Some medications can be used to reduce pain and help maintain employee productivity," he explained.

In addition, some medications can control health care costs by reducing the need for surgery, he said. "An expensive medication can be cost-saving by eliminating the need for expensive surgery."

To illustrate his point, Mr. Levy told conferees about "Actigall," a costly medication that is used to dissolve gallstones. "Employers don't like to pay for Actigall because it costs about $1,500 per year for treatment," he said.

However, the cost of the drug is minimal in comparison to the cost of gallbladder surgery, which currently runs about $10,000, and requires 10 days in the hospital and several weeks recovery time.

Mr. Levy suggested that comprehensive prescription drug plans should reflect a balance of the following components:

- Employee affordability.

Some medications can control health costs by reducing the need for surgery, Mr. Levy says.

Each plan should be cost-effective for the company but also affordable for the employee.

While the trend in prescription drug plans is to increase employee copayments, employers should not make copayments unaffordable for the worker, Mr. Levy warned.

"Copayments should not be used as barriers for buying the prescriptions," he said.

Often, if an employee needs expensive medication that is not covered by a prescription drug plan, he or she can go to a hospital to receive the drugs and treatment, which may be covered under a basic health care plan at a greater cost to the employer, Mr. Levy explained.

And, if drugs are too expensive for the employee, not buying them may cause the worker's condition to worsen, resulting in costly hospitalization.

- Access.

Employees should be able to have easy access to their prescriptions, he said.

Employers should make sure that providers they select are regularly stocked with medications and are capable of delivering prescriptions to employees quickly, he said.

- Quality standards.

Employers should use prescription drug providers that use computerized programs to screen for drug interactions and drug allergies.

These computerized systems can catch potentially dangerous interactions that might have been overlooked during an initial examination when the drug was prescribed, Mr. Levy explained (*BI*, Feb. 20).

- Utilization review.

Employers should also look for providers that offer utilization review services as an added service.

Prescription drug programs currently comprise about 5% to 10% of most corporations' health care budgets, Mr. Levy said. Utilization review can reduce employers prescription drug costs by monitoring the frequency and usage of prescriptions and controlling drug overuse and abuse, he said. ■

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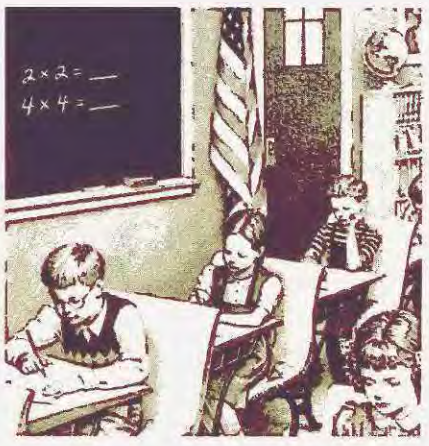

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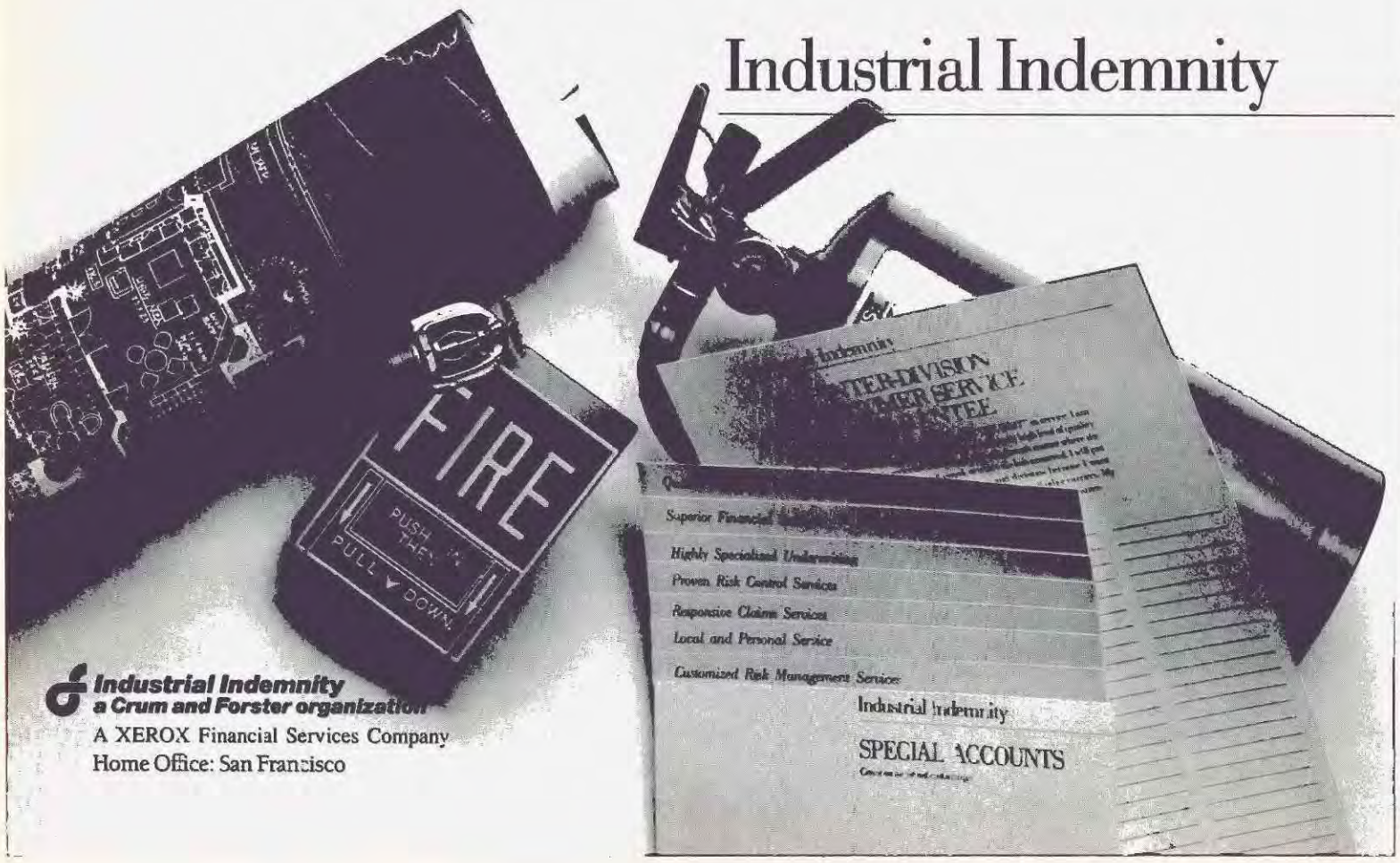

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Stress quality care when selecting providers: Experts

By KARI BERMAN

MINNEAPOLIS—Employers that put more weight on cost savings than quality when selecting managed care, utilization review and case management providers could pay more in the long run, experts say.

"Quality of care is inherently less expensive because you do it right the first time," said John M. Burns, vp of health management at Honeywell Inc. of Minneapolis.

James Couch, associate executive officer of medical systems at Metropolitan Hospital in Philadelphia, agreed: "Quality of care is probably the best way to control medical health care costs in the future."

Both experts made these observations during a session at the National Assn. of Employers on Health Care Action's National Health Management conference held May 18-19 in Minneapolis.

Maintaining quality of medical care for employees is a priority at Honeywell Inc., Dr. Burns said.

Honeywell makes sure that providers that the company is considering to include in a managed care plan are aware of exactly what is expected of them when they undergo Honeywell's Provider Quality Improvement Program. That program includes:

- Talking with the provider and learning about its quality requirements and the types of services it offers.
- Having a one-on-one meeting with the provider to agree on requirements and services.
- Establishing a provider quality plan that outlines the quality standards that Honeywell expects the provider to live by.
- Scheduling regular times for periodic surveys and reviews.

"You can build quality into a system," Dr. Burns said, advising other employers to judge the quality and cost-effectiveness of providers based on medical necessity and medical appropriateness.

"You want a provider that will give care when there is a need for medical intervention to preserve or improve health and then, once it is determined that the care is necessary, evaluate different treatment alternatives and give the best one

Continued on next page

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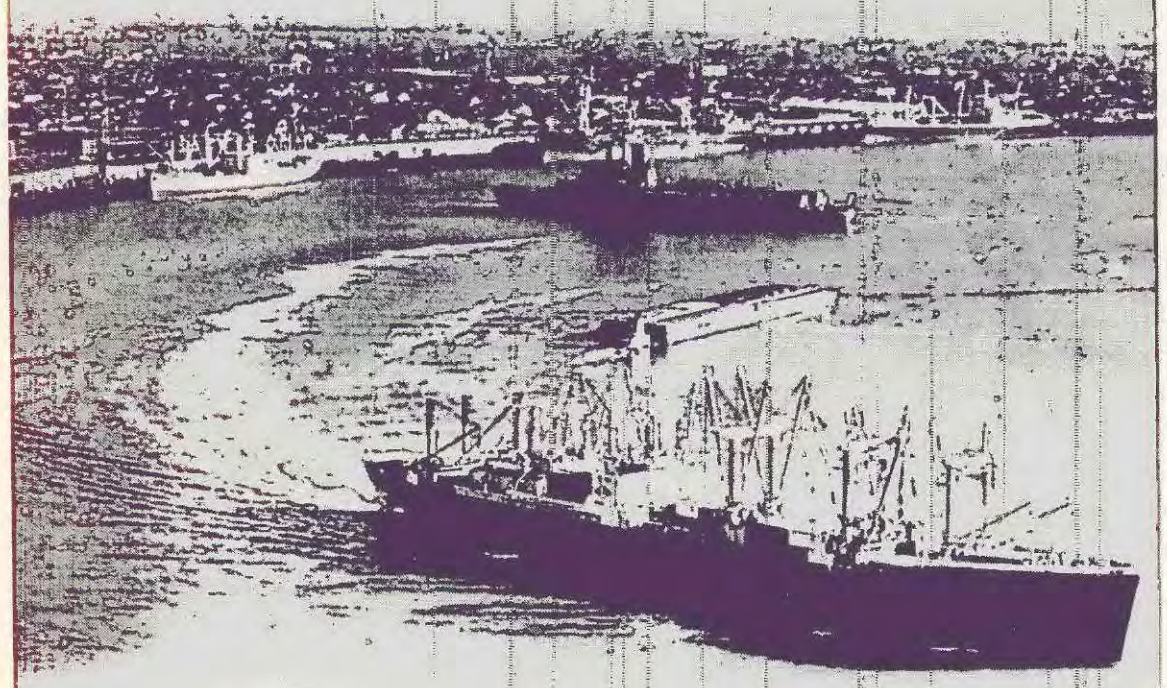

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Quality care

Continued from previous page

for the patient's individual circumstance," he said.

Costs will be significantly reduced when providers monitor procedures and employees only receive the care they need, Dr. Burns noted.

For example, at one time the rate of Caesarean sections performed on employees at some Honeywell locations reached 46%. But "that was way too high, and it has stopped," he said.

Other health care experts who spoke during the NAEHCA conference concurred that clear quality standards for acceptable medical treatment need to be redefined so that employers, employees and providers all have the same expectations.

"There was traditionally a foundation of quality in medical care," which began when the Hippocratic oath was created and healers were either compensated for satisfactory treatment or "they had their hand chopped off for poor treatment," explained Alex R. Rodriguez, corporate medical director at Preferred Health Care Ltd., a managed care firm in Wilton, Conn.

Because the line between appropriate and inappropriate medical care has blurred, the standards should be clarified, Dr. Rodriguez said.

However, attempts to establish quality standards are often opposed by physicians "who fear that standards of any kind will force them to practice cookbook medicine," said John W. Wheeler, associate medical director at Group Health Inc. in Minneapolis.

But it is the employers' responsibility to avoid judging providers solely by costs and making sure that providers are equally dedicated to practicing high standards of care, conference speakers stressed.

Dr. Wheeler suggested that when selecting a provider, employers look at the following quality components:

Proper medical care standards that have become blurred need clarification, says Dr. Alex R. Rodriguez.

- The providers should have a quality assurance program in line with the employer's expectations for quality.
- The providers should have the level of data support necessary to keep records of the kinds and costs of services that are being administered to employees.
- The provider should have physician leadership so that the employer is assured that trained medical physicians—and not businessmen—are making the final decisions based on medical need rather than cost.
- The employer should establish a physician connection between its in-house doctor, if it has one, and the provider so that records can be compared and checked.

When selecting a provider, employers should be wary of those with the lowest prices because sometimes underpricing can result in undertreatment that will cost more to correct in the long run, speakers warned.

"Although there are financial incentives for an employer to pick a less expensive provider, they should be careful that employees will not be neglected and denied necessary care," said Dr. Rodriguez.

Honeywell's Dr. Burns agreed, maintaining that "Sometimes it is better to increase your direct health care costs, like doctor and hospital bills, in order to lower indirect costs that result from having someone off that job." ■

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Business Insurance

Firm projects managed care savings

By KARI BERMAN

MINNEAPOLIS—Allied-Signal Inc. expects to save $200 million to $400 million in its health plan costs over three years under its much-publicized managed care program.

"We are very pleased with the cost savings that our managed care program has brought since we began it in March of 1988," said Gary P. Yeaw, manager of employee benefits for the Morristown, N.J.-manufacturing firm.

Mr. Yeaw shared his company's experience with implementing a managed care program during a session at the National Assn. of Employers on Health Care Action's National Health Management Conference May 18-19 in Minneapolis.

The expected $200 million to $400 million health plan costs savings at Allied-Signal is based on what the company projects it would have spent on its health plan if it had made no plan changes, Mr. Yeaw said in an interview. The range in projected savings is due to the uncertainty over inflation in future health care costs, he added.

In 1987, Allied-Signal spent $355 million on its health care plans.

Allied-Signal launched its managed care plan last year after getting hit hard by health care expenses for its 36,000 employees in 1987,, said Mr. Yeaw (*BI*, Feb. 22, 1988).

"The trends in 1987 were accelerating, and we were looking at a 30% to 40% health care cost increase in 1988," he said. "Our upper management said fix it and fix it fast."

In response, Allied-Signal's benefit planners took a comprehensive look at an array of options, he said.

"We looked at everything from getting out of the business (of sponsoring health care programs) completely and giving employees cash to pay for their health care benefits, to retaining the indemnity plan but increasing the employee deductibles and copayments," Mr. Yeaw explained.

After deciding that the first step was to consolidate the array of plans into a single managed health care program, a provider was selected.

"We decided to contract with CIGNA Healthplan Inc. to help implement our Health Care Connection managed care program," Mr. Yeaw said. Bloomfield, Conn.-based CIGNA Healthplan is a subsidiary of CIGNA Corp.

Under the plan, CIGNA guarantees that Allied-Signal's health care costs for its managed care and its indemnity plan will not rise more than stipulated percentages for each plan for each of the three plan years, beginning March 1, 1988. Under a so-called "risk contract," if Allied-Signal's health care costs increase by a greater percentages than the stipulated amounts, CIGNA will absorb the added cost.

Based on 10 months of results, the increased cost under the managed care plan about equals the amount CIGNA guaranteed. However, the indemnity plan cost is exceeding the guaranteed cost increase.

To encourage participation in its managed care offerings, Allied-Signal is offering its employees financial incentives such as lower deductibles and copayments than they would pay to remain in the indemnity plan.

Part of the success of the Allied-Signal managed care program can be attributed to the fact that it communicated the advantages to its employees, said Richard Kaplan, president of CIGNA Healthplan Inc., who was responsible for helping Allied-Signal design its managed care plan.

Mr. Kaplan estimated that 75% of Allied-Signal's employees use the managed care network 95% of the time. "The more employees who go to managed care, the more money the company saves," he said.

Allied-Signal's Mr. Yeaw suggested that employee benefit managers take the following steps before taking the plunge into managed care:

- Select a consultant that understands the demographic and philosophical needs of the company.
- Analyze the company's specific problem, objectives and potential solutions.
- Develop a plan design that makes sense and encompasses all of the company's needs.

naehca

- Select a provider service that shares the company's goals and priorities while offering flexibility and reasonable prices.
- Finalize the plan and financials.
- Communicate and educate the new managed care benefit to employees.

"87% of employers have cost savings when they introduce some kind of managed care program and add it to their existing benefit plan," said Dr. Alex R. Rodriguez, corporate medical director at Preferred Health Care Ltd. in Wilton, Conn., who also spoke at the conference.

Frustrated by the hefty price tags attached to health care, employers have increasingly been turning to managed care, Dr. Rodriguez said.

"In 1988, 12% of the gross national product was spent on health care costs," Dr. Rodriguez told attendees.

And, the future doesn't appear to be any brighter, according to other health care experts speaking at the conference who predicted that the 1989 bill for health care expenses would reach $590 billion.

Growing enrollment in both health maintenance organizations and preferred provider organizations nationwide reflects increasing employer participation and interest in combating health care costs by giving alternative managed health care, according to Dr. Rodriguez.

However, a study by Excelsior, Minn.-based Interstudy, shows the rate of HMO enrollment is slowing (see story, page 3).

While HMOs' growth rate slowed in the last year, PPOs have been popping up nationwide. The number of PPOs grew to about 600 in 1987, nearly double the estimated 364 that existed in 1986, said Dr. Rodriguez, who also predicted that by 1990, 26% of employers would offer HMOs, while 40% would offer PPOs.

However, both designing a managed care benefit and purchasing managed care services from providers is not an easy task, said one benefit manager who spoke at the session. ■

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NAM survey

Continued from page 1

NAM, though, is proposing a multipoint plan to restrain costs, increase access to health care and improve quality (see story, page 39).

The NAM health benefits survey, conducted in January with the assistance of benefit consultant A. Foster Higgins & Co. Inc., represents the organization's first effort to survey its members on health care costs and benefits structure and funding, Ms. Canner said.

NAM mailed survey questionnaires to 11,569 of its members and received 2,029 responses, a response rate of 17.5%.

However, the survey "was conducted with a very generalized questionnaire," Ms. Canner noted. For example, the survey questions that asked respondents to reveal the increase in their health care costs and those costs as a percentage of profits for 1988 were structured as multiple-choice questions. Respondents were asked to answer by selecting one of the following ranges of percentages: 5%-25%; 26%-50%; 51%-75%; and 76%-100%.

Estimates of health care costs and cost increases as a percentage of profits were determined based on a weighted average of the midpoints of the ranges of responses to the questions, according to the survey.

The cost of providing health benefits rose about 30% on average in 1988, the survey determined.

However, employers with fewer than 25 employees reported the largest increase: 33.3%. And, employers with between 25 and 50 employees said their costs increased 33.2%.

The lowest increase—19.1%—was reported by employers with between 5,001 and 20,000 employees.

A major reason why smaller employers experienced the largest increases is that they usually purchase health care benefits packages from commercial insurers or Blue Cross & Blue Shield plans and have little flexibility in designing the kinds of cost management programs that larger companies with self-funded benefits plans can implement, Ms. Canner explained.

Geographically, employers in the South Central and South Atlantic regions of the country reported the greatest health care cost increases—34.1%.

Employers in the Mid-Atlantic region reported increases of 26.7%, the lowest of all seven regions, the survey results show.

By type of industry, textile manufacturers reported the greatest increase, 34.9%, while food products manufacturers and lumber and wood products manufacturers both reported 32.1% increases.

The lowest increase in health care costs by industry group was reported by employers in the primary metals industry—24.4%.

Overall, the cost of providing health benefits equaled 37.2% of net profits on average in the last year for the employers surveyed.

"While we don't know whether this percentage differs from the percentage seen in previous years, it is clear that the cost of providing health benefits exerts a major impact on company profits," the survey notes.

Health care costs as a percentage of profits were greatest among employers with between 25 and 150 employees. Those employers reported that health care costs represented 39.3% of profits in 1988.

The next largest percentage of health care costs as a percentage of profits—38.4%—was reported by employers with between 51 and 100 employees.

The lowest percentage of health care costs as a percentage of profits—25.9%—was reported by employers with 20,000 or more employees.

Geographically, employers in the New England region reported the the highest health care costs as a percentage of profits—41.8%.

Employers in the North Central region of the country reported the next highest percentage—38.3%.

Employers in the South Central region reported the lowest health care costs as a percentage of profits—34.8%.

Manufacturers of stone, clay, glass and concrete products reported that health care costs amounted to 44.5% of profits, the highest among all industry groups.

Close behind are manufacturers of transportation equipment at 44.1%.

Manufacturers of lumber and wood products reported the lowest health care costs as a percentage of profits —28.4%.

The survey found that 99.3% of the employers surveyed offer group health benefits to their employees and that 98.4% also offer health care coverage to their employees' dependents.

When broken down according to company size, all employers with 300 or more employees offer coverage to employees and their dependents, the survey found.

Of small employers—those with fewer than 25 employees—96.3% offer coverage to their employees, and 94.4% also offer coverage to employees' dependents.

More than half—55.7%—of the employers surveyed pay the entire premium for employee-only coverage, while 43.4% share these costs with employees. Only 0.9% of the employers require employees to pay for the full cost of the coverage.

For dependent coverage, 31.7% of the employers pay the entire premium, while 53.5% share the premium with employees, and 14.6% require employees to pay the full premium.

And, a large majority of survey respondents—84.2%—oppose federally mandated health benefits, the survey found. Only 11.9% favored such mandates, while 3.9% did not answer.

The responses did not vary significantly by size of employer. However, there were minor regional variations in the responses. For example, 15.7% of the employers in the Pacific region said they favored mandated benefits, while only 7.9% of employers in the South Central region said they favored such mandates.

"A lot of this opposition is philosophical in nature. Employers are opposed to a mandate because they just don't want the federal government to be acting as a benefits manager," Ms. Canner said.

In addition, respondents may feel that additional mandates would not significantly increase the availability of health benefits to the uninsured, because almost all of the employers already provide benefits and pay for at least a portion of the costs of coverage, the survey notes. Instead, mandates "could increase administrative costs and reduce the current

Continued on next page

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NAM proposes plan to contain health costs

By JERRY GEISEL
and DONNA DiBLASE

WASHINGTON—Alarmed by out-of-control health care costs that are threatening the competitive position of U.S. business, the National Assn. of Manufacturers is proposing a 10-point plan to restrain costs, increase access to health care and improve quality.

"We can't approach the health care situation on a piecemeal basis," said Richard Heckert, chairman of the Washington, D.C.-based NAM.

"It will do us no good to focus only on access if what we're making accessible is neither consistently high in quality nor affordable," Mr. Heckert explained at a press conference last week where he outlined the plan.

In a NAM white paper called "Meeting the Health Care Crisis," the association recommends the following points for revamping the nation's health care system:

- Make health care cost data more available to employers. States should be prodded to force hospitals and physicians to make their charges publicly available. State enactment of such provider disclosure laws would be a condition of the states receiving federal Medicaid funds.
- Repeal the Section 89 welfare plan non-discrimination tests.

"These rules are creating costly administrative burdens and will discourage firms from offering a choice of health plans to their employees, subsidizing dependent coverage and could lead to the termination of health benefits altogether," NAM said.

- Provide tax incentives for prefunding retiree health care benefits. Noting that the Financial Accounting Standards Board is proposing that employers accrue as an expense against corporate earnings retiree health care liabilities from the date an employee is hired until the employee is eligible for post-employment health care coverage (*BI*, Feb. 20), NAM contends that it is only equitable that employers should be provided with tax incentives to prefund retiree health care benefits.

Under current law, an employer can only take a tax deduction for retiree health care coverage at the time a claim is paid or when it pays a premium to an insurer.

In addition, NAM says tax credits should be given to employers offering health care plans for the first time to defray some of their initial startup and administrative costs.

- Federal legislation should be considered to pre-empt the current patchwork of state medical liability laws.

"Areas for reform include placing limits on the contingent fees charged by plaintiffs' attorneys, limiting awards of punitive damages to flagrant cases and even establishing no-fault compensation for certain areas of liability—such as the recent federal legislation that removed cases of vaccine-related injuries from the tort system altogether," NAM said.

- Encourage cooperation among all purchasers and providers of health care to develop a cost management system that defines the health care product and judges its quality. Such a program should include sound public information on providers, incentives to encourage employer-based coverage and improved management of public programs.
- Educate employees about health care, stressing that they assume responsibility for their individual health and use the health care system more cost effectively. Health benefits programs also should emphasize preventive health care.
- Encourage employers to make a greater effort to control their health care plan costs by emphasizing quality and appropriate care, continuing to identify health plans that provide the best health outcomes, making judicious use of deductibles and cost-sharing and focusing on employee education.
- Continue expanding Medicare's Diagnostic Related Groups payment system for hospitals to eliminate irregularities and to update payment rates. Also, the current prevailing fee system for paying doctors should be replaced with new physician payment schedules.
- Encourage the federal government to use its purchasing power under Medicare and Medicaid to encourage a more efficient health care marketplace. Public programs should stress the use of managed care techniques to control costs and improve efficiency.
- Encourage development of insurance arrangements, such as multiemployer trusts, that enable groups of employers or workers to join together to obtain more favorable underwriting terms.

And, basic catastrophic plans that exempt employers from state benefit mandates should be made available to make coverage more affordable for small employers. ■

NAM survey

Continued from previous page

flexibility enjoyed by employers to design cost-efficient health plans," the survey says.

In fact, the surveyed employers noted several potential negative effects on private sector employers if such legislation were passed. These included increased employer costs; decreased competitiveness, especially with foreign companies; reduced flexibility in benefits design; and increased paperwork associated with legal compliance.

The survey asked employers to suggest alternatives to mandated benefits as a means of providing health coverage for the working uninsured. Some of the most common suggestions included providing special tax incentives to small businesses to encourage them to offer benefits; expanding state Medicaid benefits; and creating multiemployer trusts and state insurance pools for uninsureds.

The survey also questioned employers about their use of specific types of cost containment programs, although it did not ask employers about copayments, deductibles or other aspects of plan design. The survey found that:

- 54.6% of the employers utilize hospital pre-admission certification programs.
- 53.9% use second surgical opinion programs.
- 35.5% of respondents use alternative delivery systems, such as health maintenance and preferred provider organizations.

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For more information, contact Sharon Canner, Assistant Vp-Industry Relations, National Assn. of Manufacturers, 1331 Pennsylvania Ave. N.W., Suite 1500—North Lobby, Washington, D.C. 20004-1703; 202-637-3124.

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LOC rule triggers Lloyd's cash calls

By CAROLYN ALDRED

LONDON—Lloyd's of London syndicates already are notifying members of impending cash calls because of a new Lloyd's ruling that bans the use of letters of credit to cover syndicates' U.S. liabilities for open underwriting years.

Thousands of Lloyd's members could face massive cash calls this year and next year following the decision by the Committee of Lloyd's, underwriting agency executives agree (*BI*, May 15).

However, some Lloyd's syndicates may not have to make cash calls if Lloyd's and financial institutions can devise some alternative form of security within the next 12 months, Lloyd's sources say.

Each year, Lloyd's syndicates are required by Lloyd's to ensure that they have sufficient assets in U.S. dollars in Lloyd's American Trust Fund to cover the syndicate members' outstanding U.S. liabilities. This is known as the U.S. dollar solvency test.

However, in the past few years several syndicates that have kept their underwriting accounts open beyond the closing date under Lloyd's three-year accounting system have used letters of credit to cover their members' U.S. liabilities.

For example, syndicate 317/661, managed by R.H.M. Outhwaite (Underwriting Agencies) Ltd., last summer arranged LOCs through Midland Bank P.L.C. to cover U.S. liabilities totaling $123.5 million stemming from the syndicate's still-open 1982 underwriting year, an Outhwaite spokesman said.

Similarly, syndicate 553, managed by C.J.W. (Underwriting Agencies) Ltd., obtained a $66 million LOC last year to cover U.S. liabilities on its 1984 underwriting year, which remains open, confirmed a Warrilow agency spokesman.

Thousands of Lloyd's members could face massive cash calls this year, underwriting agency officials agree.

These letters of credit are issued by banks or other financial institutions following receipt of a supporting letter issued by the Council of Lloyd's.

However, "the Committee of Lloyd's," a group made up of working members on the Lloyd's Council, "has decided that, for the test as at Dec. 31, 1989, and thereafter, LOCs will no longer be deemed acceptable assets," said Deputy Chairman Colin Murray in a letter to managing agents, members' agents, syndicate auditors and financial institutions that issue LOCs.

But, for this year's solvency test "the Committee recognizes that special consideration should be given to those syndicates which had an LOC last year supported by a letter issued on behalf of Council," he noted.

So, for this year the Council is renewing its letters supporting LOCs issued last year but is issuing "no new supporting letters," Mr. Murray explained.

The move to ban LOCs puts syndicates with open underwriting years on an equal footing with syndicates that close their books on time and are forced to make cash calls to cover underwriting deficiencies, Lloyd's Chief Executive Alan Lord explained in a press conference earlier this month.

Lloyd's is concerned about the increasing number of syndicates that are leaving underwriting years open after the accounts are due to be closed. The syndicates claim they are unable to close the accounts mainly because of uncertainty surrounding U.S. liabilities such as pollution and asbestos (*BI*, May 1).

Lloyd's also is worried about the growing number of supporting letters it has signed to back the LOCs covering these liabilities, sources say.

"There's a growing prevalence of syndicates being left open, and some of the losses are really quite enormous. Lloyd's has to be cautious" about signing support letters for LOCs because banks may hold Lloyd's accountable if members do not pay the losses and the LOCs are drawn down, said an auditor of Lloyd's syndicates.

Continued on next page

OIL suffers record underwriting loss

By ROGER SCOTTON

HAMILTON, Bermuda—Two giant losses caused Oil Insurance Ltd., the Bermuda-based oil and gas industry mutual insurer, to record an underwriting loss of slightly more than $512 million for the year-ended Dec. 31, 1988, significantly worse than its $23.8 million loss in 1987 (*BI*, June 13, 1988).

OIL, which writes property and pollution liability insurance for 47 petroleum company shareholders, reported that net premiums written and earned dropped to $64.8 million last year from $66.1 million in 1987, while losses and loss expenses grew to $576.9 million from $89.9 million in 1987.

Writing in the company's 1988 report released last week, newly appointed President and Chief Executive Officer K. Doyle Stephens describes 1988 as "one of the worst casualty loss years in the history of the petroleum industry."

He says OIL's $576.9 million in incurred losses last year includes an increase of $30 million in OIL's reserves for incurred-but-not-reported losses and an increase of $119 million in reserves for prior year losses.

1988 was 'one of the worst casualty loss years in the history of the petroleum industry,' says OIL's President and CEO, K. Doyle Stephens, noting the effect of claims from a Shell Oil Co. refinery fire and the Piper Alpha platform loss on OIL's results.

Mr. Stephens notes that OIL's current loss reserves of $460 million compares with $141 million in 1987 and "recognizes claims payments totaling $258 million during the year."

"As a provider of catastrophe insurance to the petroleum industry, OIL received two major claims from its policyholders" in 1988, Mr. Stephens noted.

One of the claims was the explosion of a Shell Oil Co. refinery in Norco, La., which killed at least three workers and caused extensive damage (*BI*, May 9, 1988). The other loss noted by Mr. Stephens was the explosion of the Piper Alpha drilling platform in the North Sea, which is projected to cost insurers worldwide between $1.2 billion and $1.5 billion, making it the biggest single man-made loss (*BI*, July 11, 1988).

The OIL report did not say how much each of the losses cost OIL.

"As a result (of these losses), OIL sustained a substantial operating loss for the year," Mr. Stephens said.

Including operating costs of $2.2 million, OIL experienced an operating loss of $514.3 million in 1988, compared with $19.3 million in 1987. Investment income of almost $60 million last year—up more than seven fold from $7.1 million in 1987—helped trim this back to a net loss of $454.5 million.

The insurer saw its statutory capital and surplus decline 44.6% to $514.8 million at year-end 1988 from $929.5 million the previous year.

But Mr. Stephens, who took over last July for former CEO Charles Bailey, states in the new report that the company's losses are by no means a new experience.

"It is actually the seventh time in the 17-year history of OIL that the company has had an underwriting loss," he writes. "It is perhaps important to note that the periods involving the most important growth in the company, 1975-1979, 1980-84 and 1986-87, have in each case followed years in which OIL has had a particularly bad loss year. We trust that the years following 1988 will bring the same."

Despite the losses, he says that OIL's assets still exceed $1 billion.

OIL—which offers property and pollution liability coverage of $150 million per occurrence and an optional additional $150 million layer of coverage, excess of a minimum $5 million retention—saw several new shareholders join the mutual last year: Champlin Refining & Chemicals, Mobil Oil Corp., Nova Corp. and Sun Exploration & Refining Co.

In a separate report, Mr. Stephens also announced the results of OIL's affiliate, Oil Casualty Insurance Ltd., which was formed in May 1986 to insure excess general liability and directors and officers liability risks of OIL's shareholder members and other named policyholders on a claims-made basis.

OCIL had a good year, despite market conditions, said Mr. Stephens, though underwriting income fell 67.3% to $11.2 million for the 12 months ended Nov. 30, 1988, compared with $34.2 million for the same period in 1987.

Gross premiums earned dropped 43.6% to $19.8 million in 1988, from $35.1 million the previous year. Net premiums earned totaled $15.4 million, down 54.3% from $33.7 million in 1987.

After allowing for net investment expenses of $5.8 million, OCIL finished the year with a sharply reduced profit of $4.1 million, down 87.5% from $32.7 million in 1987.

Commenting on OCIL's results, Mr. Stephens said the company had been hit by pressures from increased capacity and price competition. He said the fall in profits was due mainly to a reduction in earned premiums.

"Approximately one-third of the reduction in premiums was attributed to lower prices, with the balance resulting from changes in utilization. The changes are, for the most part, improvements in the overall risk profile as more policyholders utilize or attach the coverage at higher levels," he explained.

"In addition to these factors, the decline in net income reflects the cost of improvements to the reinsurance program and the recognition of a new IBNR reserve of $4.2 million."

OCIL's capital and surplus grew by $18.7 million to $138.3 million last year, he added.

Reviewing OCIL's first 2½ years in operation, Mr. Stephens said that 30 companies now are policyholders, OCIL has repaid $30 million of the original $50 million in subordinated note financing from OIL and OCIL has a strong reinsurance program—one that limits OCIL's net retention per risk for excess general and D&O liability to $20 million and $30 million, respectively.

OCIL—which offers general liability policy limits of $100 million per occurrence excess of a $20 million retention, and D&O cover of $50 million per occurrence excess of a minimum per-occurrence retention of $20 million—attracted Champlin Refining & Chemicals, Elf Aquitaine Inc., Royal Dutch/Shell Group and Sun Exploration & Refining Co. as shareholders in 1988. ■

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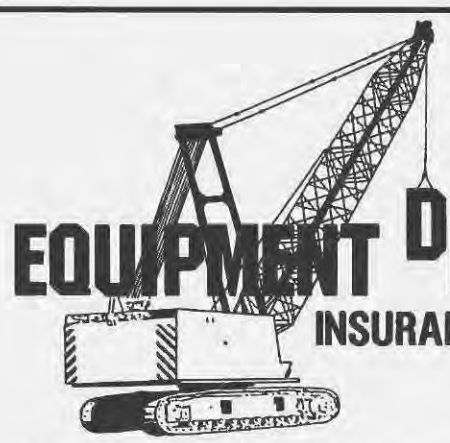

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Continued from previous page

"At the end of the day if there's a shortage of dollars in an open year which should have been closed, those dollars will have to be called," said John Gordon, chairman of Lloyd's Underwriting Agency Assn. "All the letters of credit are doing is putting off the evil day," he said.

Members also are exposing themselves to the additional risks of exchange rate fluctuations by using LOCs, Mr. Gordon said.

The move also "will mean more liquidity in the market," said Paul McNamara, the partner in charge of the insurance industry group at the accounting firm Ernst & Whinney. "It's a good thing to get reserves in cash," he added, predicting that the decision will result in earlier "calling of cash by syndicates."

However, Ken Randall, managing director of Merrett Holdings P.L.C., predicted that the move "will cause a problem" in the market, although he says he "can understand why Lloyd's is taking this action."

The decision to ban LOCs "will be an additional problem which we are going to have to look at very carefully during the next year," said an Outhwaite spokesman. However, the spokesman would not comment on whether the move will mean Mr. Outhwaite's syndicate will have to make any cash calls earlier than planned.

Some managing agents, though, already have written to members' agents and members warning them of looming cash calls because of the decision.

For example, Syndicate 895 (Run-off) Ltd. Director Chris Dickson wrote to members' agents this month to warn that the syndicate plans to make a cash call next year on its open underwriting years 1980 to 1982 as a result of the new rule.

This year, as in previous years, the agency, which is managing the runoff of syndicate 895, will be covering the deficit in the syndicate's Lloyd's American Trust Fund "by means of a letter of credit facility arranged with Barclays Bank P.L.C., thus avoiding the immediate need to fund it in cash," Mr. Dickson explained in his letter.

However, the letter notes that the new Lloyd's position on LOCs will prohibit the syndicate "from covering in the same way any deficit which may be shown by the solvency test as at Dec. 31, 1989.

"Any such deficit will in future, therefore, have to be funded by the transfer of cash or other liquid assets into the LATF," the letter said.

"If the deficit remains at its present level, this will require us to make a further cash call in June 1990, which is likely to be of the order of 3,500 pounds ($5,460) for a 20,000 pound ($31,200) share," Mr. Dickson wrote in the letter.

Meanwhile, C.J.W. (Underwriting Agencies) this year is reducing the amount of U.S. liabilities in syndicate 553's 1984 underwriting year covered by LOCs to $25 million from $66 million.

Total losses incurred by the 1,452 members of the syndicate's 1984 underwriting year currently stand at about 80 million pounds ($124.8 million). The syndicate's 1984 underwriting capacity was 32 million pounds ($37.1 million at year-end 1984 exchange rates).

The syndicate is making a cash call to members this year of about 32 million pounds ($49.9 million at current exchange rates) following two previous cash calls totaling 26.8 million pounds ($50.4 million at year-end 1988 exchange rates).

And, next year the syndicate plans to call the balance of the loss of just more than 20 million pounds ($31.2 million at current exchange rates), CJW Chairman Peter Maitland told members in a letter this month.

'At the end of the day if there's a shortage of dollars in an open year which should have been closed, those dollars will have to be called,' says Lloyd's Underwriting Agency Assn.'s Mr. Gordon. Letters of credit only put off 'the evil day.'

Although the agency had planned to call the losses anyway, the decision by Lloyd's to ban LOCs "re-emphasizes the need to call the balance of the loss next year," Mr. Maitland said.

Meanwhile, at least one syndicate has warned its members that it may have to make a cash call to cover U.S. liabilities on its 1988 underwriting year—two years before the underwriting year's accounts are due to close (*BI*, May 22).

Rose, Thomson, Young (Underwriting) Ltd., underwriting agent for marine syndicate 225, wrote to members' agents this month to explain that the syndicate currently has a solvency deficiency of 35.9 million pounds ($56 million) because of the loss of the Piper Alpha oil platform in the North Sea last year.

Although the syndicate still "is well within its reinsurance protections," loss notifications stemming from Piper Alpha have resulted in a current solvency deficiency, said Managing Director R. Horrex in the letter.

However, some sources are less pessimistic about the LOC situation and say syndicates may be able to avoid making cash calls to cover U.S. liabilities if Lloyd's and various financial institutions can devise an alternate form of security within the next 12 months.

They note that the Council's decision on LOCs is, in part, an effort to sweeten Lloyd's relationship with the U.S. Internal Revenue Service during negotiations to modify the special taxing agreement Lloyd's currently enjoys in the United States.

The U.S. Treasury Department is seeking changes in the tax agreement to ensure Lloyd's members are paying appropriate taxes reflecting recent U.S. tax law changes (*BI*, Feb. 27).

The rapid growth in the number and size of LOCs being used by syndicates to cover their U.S. liabilities concerns U.S. regulatory authorities—the IRS in particular—which are unable to levy taxes on non-income-bearing assets such as LOCs, said one Lloyd's source.

Mr. Murray noted in his letter last month to members' and managing agents and others that "consideration will. . .be given to any alternative to the provision of cash in dollars whereby income-bearing assets, which are admitted assets for Lloyd's filing with the U.S. regulatory authorities, might be maintained" in the Lloyd's American Trust Fund.

The Corporation of Lloyd's "will be exploring with selected financial institutions whether alternative acceptable financial instruments exist or may be devised and will consult the market when the possibilities, if any, have been identified," Mr. Murray wrote in his letter.

One Lloyd's source says he is "optimistic" that financial institutions will be offering an alternative to LOCs before next year to avoid forcing all Lloyd's syndicates with U.S. liabilities in their open year accounts to make cash calls. ■

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The Townspeople of a Small New England Community can tell you what happens. In early December 1987, a fire engulfed an interconnected mill complex, which was destroyed. "It was scary," said one resident. "All I could think of was the whole thing going up in flames." Another resident saw a "... ball of flame. It shot up seven or eight stories." Billowing, black smoke was seen 30 miles away, while down on the streets the intense heat melted two tractor trailers, peeling their sides away and exposing steel ribs. Fire companies from 15 communities responded. Water from a nearby river was used to fight the fire. Runoff of the water and various unknown chemicals, some burning, spilled into storm drains which belched balls of fire. The town's water supply was contaminated and residents were warned not to drink or wash with municipal water, even if boiled, until it was declared safe. The local hospital cancelled elective surgery and sterilization of equipment. Schools, factories and restaurants closed. More than two dozen businesses downwind of the fire were evacuated. The next day, one of the firefighters commented that the charred mills resembled "... Europe during World War II."

The disaster occurred at a time when the small town was experiencing new growth. Population was increasing. New businesses were moving in. A town-sponsored industrial park was half full. Now, 190 people are out of work, perhaps permanently, and the consequential economic loss—greater than the actual destruction of the building and its contents—may approach $50 million.

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First-quarter insurer results

Continued from page 1

Among other survey results:

- Investment income increased 9.1% in the first quarter to $3.3 billion from $3 billion in the first quarter of 1988. This compares with an 11.3% increase in investment income during calendar year 1988.
- Policyholder surplus among the 24 insurers reporting the data increased 9.5% to $35.1 billion as of March 31 from $32.1 billion as of March 31, 1988. This compares with the 12.8% increase in calendar year 1988.
- Net income declined 0.6% to $1.81 billion from $1.82 billion.

This quarter, all insurers' results reflect Financial Accounting Standards Board Statement No. 97. Under FASB 97, realized capital gains and losses now are reflected in pretax operating income, rather than being reported separately. The statement also changes the accounting for certain life insurance and annuity business.

Because of these accounting changes, *BI* now ranks commercial property/casualty insurers' quarterly results according to change in net income instead of aftertax operating income, which had not included non-operating gains and losses.

BI's survey of major commercial property/casualty insurers also includes for the first time this quarter Omaha, Neb.-based Berkshire Hathaway Group and Transamerica Insurance Group.

In addition, *BI* now is reporting results for Kemper National Property-Casualty Cos. rather than Kemper Corp. Kemper Corp. has just completed the sale of American Motorists Insurance Co., its national property/casualty insurance subsidiary, to Lumbermens Mutual Casualty Co. in exchange for Kemper Corp. stock (*BI*, May 22).

Kemper National's insurance units include Lumbermens Mutual, American Motorists, American Manufacturers Mutual Insurance Co. and American Protection Insurance Co.

Insurance industry observers generally say they do not foresee any pricing improvement for at least this year and well into next.

"I don't see anything in the earnings that makes me become more optimistic about the cycle ending more abruptly than might otherwise be the case," said David Anthony of Fox-Pitt, Kelton in New York.

He believes property/casualty pricing will turn in mid-1990 "unless something dramatic happens."

Right now, insurers' returns on capital are too high to make a case for a turn in the cycle happening any sooner, Mr. Anthony said.

"My initial reaction to the first-quarter numbers is the hope for a quick pricing upturn now looks like sort of management wishful thinking," commented Michael Morrissey, a principal with Firemark Consultants Inc. in Morristown, N.J.

"I think it's probably going to take a year or two" for the cash-flow slowdown to reach the point where there is an impetus for a pricing upturn, said Mr. Morrissey. "We see it as an extended malaise in the business that's not going to turn around soon," he added.

"I think the balance of the year is going to be difficult for most companies. The competition is still alive and well, and price declines are still there," said a CIGNA Corp. spokes-

Continued on next page

Lloyd's '86 profits may fall short of predictions

By STACY SHAPIRO

LONDON—Lloyd's of London should post banner global profits for its 1986 underwriting year, though the profits will only be about half of what underwriters were predicting two years ago, a Lloyd's syndicate analyst estimates.

Lloyd's, which will announce its 1986 global results in September, will increase its profits—after profit commissions are deducted—to 514 million pounds ($930.3 million at year-end 1988 exchange rates), nearly five times more than Lloyd's 1985 global profits of 108 million pounds ($203 million at year-end 1987 exchange rates) after commissions, according to Chatset Ltd.

However, "there was much talk two years ago, as underwriters searched for claims, of a 1 billion pound ($1.8 billion) profit for Lloyd's" for the 1986 underwriting year, said Chatset in its 1986 Underwriting Results Review. "There have, however, been warning signs that this figure will not be achieved."

In fact, Chatset has reduced its prediction of Lloyd's 1986 profits to 514 million pounds from the 800 million pounds ($1.4 billion) it had estimated in January.

"Where have all the profits gone?" Chatset asks rhetorically. "Bolstering up old years seems to be the answer."

Many syndicates are now adding to reserves to pay outstanding U.S. liability and pollution claims from past underwriting years, Lloyd's market observers concur.

'The problems of losses on the old years arising out of pollution and asbestos are very apparent,' says Chatset of the marine market. In particular, marine syndicates underwritten by Richard Outhwaite and Stephen Merrett 'are beset with problems arising from reinsuring other syndicates' open years.'

According to Chatset, Lloyd's non-marine market had a "very good year" in 1986, which was the first full year of rate hikes after the soft market of the early 1980s and the year in which the claims-made liability policy form was introduced in the London market.

The non-marine market, with a stamp capacity of 2.4 billion pounds ($4.3 billion), will post an estimated profit of 312 million pounds ($564.7 million), according to Chatset.

However, non-marine syndicates that have not closed prior accounting years face at least 58 million pounds ($105 million) of announced losses in the open years, and another 37 million pounds ($67 million) of losses from open years could possibly be reported. That would reduce the total profit for the non-marine market to 217 million pounds ($392.8 million), says Chatset.

Lloyd's marine market, with a total capacity of 2.7 billion pounds ($4.9 billion) in 1986, should show a profit of 200 million pounds ($362 million) after losses from open years of account totaling an estimated 30 million pounds ($54.3 million) are deducted, Chatset predicts.

"The problems of losses on the old years arising out of pollution and asbestos are very apparent," says Chatset of the marine market. In particular, marine syndicates underwritten by Richard Outhwaite and Stephen Merrett "are beset with problems arising from reinsuring other syndicates' open years."

Also, marine syndicate 65, underwritten by former underwriter Henry Chester has uncovered a "serious shortfall" in past underwriting years and has substantially increased reserves for both asbestosis and pollution claims (*BI*, May 1).

In addition, marine syndicate 206, managed by R.W. Sturge & Co., is showing a 7 million pound ($12.7 million) profit for 1986, which is "disappointing" for what is supposed to be a "vintage" year, said Chatset. "One suspects that the 1986 year has been affected by old year losses."

Other syndicates whose 1986 results will be hurt by prior year losses, according to Chatset, include:

- Syndicate 764, managed by Philip N. Christie & Co. Ltd., with a loss of 25% for every 10,000 pounds ($18,100) in premium underwritten by its members.
- Syndicate 108, managed by John Poland & Co., with a 7.2% loss for every 10,000 pounds in premium underwritten.
- Syndicate 287, managed by Spratt & White Ltd., with no loss to members reported, though the 1986 underwriting year will be left open.

Meanwhile, Lloyd's aviation market "had a bumper year" in 1986, said Chatset.

The aviation market as a whole should report a profit in excess of 100 million pounds ($181 million) from a total stamp capacity of 484 million pounds ($876 million), Chatset predicts.

The three Sturge-managed aviation syndicates earned profits of more than 30% of their stamp capacity, while other major aviation syndicates averaged profits of around 20%, Chatset says. ■

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Summary of major property/casualty insurers' first-quarter results

(All amounts in thousands of dollars)
(Ranked by change in net income)

Rank 1989	Corporate: Consolidated revenues 1989	Corporate: Net income 1989	Corporate: Percent increase (decline) 1988-1989	Property/casualty operations: Combined[1] ratio 1989	Combined[1] ratio 1988	Net premiums written 1989	Percent increase (decrease) 1988-1989	Pretax underwriting income (loss) 1989	Percent increase (decline) 1988-1989	Pretax investment income 1989	Percent increase (decrease) 1988-1989	Policyholders surplus 1989	Percent increase (decrease) 1988-1989
1. Sentry Insurance Cos.[2]	$305,942	$13,366	1,071.4%	104.9	107.4	$271,256	(8.8)%	$(15,662)	45.4%	$36,220	14.5%	$559,431	14.2%
2. Ohio Casualty Corp.	403,712	38,633	131.8	102.1[3]	104.1[3]	343,990[3]	(2.3)	(9,723)	46.6	46,424	8.8	499,339	10.3
3. Travelers Corp.	3,169,300	97,800	48.9	109.7	105.3	1,257,300	(8.2)	(128,800)	(95.2)	172,200	15.0	1,843,700	(2.0)
4. Aetna Life & Casualty Co.	4,557,800	173,600	30.9	112.8	111.8	1,608,700	0.2	(205,300)	(10.0)	244,000	8.2	2,333,500	9.1
5. Hartford Steam Boiler	114,096	19,762	20.3	80.8	84.1	71,601	1.4	13,739	20.7	9,197	12.4	279,906	21.0
6. AmBase Corp.	847,600	25,600	15.8	107.5[2]	106.0[2]	542,500	(2.5)	(45,100)	(4.7)	88,000	3.5	826,200	7.4
7. American International Group	3,431,998	343,480	15.1	98.9[2]	99.5[2]	2,229,509	5.1	24,473	35.4	224,491	13.4	N/A	N/A
8. General Re Corp.	733,554	155,878	13.5	98.9[3]	99.0[3]	421,206	(17.8)	8,958	390.6	150,753	16.6	2,402,331	16.3
9. CIGNA Corp.	3,688,100	85,500	9.2	112.0	106.5	1,480,200	(4.2)	(171,900)	(84.6)	210,400	7.3	1,950,000	(4.8)
10. USF&G Corp.	1,127,786	30,921	3.9	107.2[2]	106.2[2]	1,046,737[2]	18.8	(64,107)	(9.3)	160,478	2.9	1,438,984	9.7
11. CNA Financial Corp.	2,177,000	180,800	2.7	111.6[2]	106.0[2]	1,466,000[2]	11.3	(185,900)	(84.1)	247,300	21.6	2,762,000	28.8
12. Chubb Corp.	992,000	104,900	2.3	99.8	96.0	630,500	(6.5)	6,100	(77.2)	103,100	20.9	1,393,100	7.5
13. Berkshire Hathaway Group	210,562	41,647	0.7	107.4	105.2	152,298	19.8	(11,419)	(46.8)	55,865	12.6	N/A	N/A
14. The St. Paul Cos. Inc.	948,237	90,231	(1.3)	103.5[2]	103.7[2]	677,846	4.6	(30,371)	(20.8)	49,628	16.3	1,352,607	5.3
15. Fremont General Corp.	99,521	5,958	(5.2)	104.8	106.5	73,380	7.7	(3,312)	23.4	10,865	12.9	141,403	27.3
16. Lincoln National Corp.	1,785,200	51,000	(6.4)	101.5	98.3	578,500	8.3	(12,200)	(349.0)	75,500	16.2	2,459,500	16.4
17. Crum & Forster Inc.	1,122,300	83,500	(8.6)	109.7	108.4	844,300	2.9	(85,100)	(29.7)	147,000	12.2	1,400,200	12.0
18. SAFECO Corp.	705,273	65,594	(12.2)	105.7	99.3	389,744	4.2	(22,047)	(1,009.5)	62,172	20.8	897,747	17.7
19. Hartford Insurance Group	2,121,761	65,705	(18.4)	107.1	104.5	1,576,028	(3.6)	(130,926)	(63.8)	210,372	14.7	2,619,782	0.1
20. Reliance Ins. Co. & subs.	807,639	37,262	(19.2)	104.9[2]	100.1[2]	493,357	15.5	(28,230)	(374.9)	53,690	10.1	N/A	N/A
21. Old Republic Int'l	271,583	18,093	(19.7)	117.2	102.7	156,701	1.8	(25,218)	(550.8)	34,747	15.0	644,584	8.7
22. Fireman's Fund Ins. Cos.	830,732	36,470	(43.0)	113.6	107.5	673,599	(12.8)	(90,712)	(51.8)	114,822	(0.8)	1,433,179	4.2
23. Continental Corp.	1,487,600	44,200	(49.2)	110.8[2]	103.7[2]	1,186,600[2]	0.1	(115,300)[2]	(144.3)	170,800	22.1	1,889,300	17.9
24. Transamerica Ins. Group	466,027	11,715	(82.7)	112.6	107.2	401,307	(0.4)	(57,336)	(118.8)	50,685	12.6	954,670	4.0
25. Royal Group (U.S. subs.)	N/A	(7,100)	(135.7)	119.0	109.7	554,700	2.8	(102,300)	(174.3)	75,500	7.5	N/A	N/A
— Kemper National P/C Cos.[2]	N/A	N/A	N/A	98.9	103.0	737,866	12.6	(33,585)	31.5	75,431	18.2	1,782,203	7.4
— Nationwide Mutual Ins. Co.[2]	N/A	N/A	N/A	105.5	106.2	1,397,141	(2.1)	(60,981)	19.5	160,371	5.9	2,729,694	11.2
— Commercial Union Ins. (U.S.)[2]	N/A	N/A	N/A	111.0[3]	106.8[3]	323,500	1.5	(42,100)	(39.4)	39,500	6.2	545,900	3.1
— Liberty Mutual Ins. Co[2]	N/A	N/A	N/A	117.2	116.0	1,692,225	(9.2)	(222,750)	(5.0)	246,775	13.7	N/A	N/A
Cumulative	32,405,323	1,814,515	(0.6)	107.7	105.6	23,278,591	0.2	(1,847,109)	(46.1)	3,326,286	9.1	35,139,260	9.5

[1] After dividends. [2] Statutory. [3] Before dividends. N/A-Company did not provide data.

Continued from previous page

man. While rate cutting momentum may have slowed, he said, "it will certainly not help earnings."

This year, "we should see a strong decline in property/casualty earnings if the companies are being honest with reserves and everything else," said the CIGNA spokesman. However, he said insurers are not suffering enough to hike rates. "They have to be on the critical list before they raise prices."

Pricing will not change before mid-1990, said Shearson's Mr. Ghose. "There's still too much capital chasing too little business," and insurer cash flows are not slowing as fast as expected because of higher interest rates, he said.

"I think things will just ebb downward," said David P. Wells, vp with Merrill Lynch Pierce Fenner & Smith in New York. "I don't see any reason why the market shouldn't continue to soften."

Returns on equity and cash flows are not bad enough to make insurers feel the need to tighten rates, said Mr. Wells.

"I just don't think (returns will) get that low this year," he said, adding that he does not expect a turnaround during the first half of next year as well. There may be a market hardening, however, in the second half of 1990, he added.

"Fireman's Fund's position is, we don't see any improvement through '89. In fact, we see it getting worse," said a spokeswoman for Fireman's Fund Corp. "There's very little potential for it to turn before the end of 1990."

"My guess is that's too optimistic," commented Barbara Stewart, president of Stewart Economics in New York. Even with the deteriorating margins, the market is nowhere near the point where insurer insolvencies are widespread or where "insurers would generally panic and withdraw from the market," she said.

"Absent a super catastrophe," a reduction in capital to the point where it would stabilize or raise prices "is very likely to be a slow and painful process," Ms. Stewart said. "We would look to another several years of eroding margins."

"We see the market turning as the impact of paying more taxes and the declining interest rates is felt by other insurance companies, and we think that will happen sooner rather than later," said Ed Santos, Transamerica's chief financial officer, though he could not be more specific.

Observers pointed out that premium growth will continue to be slow this year, while combined ratios deteriorate.

They estimate that net written premium growth will be no more than 3% this year, and some said it was possible that premium volume could even decline.

Observers are estimating that insurers will post combined ratios in the 108.5% to 110% range in 1989, which will worsen next year to 112% to 113%.

Some observers are concerned about the general trend among insurers to add less to reserves.

"Fewer companies are adding to reserves the way they did, so I'm less happy about the reserves situation," said David Seifer, vp at Donaldson, Lufkin & Jenrette Securities Corp.

There was a "noticeable lack of reserving" in the first quarter, said Ms. Vogel.

While she said she could not quantify it, "the amount of reserving for both current and prior periods is not as strong as it had been" two years ago, Ms. Vogel explained. She added it is possible, though, that reserves have reached adequate levels.

However, reserves are not as adequate "as they would make them out to be," commented Myron M. Picoult, senior vp at Oppenheimer & Co. in New York.

Property/casualty insurers are underreserving right now, said Firemark's Mr. Morrissey, adding that they never caught up with the "inflationary bulge" of losses in the late 1970s, he said.

The slowdown in reserve increases that marked late last year and early this year are "an indication of the industry's determination to minimize the combined ratio increase," he said.

"Maybe they're doing a little bit of management of earnings," said Mr. Anthony, referring to the decision to add less to reserves to bolster earnings. "It's not a surprising event," he said, adding this scenario occurs during every down cycle.

"One can only speculate that there is some sort of earnings management going on," said Ms. Stewart. "It's been shown to occur in the past, and there's no reason to believe it isn't happening again," she added.

"I think on the new business that's going on the books they are beginning to underreserve," said Shearson's Mr. Ghose. It is difficult to say, however, whether insurers' overall book is underreserved because insurers have added to reserves over the past couple of years "to make up for past sins."

Mr. Luce said he believes insurers made up for previous reserve shortfalls in 1985-1988. "They just don't need to put up as much now," he said, adding that reserve levels are "pretty good."

Observers were cheered in the first quarter by improving group health insurance results among multiline insurers, though it is not clear to what extent improved group health results will offset declining property/casualty results.

CIGNA's employee life and health benefits segment, for instance, reported $100,000 in income for the first quarter, including net realized investment losses of $2.2 million. This compares with a $53.7 million loss during 1988's first quarter, including a net realized investment gain of $2 million.

The earnings turnaround primarily reflects rate increases for group health care programs, the CIGNA spokesman said.

The spokesman noted that price increases that affected 40%-45% of the insurers' health maintenance organization business were introduced in January alone.

"I think most multilines will likely see an improvement in group health" results this year, he said. This will "come close to, if not entirely offset the property/casualty declines," allowing parent companies to post "essentially flat earnings."

The improvement in group health insurance results was a "long time coming," said Mr. Morrissey. He said it is possible that multiline insurers will post earnings increases this year "because of the magnitude of the savings in the group health results."

Mr. Seifer said group health results were better than he had expected, though property/casualty results were worse. "The deterioration in property/casualty underwriting is going to dominate the improvement in group health so that the net is worse," he predicted.

"The indications are continuing to show improvement, and hopefully that will continue for the balance of the year," commented Ms. Vogel, adding that group health results for some insurers will offset deteriorating property/casualty results.

However, Mr. Luce said that "my question" about the group health rebound "is how long it's going to last."

He added, however, he expects the improvement in group health results to last about 18 months.

"They may be starting to get ahead of the eight-ball," commented Mr. Anthony.

Observers also pointed to the lack of major catastrophes during the first quarter as a positive factor affecting property/casualty results.

"Weather is usually an important factor in first-quarter numbers and we haven't seen much of that," commented Mr. Lewis.

The industry is enjoying a "remarkable spell" of catastrophe-free experience, except for some losses on the West Coast, said Mr. Ghose. "They've been dodging the bullet."

Observers say that while there has been no significant change in investment strategies, insurers are putting more funds into taxable instruments to avoid paying the alternative minimum tax mandated by the Tax Reform Act of 1986 and to offset underwriting losses as well.

"I think more seem to be moving toward taxable securities," said Mr. Anthony, adding that insurers' higher tax rates on investment income seems to confirm that.

"I think everyone is adjusting their portfolios as they go along to avoid the AMT," commented Mr. Luce.

"There's very little municipals buying going on by these companies right now," commented Mr. Morrissey.

"Companies are continuing to buy taxables, and most are staying in fixed income vs. equity" investments, said Ms. Vogel.

However, in the last six to nine months, more insurers have been investing in equities, said Mr. Ghose, though he added that insurers' involvement in the equity market has not reached the level it did before the October 1987 stock market crash. ■

Westinghouse

Continued from page 2

missing them or parts of them," the appellate court said.

Judge Weiss also said that each of the 23 states involved in the Westinghouse litigation has a strong interest in applying its own state laws.

But the appellate court disagreed. "The notion that the insured's rights under a single policy vary from state to state depending on the state in which the claim invoking coverage arose contradicts not only the reasonable expectation of the parties but also the common understanding of the commercial community," the appellate court ruled.

Policyholder attorneys nationwide are applauding the appellate court's ruling.

"The ruling was exceptionally clear and forceful," said Westinghouse attorney Peter Kalis of Kirkpatrick & Lockhart in Pittsburgh.

'The ruling was exceptionally clear and forceful,' says Westinghouse attorney Peter Kalis of Kirkpatrick & Lockhart in Pittsburgh, who lauded the court for 'laying bare the motives of certain insurers who pursue duplicative litigation.'

Mr. Kalis lauded the court for "laying bare the motives of certain insurers who pursue duplicative litigation."

Policyholder attorney Eugene Anderson of Anderson Russell Kill & Olick in New York agreed. "This is the first decision in which a court has recognized that insurance companies are using the courts as a weapon by imposing on 'the judicial system and the adversary' endless delay and expense," he said.

However, insurer attorney Timothy C. Russell said the appellate court decision was "erroneous." Mr. Russell of Drinker, Biddle & Reath in Washington, D.C., represented insurers collectively known as the "Lumbermens Group" that worked to splinter the Westinghouse case.

"The appellate court's suggestion that pollution coverage issues should be decided as a matter of abstract legal principle without paying close attention to the specific facts of a claim is erroneous," Mr. Russell said.

The appellate court also erred in ruling "that a single state's law should apply irrespective of the location of the waste sites, " Mr. Russell asserted.

While the appellate court said the Westinghouse litigation should be heard in one state trial court, the panel did not indicate which state trial would be the most appropriate forum.

Westinghouse wants the litigation heard in New Jersey state court, but some insurers want the case heard in federal court in Pennsylvania, where Westinghouse is based.

It is unclear whether the Westinghouse litigation will be heard in federal or state court. It is possible that both courts would hear duplicate litigation and issue conflicting rulings (*BI*, Sept. 19, 1988).

Most attorneys contacted agreed that the appellate court ruling will make New Jersey an even more attractive forum to policyholders litigating with their insurers because the decision is binding on all New Jersey trial courts.

"The decision will have a direct influence on what goes on in New Jersey," said Mr. Russell, the insurer attorney. "Policyholders will again begin to flock to New Jersey."

Mr. Anderson, the policyholder attorney, agreed. "The decision will definitely enhance the number of filings in the state of New Jersey" by policyholders, he predicted.

Both Mr. Russell and Mr. Kalis, Westinghouse's attorney, also noted that other New Jersey trial court judges who had ruled that large coverage cases should be splintered would have to reverse their decisions on motions for reconsideration.

In addition, the Westinghouse decision cements trial court decisions in New Jersey that large hazardous waste coverage cases should be consolidated, attorneys say.

For example, litigation between Allied-Signal Corp. and 177 of its liability insurers will remain consolidated in trial court in Morristown, N.J., as a result of the Westinghouse decision. New Jersey Superior Court Judge Reginald Stanton ruled on Aug. 25, 1988, that the entire Allied-Signal case should be heard in his court (*BI*, Aug. 29, 1988).

"The Allied-Signal case is bound without a question," Mr. Kalis observed.

Similarly, insurers litigating with American Telephone & Telegraph Co. in a Newark, N.J., state court will be unable to splinter that case as a result of the Westinghouse ruling, attorneys said.

And, the Westinghouse decision could have a "profound" impact on hazardous waste coverage litigation outside New Jersey, attorneys say.

"Because of the strength of the opinion and the clarity of its reasoning, it will shape the debate" on whether massive coverage cases should be consolidated or splintered, Mr. Kalis said.

"The decision is a clear and unequivocal repudiation of the wasteful and duplicate approach taken by some insurers," he said. "It will have a profound effect" on other courts, he predicted.

Policyholder attorney Mr. Anderson also said the decision would have a significant impact on litigation between policyholders and insurers over whether their coverage disputes should be combined or fragmented.

"This decision is so clear and so persuasive that it would take a Neanderthal court to go the other way," Mr. Anderson said.

Insurer attorney Joseph Manta, of Manta & Welge in Philadelphia, agreed. "People have been looking to the Westinghouse case for guidance," and the appellate court's ruling in the Westinghouse case will have a "spill-over effect" on other courts, he said.

"The trend is toward comprehensive litigation," said Mr. Manta, who represented insurers in the Westinghouse litigation that sought to keep the case consolidated but heard in federal court.

Among the massive hazardous waste coverage lawsuits that could be influenced by the Westinghouse decision are those involving Union Carbide Corp. and United Technologies Corp., attorneys say.

Danbury, Conn.-based Union Carbide is litigating with 115 of its liability insurers for the costs to clean 19 hazardous waste sites nationwide.

Connecticut Superior Court Judge Robert A. Fuller ruled on Feb. 6 that the case was too unwieldy to be handled by his court (*BI*, Feb. 27; May 9, 1988).

That decision is being appealed to the Connecticut Supreme Court, said Union Carbide attorney David Zabel of Cohen & Wolf in Bridgeport, Conn.

The appellate court decision in the Westinghouse case will be cited to the Connecticut Supreme Court because the Connecticut trial court had relied on the trial court decision in the Westinghouse case, said Union Carbide attorney Robert D. Chesler of Lowenstein, Sandler, Kohl, Fisher & Boylan in Roseland, N.J.

Similarly litigation filed by Hartford, Conn.-based United Technologies Corp. against more than 200 of its liability insurers for the costs to clean up 70 hazardous waste sites nationwide could be influenced by the appellate court ruling in the Westinghouse case.

Massachusetts Superior Court Judge John L. Murphy Jr. ruled in March that he would hear only portions of this litigation that involve the Massachusetts sites (*BI*, March 13).

A petition is pending before a Massachusetts appellate court seeking review of this decision, attorneys say.

Mr. Kalis, the Westinghouse attorney, also represents United Technologies, and Mr. Russell, who represented the insurers that tried to split the Westinghouse case, also represents the insurers that splintered the UTC litigation.

Mr. Kalis said he believes the appellate court ruling in the Westinghouse case will influence the UTC litigation.

But, Mr. Russell pointed out that the Westinghouse decision "has no binding effect" on Massachusetts courts. ■

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PROFILES

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Oregon fund surplus falls

SALEM, Ore.—Rising medical costs contributed to a $49.9 million decline in surplus in 1988 for the State Accident Insurance Fund Corp., which provides workers compensation insurance to 48,000 employers in Oregon, a spokeswoman said.

Despite the decline, SAIF reported a 1988 surplus of $153 million.

"We are not insolvent by any means," said the spokeswoman for the fund, which wrote $250 million in premium last year.

In a report SAIF made earlier this year to the Oregon Legislature, the insurer noted that unless meaningful reform of the state's workers compensation system occurs, SAIF's surplus would continue to decline at a similar rate on an annual basis, she explained.

For example, the insurer expects its surplus to decline by about another $50 million this year.

To help control costs, SAIF is recentralizing its claims processing systems by moving some 400 employees from branch offices back to its Salem headquarters, she said.

—By Donna DiBlase

Top 20 merger

Continued from page 1

The brokers' combined 1988 gross revenues of $341.6 come within $26 million of RBH's nearest competitor, Frank B. Hall & Co. Inc.

Hall reported $366.9 million in gross revenues in 1988, down 5.2% from $386 million in 1987, which represented a 1.3% decline from $390.9 million in 1986.

However, Bayly, Martin & Fay's revenues have shrunk in recent years, too. Its highest revenue this decade came in 1986, when BMF reported $92.7 million in gross revenues.

Since then, revenues have shrunk 19.4% to $74.7 million in 1988, largely because of the depressed oil industry and discontinued operations.

But while Bayly, Martin & Fay has "had some problems over the past several years, they are largely cleaned up" now, according to financial analyst Thomas G. Rosencrants, senior vp and director of research for Interstate/Johnson Lane in Atlanta.

"From the perspective of Bayly, Martin & Fay people, this is one of the best things that could happen to them," Mr. Rosencrants said.

"RBH is clearly on the upswing," he added.

Referring to RBH Chairman and Chief Executive Officer Patrick G. Ryan, who is also president and CEO of Aon, Mr. Rosencrants said: "Pat Ryan has demonstrated the ability to make acquisitions that make sense and fold them into his existing operations with a minimum of hassles on both sides. There aren't too many people who could accomplish that."

Mr. Rosencrants said that "the odds appear to be quite high that RBH revenues will meet or exceed Frank B. Hall's sometime in 1990."

He also pointed out that acquisitions RBH made in December 1988 and January 1989 also will contribute to RBH's gross revenues in 1989.

RBH's and BMF's combined revenues "would lift them above Frank B. Hall" within 12 months after the acquisition, predicted financial analyst Samuel G. Liss, director of Salomon Bros. in New York.

"From a national broker ranking point of view, it's an important move for Aon," although the proposed acquisition's revenue impact on Aon Corp.'s total revenues would not be significant, Mr. Liss said.

"Culturally, there is a very good match," said RBH President and Chief Operating Officer Arthur F. Quern.

"They (BMF) are very service oriented, as we have been, and in the last few years they have done an excellent job of expense control and expense management. They've focused on niche strategies, developed some strengths in selected areas and tried to create a good cadre of professionals," Mr. Quern added.

"Plus, both organizations have a strong history of major account risk management," Mr. Ryan said.

This is "clearly a situation where two major brokers, coming together, make for one much stronger" broker, Mr. Ryan said.

The two brokers represent a "very strong fit," he said.

"It's one of those marriages made in heaven," BMF's Mr. Kent observed.

Neither Mr. Ryan nor Mr. Kent would discuss any plans for a management restructuring after the acquisition.

"We're certainly conscious of the fact that they have some excellent employees who we are getting with the transaction, but we would not want to comment on who is going to manage what. We are not at that stage," Mr. Ryan said.

The transaction is subject to "the execution of mutually acceptable definitive agreements, regulatory approval and satisfactory completion of buyer due diligence studies," Aon announced.

RBH and BMF attorneys are currently working on filing papers seeking approval of the merger under the federal Hart-Scott-Rodino Antitrust Improvement Act of 1976, under which the Department of Justice must approve acquisitions to ensure they do not violate federal antitrust laws, Mr. Kent explained.

'It's one of those marriages made in heaven,' BMF's Greg B. Kent says of the merger with RBH.

The proposed acquisition "is consistent with the Aon strategy of continuing to build a major position in the commercial insurance brokerage business," Mr. Ryan explained.

Aon has been "systematically" pursuing a strategy "to invest in the growth of Rollins Burdick Hunter Group over the last five years," he noted.

"We have invested a lot of resources in this segment of the business."

Mr. Kent explained that acquisition discussions grew out of talks he and RBH had had about the sale of a small BMF office that, ironically, BMF eventually sold to another broker.

"We weren't looking for a buyer" originally, he said.

However, "when you sit down and talk to someone and start talking about your company and what you do, as time went on, things got very interesting," he said.

"We like to build on specific strengths—acquisitions where we can complement what the acquired company brings and they can bring specific skills to us—and I think that's what you see in this acquisition," Mr. Ryan said.

BMF's operations "will fit in nicely" with RBH's, agreed Mr. Rosencrants of Interstate/Johnson Lane.

Messrs. Ryan, Quern and Kent pointed out that the proposed merger will strengthen several niche markets for RBH.

For example, both brokers are strong in marketing insurance for the energy, aviation and real estate industries, they said.

BMF's expertise "in the energy field complements the strength we have in that area," Mr. Quern said.

In addition, both brokers provide brokerage and risk management services for companies formed as a result of leveraged buyouts, Mr. Kent pointed out.

"That's one area we'll put a great deal of focus on after the transaction is completed," Mr. Kent said. "We already are, and so are they," he added.

Other niche markets that BMF would bring to RBH include entertainment. BMF's American National General Agencies Inc. wholesale operation specializes in the entertainment business and has offices in New York; Los Angeles; Denver; Phoenix, Ariz.; St. Louis; and London.

ANGA serves as an underwriting manager and holds an exclusive marketing arrangement with Chubb Corp. to write entertainment accounts on the East and West coasts (*BI*, June 20, 1988).

BMF generates 16.6% of gross revenues from wholesale brokerage operations. RBH does not currently have wholesale brokerage operations.

Other niche markets BMF has developed are:

- Municipal liability, which is marketed by wholesaler MarinCo Inc. in San Antonio, Texas.
- Gaming. In response to the booming gaming industry, BMF has offices in Las Vegas; Reno, Nev.; and Atlantic City, N.J. RBH does not have brokerage offices in any of those cities.
- Jewelers block.
- Underwater diving.

"They have developed some real expertise in niche identification and specialization," Mr. Quern said.

The merger also will bring RBH into 14 new cities and improve the broker's presence in the South and West.

"There are geographic locations they have that we don't and we have that they don't," said Mr. Ryan.

RBH has 42 U.S. retail brokerage offices, and BMF has 26.

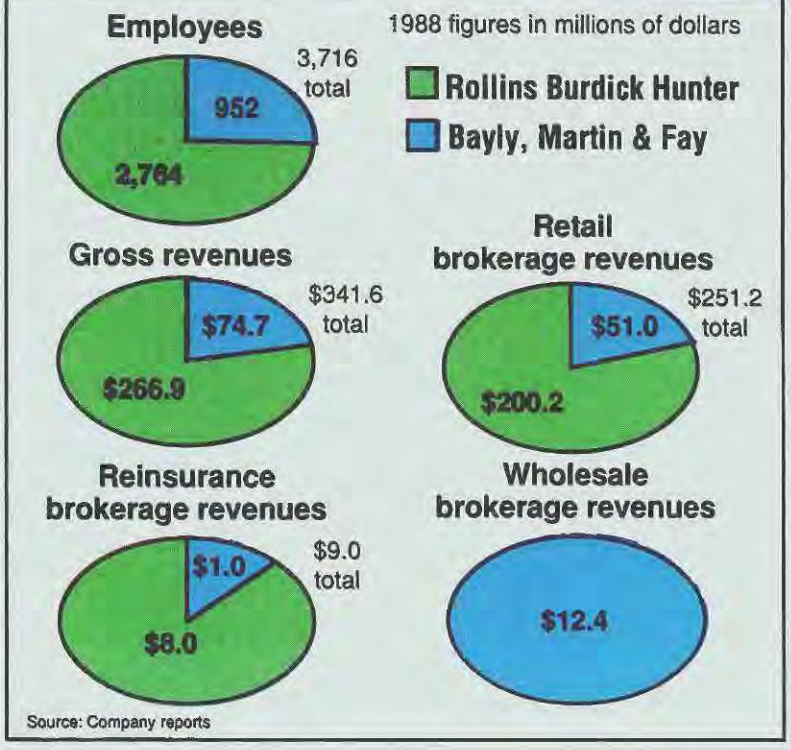
RBH generally has the larger office in the majority of the 12 cities where both brokers have a presence, according to Mr. Quern.

"We think the combination (of offices) in those places looks very promising," Mr. Quern observed.

"The combination would add to our Florida presence nicely, increase our Texas presence and add to our Southern California presence, which is something we have been building for awhile," Mr. Quern said.

"They are also in Atlantic City, N.J., which we are not," Mr. Quern added. ■

How RBH and BMF stack up



Source: Company reports

Update

City considers 'live-in' benefits

SAN FRANCISCO—A proposed city law that would extend some employee benefits traditionally offered only to married city workers to non-married city workers with "domestic partners" is expected to unanimously pass the San Francisco Board of Supervisors on Tuesday, according to a spokesman for Mayor Art Agnos.

The domestic partnerships law proposed by city Supervisor Harry Britt "gives non-married city employees the same sick leave, bereavement leave and maternity (paternity) leave benefits as married workers," the spokesman said.

However, the law would not require the city to extend health insurance benefits to domestic partners of city employees. "These benefits are approved and provided through the city's Health Services System," the spokesman explained.

The city does not pay for the health benefits of spouses or dependents of city employees. However, the legislation would enable the mayor to create a task force to study the possibility of extending health benefits to both married and non-married dependents and partners of city employees, the spokesman said.

Outhwaite plan being studied

LONDON—R.H.M. Outhwaite (Underwriting Agencies) Ltd. is trying to persuade Lloyd's of London to accept a plan to settle syndicate 317/661's problems stemming from runoff reinsurance policies the syndicate wrote in 1982 and earlier years.

The proposed plan includes the use of financial reinsurance to cover future payments of the losses, confirmed a spokesman from Lloyd's broker C.E. Heath P.L.C., which devised the plan with Outhwaite and London-based Midland Bank P.L.C.

Although Midland Bank confirmed it "is in discussions about the Outhwaite matter," neither it nor Heath would comment further on the plan, which was presented to Lloyd's Chairman Murray Lawrence in mid-April. Lloyd's also refused to comment.

Last year, Outhwaite reported that outstanding liabilities for the 1982 underwriting year stood at 263.3 million pounds ($410.7 million at current exchange rates), which, after reinsurance, would result in a loss to members of 85.4 million pounds ($133.2 million). However, uncertainty over total losses has forced Outhwaite to keep the 1982 account open (*BI*, Aug. 29, 1988).

The agency's proposal would involve a substantial payment by Outhwaite members but, in return, the members' liability would be capped, market sources say.

Meanwhile, Outhwaite has not released the 1988 results from the syndicate's 1982 underwriting year because auditor Ernst & Whinney says Outhwaite's estimate of outstanding liabilities is too low.

Wrongful dismissal damages

SAN FRANCISCO—A California Supreme Court decision that prohibits plaintiffs from seeking punitive and emotional distress damages from former employers in wrongful dismissal cases applies retroactively to thousands of cases pending in state courts, the court ruled last week.

In *Robert Newman vs. Emerson Radio Corp.*, the court, by a 4-3 vote, found that its Dec. 29 decision in *Foley vs. Interactive Data Corp.* applies to all wrongful dismissal cases pending as of Jan. 30.

Extension of the Foley ruling to pending cases could force retrial of many wrongful dismissal claims that have already been tried and for which verdicts have been reached, said Brad Seligman, an attorney with Farnsworth, Saperstein & Seligman in Oakland, Calif. Mr. Seligman represented a consortium of law groups, including the California Trial Lawyers Assn., in arguing in the Newman case that the court should not apply its Foley decision retroactively.

Reinsurers' combined ratio up

WASHINGTON—The U.S. reinsurance industry posted a 103.3% combined ratio for the first quarter of 1989, according to a survey of 76 reinsurers by the Reinsurance Assn. of America.

The industry had posted a 101.2% combined ratio for the comparable period a year ago, according to a 1988 RAA survey of 78 reinsurers (*BI*, June 27, 1988).

The 76 reinsurers surveyed for 1989's first quarter posted $3 billion in net premiums written, down 3.2% from $3.2 billion in 1988's first quarter. They reported a 72.7% loss ratio and a 30.6% expense ratio.

Briefly noted

UNR Industries Inc. has reached settlements totaling $43 million with four insurers over asbestos bodily injury claims. Under terms of the settlements, Home Insurance Co. will pay approximately $24.5 million; Continental Insurance Co. and First State Insurance Co. will pay $7 million each; and Zurich Insurance Co. will pay $4.5 million. To date, UNR has reached settlements with its insurers totaling $71.8 million. . . .**The Home Group Inc.** has changed its name to AmBase Corp., effective May 19. . . .A hearing on the **insurance industry antitrust litigation** originally scheduled for July 7 in U.S. District Court in San Francisco has now been set for Sept. 15 at 11 a.m. (*BI*, May 1). . . .The California 1st District Appellate Court on May 23 rejected several insurers' petition for a rehearing of its decision that **Aerojet-General Corp.** is insured for the costs of a massive hazardous waste cleanup (*BI*, May 1). The court denied the insurers' contention that the court ignored pertinent information. . . **USF&G Corp.** has put up for sale its Canadian property/casualty insurance operations to focus on its U.S. business. USF&G, which has written property/casualty insurance throughout Canada since 1903, wrote $100 million Canadian ($83.8 million at year-end exchange rates) in premiums in 1988. . . .**David Walker**, assistant secretary at the Labor Department's Office of Pension and Welfare Benefits Administration, is resigning next month to become national director for compensation and benefits in the Washington, D.C., office of Arthur Andersen & Co. . . .**Zurich Insurance Co.** has completed its acquisition of Maryland Casualty Co., the property/casualty insurance unit of American General Corp., for $740 million (*BI*, Feb. 20).

Howden trial

Continued from page 3

Carpenter—along with former Howden Deputy Chairman Ronald Comery and former Director Allan Page—owned and controlled a "secret empire," which they funded by siphoning off Howden and Lloyd's syndicate premiums through reinsurance transactions. Dividends from the holdings were intended to benefit them, their families and others, including Mr. Posgate, prosecutors say.

Among the holdings: shares in a secret Swiss syndicate that owned 51% of the Banque du Rhone et de la Tamise, a Swiss bank bought from Howden.

Mr. Comery died in 1987. Charges against Mr. Page were dropped last year because he is terminally ill.

During his testimony, Mr. Bogardus, who remains an A&A director, said A&A approached Mr. Grob about a merger in August 1981, after a planned merger with Sedgwick Group P.L.C. fell through.

The Howden acquisition team—including Messrs. Grob, Comery and Carpenter—was asked to provide audited financial statements and "general business information," said Mr. Bogardus. From the information provided, Howden looked like "it was on a good course" and nothing reported "displeased" A&A, he said.

In September 1981, based on the information from Howden, A&A offered to buy Howden, he said. Ultimately, A&A paid $299.9 million in stock and cash for Howden (*BI*, Sept. 28, 1981).

From September 1981 until January 1982, when the A&A offer became unconditional, A&A officials headed by then-Chief Financial Officer William F. Farley examined Howden's financial records. But at no time did Howden officials reveal that Messrs. Grob, Page, Carpenter and Comery held secret interests in, among other things, reinsurers that accepted business from Howden units, the former A&A officials said.

Had A&A been told of these holdings, it could have affected the outcome of the merger negotiations, said Mr. Bogardus. A&A would have had to investigate the information "as part of the due diligence" process before an acquisition, he said.

A&A management also was not told during the merger negotiations that the four Howden executives and Mr. Posgate each had a share in a syndicate that bought the Banque du Rhone, Mr. Bogardus said.

As part of the acquisition agreement, directors on both sides had to sign "responsibility statements" to say that information and documents discussed during the negotiations were accurate, he said.

On Feb. 12, Mr. Page telephoned A&A's Mr. Farley to say that Mr. Posgate's syndicate, which was managed by Alexander Howden Underwriting Ltd., would post a loss for the 1979 underwriting year, which was then closing, Mr. Farley testified. Mr. Page said the expected loss was 15 million pounds ($23.4 million at current exchange rates) and indicated that about 5 million pounds ($7.8 million) of the loss was reinsured with Sphere Drake Insurance Co. Ltd., a Howden unit, said Mr. Farley. That loss exceeded Sphere Drake's reserves, Mr. Farley said he was told.

Then, at a meeting in early March with Messrs. Page, Carpenter and Comery, Mr. Farley said he learned that the syndicate's loss was 50 million pounds ($78 million), rather than 15 million pounds, and that Sphere Drake's and Howden's Bermuda underwriting operations' share of the loss was 15 million pounds of the loss rather than 5 million pounds.

The Howden executives expressed surprise about the claims and the size of the Posgate loss and said they were told by Mr. Posgate that there would be a profit in 1979, said Mr. Farley.

On March 18, during a regular A&A board meeting at Howden's headquarters in London, Mr. Grob gave an oral report on the underwriting problem. "He said it was a total surprise to him," Mr. Bogardus testified. "We made it known to him that (it) wasn't satisfactory that the Howden group had taken the risk inhouse. It was contrary to what we were told during negotiations."

Because of the syndicate's loss and its reinsurance with Howden underwriting operations, Mr. Bogardus said he instructed A&A auditor Deloitte Haskins & Sells to widen its investigation into Howden's books. Deloitte already was auditing Howden for U.S. regulatory purposes.

Mr. Bogardus confirmed that Deloitte subsequently uncovered information concerning Southern International Reinsurance Co. S.A., a company that prosecutors allege was a bogus Panamanian reinsurer secretly owned by Messrs. Grob, Carpenter, Comery and Page. Sphere Drake had retroceded business written by Mr. Posgate's syndicate to SIR for a 5.2 million pound ($8.1 million) premium, he said.

Mr. Bogardus recalled that he later asked Mr. Grob whether SIR was a licensed insurance company, "and he said 'Yes, in Panama, and if not in Panama, in Switzerland.' "

In May 1981, Mr. Farley testified he traveled to London to learn more about SIR and the Howden underwriting shortfall.

"Day by day we were learning things," said Mr. Farley.

For example, he said Mr. Grob told him that SIR was established by "some friends" of the Howden group to help Howden average out its losses and profits in its underwriting business. Mr. Grob explained that Howden "guaranteed the ($3 million) capital of SIR" and guaranteed "a rate of interest" on the capital, according to Mr. Farley.

But Mr. Farley said he was told by other Howden employees that SIR was managed and controlled "by Howden people."

Throughout the discussions with Howden executives, Mr. Farley said he had insisted that the owners of SIR be revealed and that financial statements be released along with a list of contracts between Howden units and SIR. But he was told that the owners could not be revealed because of Swiss secrecy laws and that any information about the company could be obtained from Mario Benbassat, a director of the Banque du Rhone, said Mr. Farley.

In fact, he said Mr. Grob told him "I was making mountains out of molehills and if I understood reinsurance a little better, I'd know this wasn't a problem."

On June 15, 1982, Mr. Page sent a letter to Mr. Farley that stated that Sphere Drake's deficit, excluding the 5.2 million pounds owed to SIR, totaled 15.2 million pounds ($23.7 million) and asked that A&A cover the shortfall, Mr. Farley said.

On June 30, Mr. Farley and then-A&A Treasurer Ronald Berardi met with Howden executives to discuss SIR, among other things, said both Mr. Farley and Mr. Berardi, who now is executive vp and chief financial officer at Fred S. James & Co. Inc.

During the meeting Mr. Page indicated that SIR was formed by Swiss bankers for $3 million and that SIR's owners were only known by the Swiss bankers because of secrecy laws, said Mr. Berardi, who read from his notes from the meeting. Otherwise, "we received literally no answers" about SIR, he said.

Another meeting with Howden executives concerning SIR was held in early July, Messrs. Farley, Berardi and Bogardus testified. "For the first time, we saw a list of contracts of money out of Howden and into SIR," said Mr. Farley, adding that Howden ceded more than $50 million to SIR.

Mr. Page also said that for 8.8 million pounds ($13.7 million) "A&A could purchase SIR and take it over," Mr. Berardi recalled.

Mr. Farley said that he was not satisfied with the information A&A was being given about SIR and grew "quite irritated. . . .I requested specifically that they turn the (SIR) records over to me and to Deloitte."

Mr. Farley also had discovered that Mr. Grob was the chairman of the Banque du Rhone and requested that Mr. Grob force Mr. Benbassat to release information about SIR.

Following these discussions, A&A officials conducted a series of intense meetings the week of July 5, including a "social" dinner between Mr. Bogardus and Mr. Posgate on July 8. At the dinner, Mr. Posgate told Mr. Bogardus that Messrs. Grob, Comery, Carpenter and Page were "crooks" and that he was "tainted" by their actions, Mr. Bogardus recalls.

During the course of the evening the two men also discussed "works of art" in Mr. Posgate's possession, Mr. Bogardus said. A&A by that time had uncovered in its investigations that some works of art held by Mr. Posgate were bought with money from SIR and in reality belonged to Howden, A&A officials testified.

In particular, A&A understood that Mr. Posgate had received, through Mr. Grob, a Henry Moore statue and paintings by Pissarro and Redon that belonged to the company, Mr. Bogardus said.

During the dinner, Mr. Posgate "said the statue was on loan from the company," Mr. Bogardus testified. "About the Redon, I don't remember what he said. The Pissarro he first said was not his, but I vividly remember him saying 'You can go down right now and pick it up from my house if you want.' "

Mr. Bogardus said he also asked Mr. Posgate if he was an owner of the Banque du Rhone. "He said he was not."

Later on July 8, Messrs. Farley, Berardi, Bogardus and others decided if they were not given satisfactory information the next day, A&A would instruct Deloitte to "secure the building" and search for documents on SIR, said Mr. Berardi.

On July 9, Mr. Bogardus confirmed he went to Mr. Grob's house in London with at least one other A&A official and told Mr. Grob that A&A had decided to "suspend" Messrs. Carpenter and Page as well as Sydney Todd, who worked for Mr. Page, from the Howden offices.

"We told Mr. Grob that we would need to examine papers and files in those offices and needed complete freedom to do so and we couldn't with them on the premises," Mr. Bogardus recalled. "He said he wanted to speak to them first and I think we agreed. Then we went back to the Howden offices (and) we waited a short period of time."

Meanwhile, Mr. Berardi said, he and Deloitte representatives met with Mr. Page and possibly Mr. Carpenter. During the meeting, Mr. Berardi said Mr. Page took a telephone call and said that he had to leave the meeting to go to Mr. Grob's house.

That was Mr. Berardi's prearranged cue to call Deloitte's and have the auditor seal the building, Mr. Berardi told the jury. Messrs. Grob, Carpenter, Page and Comery were not allowed back into the building without an escort and were not allowed to take any documents without permission, the jury was told.

"I authorized searches," said Mr. Bogardus.

Mr. Page at one stage tried to retrieve his briefcase and lied to Mr. Berardi that Mr. Farley had given his permission, when in fact he had not, Mr. Berardi said.

When the briefcase was searched by Mr. Berardi and Deloitte staffers, they found bank statements for trusts secretly owned by the four Howden executives, Mr. Berardi said. And on Mr. Page's desk was a power of attorney for SIR, Mr. Berardi said.

In addition, statements from the Banque du Rhone and documents concerning SIR and another allegedly bogus reinsurer, New Southern Reinsurance S.A., were found in Mr. Todd's briefcase, Mr. Berardi said.

On July 27, A&A announced that it was extending its fair value audit of Howden to examine accounting "irregularities" amid rumors that millions of pounds were missing from the company (*BI*, Aug. 2, 1982).

Mr. Bogardus said he met with Tony Shearer, who headed the Deloitte investigation, "on a daily basis" after July 27 and received a list of companies about which Mr. Bogardus questioned Mr. Grob at a private meeting around that date. The companies included the Banque du Rhone; several reinsurance companies, including SIR; an entity called IRA Anstalt, which allegedly paid $750,000 for Mr. Grob's villa in France; "Donner" Holdings, also called Denaidon Holdings, which was allegedly set up to buy Mr. Posgate's house; and several trusts that allegedly were set up to siphon money from Howden to capitalize SIR and buy the Banque du Rhone, among other things.

Although Mr. Grob gave a partial explanation concerning the ownership of the Banque du Rhone, "he said he disclaimed any knowledge of anything on the list. . .and said they were connected to Mr. Page in some way," said Mr. Bogardus.

After a series of negotiations, A&A reached a settlement in the early hours of Aug. 14 with Messrs. Grob, Carpenter, Comery and Page to hand over assets that A&A claimed belonged to Howden, Mr. Bogardus said. In return, A&A said it wouldn't sue the ex-Howden officials for their alleged misuse of $56 million in Howden assets (*BI*, Sept. 27, 1982).

Also on Aug. 14, A&A officials—including Mr. Bogardus, Mr. Berardi and current A&A Chairman Tinsley Irvin—met with Mr. Posgate at his house and discussed, among other things, his works of art.

Mr. Bogardus testified that Mr. Posgate now took the position that the Pissarro "was a gift from Howden to him and it was his picture. I believe he said it was a gift made by Mr. Grob, but was the company's gift and not Mr. Grob's private gift."

In addition, Mr. Posgate denied he was an owner of the Banque du Rhone, but then said that he might have an interest in the bank because "Mr. Grob had a tendency to give gifts without telling anyone about them," Mr. Bogardus said.

Mr. Posgate then phoned Mr. Benbassat at the bank and ascertained that he was an owner, Mr. Berardi said. Mr. Posgate then asked Mr. Benbassat how he could turn over the shares "immediately" to A&A, said Mr. Berardi.

The alleged misappropriation of funds at Howden was publicly revealed on Sept. 20, 1982, when A&A filed suit against Messrs. Grob, Carpenter, Comery, Page and Posgate, following the discovery of additional misappropriations.

The trial is scheduled to continue this week with Mr. Irvin and Mr. Benbassat among the witnesses. ■

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State Farm insureds seek dividends

By STACY ADLER

LOS ANGELES—In another attack on State Farm Mutual Auto Insurance Co., California automobile policyholders are charging that the mutual insurer is retaining too much of its policyholders' premiums as surplus, rather than issuing dividends.

This latest allegation is an amendment to an earlier policyholder lawsuit against Bloomington, Ill.-based State Farm alleging the insurer should not have used policyholder surplus to contribute to the Proposition 103 battle in California (*BI*, Sept. 5, 1988; Aug. 22, 1988).

Los Angeles Superior Court Judge Barnet Cooperman had refused to uphold an injunction stopping State Farm from contributing to the political battle in California, but permitted the plaintiffs to amend their original lawsuit.

In their amended lawsuit filed May 22, the policyholders seek future rate reductions equaling the estimated $5 million spent to fight Proposition 103, and $6.87 billion in dividends from the insurer's surplus.

Policyholders call State Farm's premium-to-surplus ratio of 1.23-to-1 for 1988 "unconscionable." The lawsuit points out that the average premium-to-surplus ratio of the 20 largest property/casualty insurers is 2.17-to-1.

"State Farm, unlike any other major property and casualty company, is pursuing a bizarre policy of accumulating more and more and more surplus by refusing to distribute reasonable dividends and by plowing its extra premium and investment income back into the surplus," the amended complaint alleges.

The policyholders say if State Farm distributes $6.87 billion of its surplus to its policyholders in the form of a dividend, the insurer's premium-to-surplus ratio would be in line with industry averages.

A State Farm spokesman said the company believes it needs a large surplus—$14 billion at year-end 1987—to back up the 50 million policies, totaling $13.5 million in direct written premiums, the giant insurer writes. "It is not excessive," he said.

However, "State Farm retains 260% more than the most miserly company," says William Shernoff, the attorney who filed the suit on behalf of policyholders. Because the policyholders of a mutual insurer are the owners of the insurer, they are entitled to decide what the premium-to-surplus ratio should be, he added.

The problem is that "psychologically, most policyholders don't realize they are the owners of a mutual insurance company," said Mr. Shernoff of Shernoff, Scott & Bidart in Claremont, Calif.

"Once policyholders wake up and realize they have dividend rights and rights to vote on management changes, it could revolutionize mutuals," he predicted.

The lawsuit was brought by longtime State Farm policyholder Benjamin G. Barnes on behalf of all State Farm policyholders. ■

Posgate's syndicate

Continued from page 3

pected to receive from other syndicates in the 1986 underwriting year that just closed under Lloyd's three-year accounting system.

In general, Lloyd's members had expected 1986 to be a banner year (see story, page 42). But the syndicate 126 cash call probably will "wipe out most of the members' profits," said the syndicate member.

Syndicate 126 shut down at the end of 1982, following allegations that Mr. Posgate was involved in the misappropriation of millions of pounds of funds from the syndicate and from underwriting units of Alexander Howden Group Ltd. (see story, page 3).

Mr. Posgate, who was chairman of Howden subsidiary Alexander Howden Underwriting Ltd. and managed syndicate 126 until he was fired by Alexander & Alexander Services Inc., which acquired Howden in 1982, currently is being tried on charges of conspiracy to defraud Howden and the syndicate members.

Mr. Posgate—who underwrote for syndicate 126 and marine syndicate 127, which were managed by AHUL, and for syndicate 700/701, which was managed by Posgate & Denby (Agencies) Ltd.—had been dubbed "Goldfinger" in the London market because his syndicates were always considered to be highly profitable.

However, ASM, which has been running off syndicate 126's business for the still-open 1980, 1981 and 1982 underwriting years, reported last year that the 1982 account was showing a loss of 38% of its stamp capacity of 26.9 million pounds ($42 million at current exchange rates), or 10.2 million pounds ($15.9 million).

ASM did not ask the members to fund the loss at that time.

In the letter sent May 3 to all members' agencies representing syndicate 126 names, ASM Chairman Jeremy Hardie said that because of new "loss advices" sent to the syndicate in December and January, the 1982 loss had ballooned to 123% of stamp capacity, or 33.1 million pounds ($51.7 million).

The syndicate's accounts had been reviewed earlier this year by the Tillinghast division of Towers, Perrin, Forster & Crosby Inc., he noted.

The huge deficit arises from a "general deterioration," and particularly from Mr. Posgate's alleged participation on an accountants professional liability line slip administered by Minet International Professional Indemnity Ltd., Mr. Hardie said.

For example, earlier this year, syndicate 126 was told by the Lloyd's Underwriting Non-Marine Claims Office that it owed more than $3.4 million for one day's claims on the Minet line slip, said Michael Harris, who took over the syndicate following Mr. Posgate's ouster in 1982.

However, syndicate 126 argues that it is not liable for losses filed under a 24-month discovery clause contained in the coverage. As a result, six of the Big Eight accounting firms are suing the syndicate for failing to extend coverage (*BI*, Dec. 12, 1988).

Mr. Hardie's letter says that syndicate 126's losses also relate to "asbestos losses and pollution related claims."

In addition to the 1982 loss, Mr. Hardie informed members of syndicate 126 that although the open 1980 and 1981 underwriting years were showing small profits, their results are deteriorating. As a result, no profits from those years will be distributed, he said.

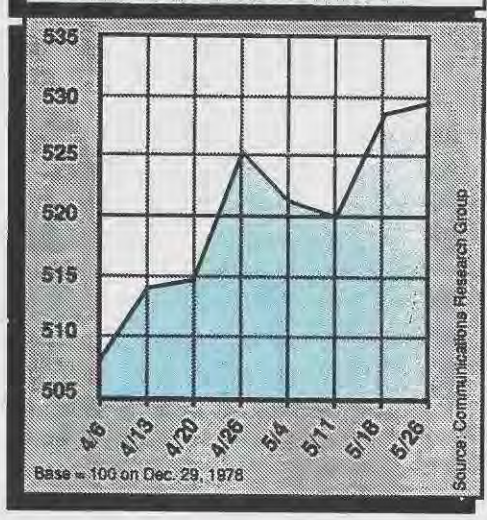
In the letter, ASM set a July 14 deadline for paying the cash call. And cash—not letters of credit—must be collected because most of the losses have to be paid in U.S. dollars.

The cash call was spurred, in part, by Lloyd's recent ruling that all U.S. dollar liabilities must be paid into Lloyd's American Trust Fund in cash rather than in letters of credit, said Mr. Harris (see story, page 40).

Meanwhile, Alexander Howden & Beck's Mr. Turner is investigating why the huge syndicate 126 loss wasn't anticipated in 1987, when Mr. Posgate's marine syndicate 700/701, which was managed by Posgate & Denby, recognized that its participation on the Minet slip would contribute to a 1982 loss equaling more than 80% of its stamp capacity.

Based on information from Lloyd's 1984 League Tables published by analyst Chatset Ltd., syndicate 700/701 showed a 1982 loss of 11.8 million pounds ($18.4 million at current exchange rates), or 83.7% of its 1982 stamp capacity of 14.1 million pounds ($22 million). ■

BI Insurance Index



Insurance industry stocks continued to climb last week, as the *Business Insurance Index* rose 1.0 points to 529.6 on May 25, from 528.6 on May 18. Advancing issues were led by Seibels Bruce Group Inc., up 11.1%; American Indemnity Financial Corp., up 10.9%; and Forum Re Group (Bermuda), up 10.6%. Declining issues followed Western Health Plans Inc., down 16%; U.S. Healthcare, down 8.8%; and FHP International Corp., down 7.3%. The most active issue during the period was Sears, Roebuck & Co. (Allstate), 4.9 million shares traded. The *BI Index* gained a slight 0.2% for the period; the Dow Jones 30 Industrials were up 0.5%; and the Standard & Poor's 500 and the New York Stock Exchange Composite each gained 0.4%.

British Issues

May 25 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High	1 Week Low
Comml Union	372	12.9	25.3	6.8	381	372
Genl Accident	966	9.0	58.7	6.1	973	965
Gdn Royal Exch	206	10.6	13.3	6.5	212	206
Royal	400	12.5	30.0	7.5	407	400
Sun Alliance	1103	8.6	54.7	5.0	1129	1103
Brokers						
Bradstock	222	12.5	9.0	4.1	222	222
CE Heath	482	15.3	34.5	7.2	482	480
Hogg Robinson	140	12.4	8.7	6.2	145	140
Lloyd Thompson	220	16.9	8.0	3.6	221	220
PWS Holdings	50	13.5	4.6	9.3	50	46
Sedgwick Grp	260	21.5	16.0	6.2	262	257
Steel Brrl Jones	230	19.7	13.3	5.8	231	230
Willis Faber	229	17.0	15.3	6.7	238	229

Source: Philip Olsen/Alan Clifton, Insurance Industry Specialists Kitcat & Aitken Stockbrokers, London

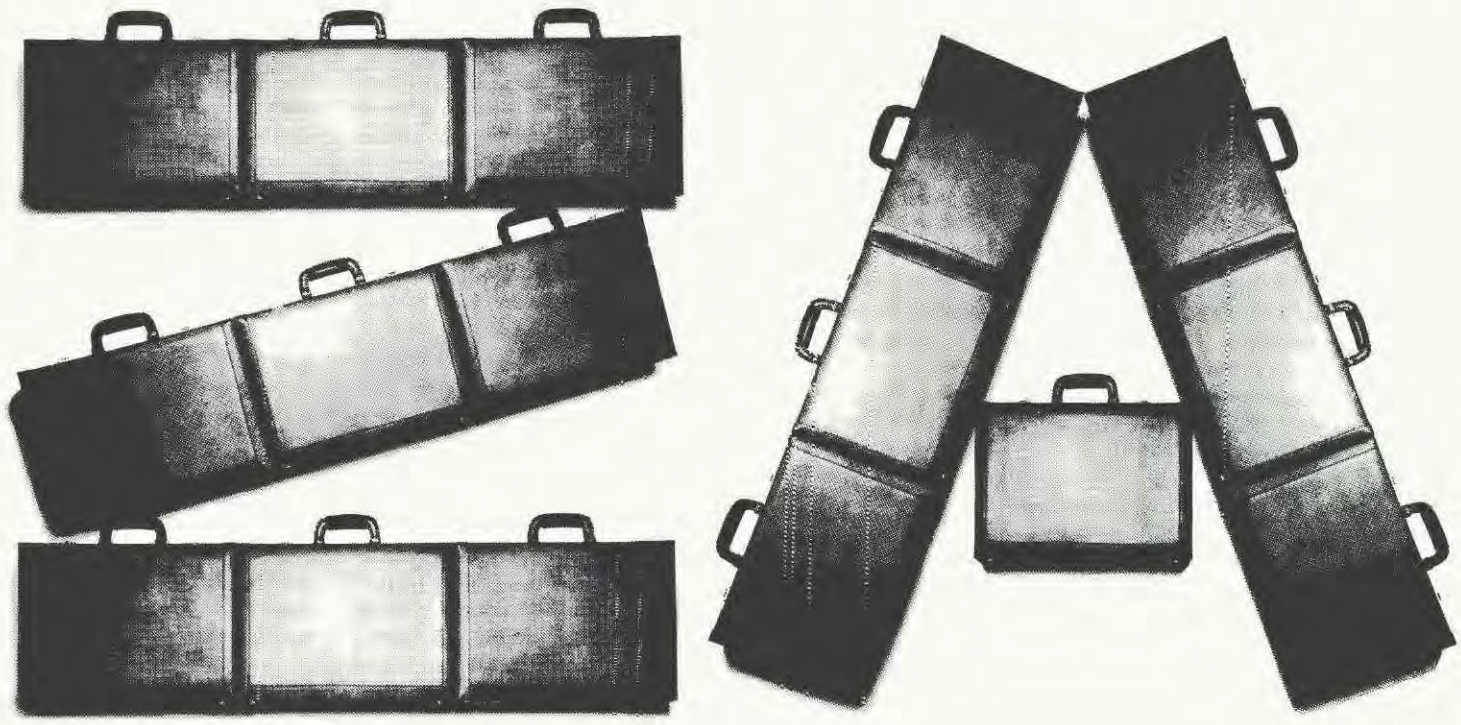
BI Industry Stock Report

MAY 25, 1989 — 5/19/89 THRU 5/25/89

		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 Svcs	NYSE	25.13	0.5	6.9	26.50	22.63	288	1.00	4.0	17.0	3.71	6.77
Corroon & Black Corp	NYSE	35.50	1.4	14.0	35.75	30.75	273	1.24	3.5	13.9	12.40	2.86
Gallagher Arthur J. & Co	NYSE	19.63	0.0	17.2	19.88	16.13	14	0.52	2.6	13.9	5.33	3.68
Hall Frank B. & Co	NYSE	3.50	3.6	21.5	4.63	2.50	160	0.00	0.0	-2.0	0.00	N/A
Hilb, Rogal & Hamilton	OTC	14.50	1.8	-4.9	15.75	13.75	120	0.20	1.4	13.1	4.60	3.15
Marsh & McLennan Cos. Inc.	NYSE	61.25	0.2	8.9	64.50	55.13	516	2.50	4.1	15.2	6.48	9.45
Poe & Assoc Inc	OTC	8.75	0.0	6.1	8.75	8.25	0	0.40	4.6	9.5	0.27	32.41
BROKERS	AVERAGE		1.1	10.0					2.9	11.5		
CONGLOMERATES & HOLDING COMPANIES												
Berkley W R. Corp	OTC	31.00	1.2	5.1	34.00	29.25	230	0.40	1.3	6.5	20.24	1.53
Berkshire Hathaway Inc. DEL	NYSE	6200.00	-1.2	31.9	6673.00	3567.00	74	0.00	0.0	21.9	2492.68	2.49
ITT (Hartford Group)	NYSE	58.38	2.4	16.5	59.50	49.75	1835	1.48	2.5	10.0	56.33	1.04
Sears Roebuck & Co. (Allstate)	NYSE	47.75	1.9	16.8	48.00	40.13	4878	2.00	4.2	17.9	36.09	1.32
CONGLOMERATES	AVERAGE		1.1	17.6					2.0	14.0		
INSURERS/REINSURERS												
Aetna Life & Cas Co	NYSE	53.50	0.9	13.2	54.88	46.75	589	2.76	5.2	8.2	58.11	0.92
AmBase Corp	NYSE	13.13	-0.9	19.4	14.50	11.00	49	0.20	1.5	5.3	18.66	0.70
American General Corp	NYSE	35.00	-2.5	17.1	36.13	29.50	824	1.50	4.3	10.6	28.04	1.25
Amer Heritage Life Invt	NYSE	26.75	2.9	3.9	27.88	25.00	2	1.20	4.5	10.6	22.47	1.19
Amer Indty Fin'l Corp	OTC	12.75	10.9	21.4	12.75	9.50	15	0.56	4.4	8.2	17.06	0.75
American Int'l Group	NYSE	82.13	-0.7	21.2	84.88	66.25	1014	0.48	0.6	11.5	33.55	2.45
Aon Corp	NYSE	33.88	0.7	21.0	34.25	27.00	349	1.40	4.1	11.8	16.67	2.03
Argonaut Group	OTC	54.38	0.2	24.3	56.00	43.50	83	0.00	0.0	7.5	36.83	1.48
AVEMCO Corp	NYSE	23.38	1.1	-9.7	26.13	22.63	15	0.40	1.7	12.3	9.20	2.54
Baldwin & Lyons Inc	OTC	17.38	1.5	16.8	17.50	14.50	2	0.20	1.2	6.8	17.57	0.99
Belvedere Corp	AMEX	5.00	-2.5	11.1	6.50	4.50	4	0.04	0.8	7.6	8.43	0.59
Chandler Insurance	OTC	11.75	-1.1	27.0	0.00	0.00	129	0.00	0.0	5.4	8.93	1.32
Chubb Corp	NYSE	68.25	2.8	17.7	69.00	57.63	772	2.32	3.4	7.9	53.50	1.28
CIGNA Corp	NYSE	54.75	2.3	16.2	56.13	45.88	612	2.96	5.4	9.6	53.08	1.03
CNA Fin'l Corp	NYSE	71.38	1.1	18.0	73.25	57.63	232	0.00	0.0	11.1	46.40	1.54
Continental Corp	NYSE	35.00	2.2	8.1	36.00	31.50	743	2.60	7.4	23.8	42.10	0.83
Durham Corp	OTC	32.50	0.0	-1.5	33.75	30.00	16	0.92	2.8	18.8	26.32	1.23
Fireman's Fund Corp	NYSE	32.88	2.8	12.4	34.88	29.00	497	0.60	1.8	8.2	32.74	1.00
Forum Re (Bermuda)	OTC	1.25	10.6	-23.3	1.75	1.13	0	0.00	0.0	-9.6	2.53	0.49
Fremont Gen Corp	OTC	15.25	-4.7	14.0	18.25	12.13	228	0.60	3.9	11.7	16.06	0.95
Frontier Insurance Group	OTC	15.75	2.4	26.0	0.00	0.00	31	0.00	0.0	7.4	7.53	2.09
General Re Corp	NYSE	64.25	-1.0	15.8	68.25	54.38	985	1.36	2.1	12.1	29.04	2.21
Hanover Ins Co	OTC	26.25	0.0	-1.9	30.25	25.75	68	0.44	1.7	5.4	31.47	0.83
Harleysville Group Inc	OTC	22.38	-0.5	24.3	0.00	0.00	13	0.48	2.1	7.8	18.94	1.18
Hartford Steam Boiler	OTC	41.25	1.2	12.2	42.50	34.75	220	1.40	3.4	11.4	13.04	3.16
Kans City Life Ins	OTC	35.75	0.0	3.6	35.75	32.75	35	0.00	0.0	12.8	39.22	0.91
Kemper Corp	NYSE	35.75	-1.4	49.0	35.75	32.75	436	0.84	2.3	12.8	28.91	1.24
Lawrence Ins. Group	AMEX	7.75	-3.1	-1.6	8.50	6.63	3	0.24	3.1	16.5	3.19	2.43
Liberty Corp. S.C.	NYSE	33.63	-1.1	-6.6	38.00	32.50	281	0.80	2.4	19.1	21.17	1.59
Lincoln Nat'l Corp	NYSE	48.13	-1.0	9.4	50.63	42.75	211	2.48	5.2	11.9	39.12	1.23
NAC Re Corp	OTC	39.00	2.0	22.8	39.00	31.00	237	0.00	0.0	14.0	22.81	1.71
Navigators Group	OTC	24.50	2.1	22.5	25.25	20.50	4	0.00	0.0	10.5	15.22	1.61
Nobel Ins Ltd	OTC	2.25	-5.5	-52.6	5.00	1.50	93	0.42	8.7	-8.7	7.76	0.29
Northwestern Nat'l Life	OTC	34.13	-2.5	9.6	35.13	26.88	222	1.20	3.5	12.3	37.50	0.91
Ohio Cas Corp	OTC	43.00	-0.6	20.3	45.25	35.50	315	2.08	4.8	6.2	33.30	1.29
Olc Rep Int'l Corp	OTC	24.00	-0.5	0.0	28.88	23.38	285	0.74	3.1	13.4	26.50	0.91
Orion Cap Corp	NYSE	21.75	0.0	41.4	22.25	15.38	27	0.84	3.9	7.1	12.93	1.68
Phoenix Re Corp	OTC	9.38	0.0	-1.3	11.00	8.75	58	0.00	0.0	5.2	12.49	0.75
Protective Life Corp	OTC	14.38	1.8	8.5	14.50	12.88	56	0.70	4.9	71.9	14.54	0.99
Re Capital Corp	AMEX	11.25	4.7	23.2	11.25	9.13	6	0.00	0.0	11.3	12.60	0.89
RLI Corp.	NYSE	8.00	3.2	4.8	9.25	7.13	17	0.36	4.5	7.8	10.71	0.75
Provident Life & Acc Ins Co	OTC	23.00	5.1	19.5	0.00	0.00	640	0.68	3.0	9.7	21.96	1.05
St. Paul Cos. Inc.	OTC	49.88	0.8	14.7	51.00	43.00	600	2.20	4.4	6.8	32.00	1.56
SAFECO Corp	OTC	28.75	0.4	21.7	29.13	23.13	1099	1.20	4.2	7.2	24.88	1.16
SCOR US Corp	NYSE	8.75	-2.8	-4.2	9.50	7.50	23	0.20	2.3	6.6	10.35	0.85
Seibels Bruce Group Inc	OTC	12.50	11.1	9.8	0.00	0.00	67	0.80	6.4	10.4	13.42	0.93
Selective Ins Group Inc	OTC	24.00	0.0	4.3	25.50	21.75	48	1.40	5.8	5.2	22.33	1.07
Statesman Group Inc	OTC	2.56	2.4	-18.2	4.00	2.38	184	0.05	2.0	64.0	3.48	0.74
Tokio Marine & Fire Ins	OTC	72.25	-1.0	-20.9	95.50	70.75	47	0.22	0.3	43.8	0.00	N/A
Torchmark Corp.	NYSE	38.88	0.3	27.5	39.63	30.00	238	1.20	3.1	11.9	12.24	3.18
Transamerica Corp.	NYSE	34.63	0.4	2.2	36.00	32.75	425	1.88	5.4	7.8	30.70	1.13
Travelers Corp.	NYSE	40.63	2.2	16.9	40.88	34.50	942	2.40	5.9	31.7	44.85	0.91
Trenwick Group Inc	OTC	16.25	1.6	12.1	17.75	13.75	155	0.24	1.5	9.2	16.91	0.96
United Fire & Cas Co	OTC	30.75	2.5	0.8	30.75	29.00	11	1.20	3.9	5.6	22.56	1.36
United States Fid & Gty	NYSE	32.25	-0.8	13.2	33.13	28.50	586	2.80	8.7	12.0	22.57	1.43
UNUM Corp	NYSE	32.75	0.4	21.3	33.75	26.63	480	0.60	1.8	10.8	30.64	1.07
USLIFE Corp	NYSE	43.50	1.4	24.7	44.88	34.13	214	1.40	3.2	10.6	54.27	0.80
Washington Nat'l Corp	NYSE	25.38	-0.5	-6.0	27.63	24.00	13	1.08	4.3	-18.1	32.33	0.79
Zenith Nat'l Ins Corp	NYSE	18.38	0.0	5.0	19.75	16.75	77	0.80	4.4	8.5	13.61	1.35
INSURERS/REINSURERS	AVERAGE		0.9	10.5					3.2	11.8		
HEALTH MAINTENANCE ORGANIZATIONS												
FHP International Corp.	OTC	25.50	-7.3	110.2	29.00	11.75	417	0.00	0.0	13.0	3.54	7.20
HMO America Inc	OTC	3.25	-7.1	245.7	3.94	0.94	247	0.00	0.0	-5.2	1.12	2.90
Maxicare Health Plans	OTC	0.28	0.0	-62.7	0.81	0.13	0	0.00	0.0	0.0	0.00	N/A
Pacificare Health Systems	OTC	28.00	1.8	128.6	32.50	12.25	83	0.00	0.0	22.4	6.35	4.41
Safeguard Health Ent	OTC	7.50	1.6	36.4	0.00	0.00	192	0.00	0.0	12.7	2.99	2.51
Sierra Health Services	AMEX	4.25	-3.0	160.7	4.88	1.50	124	0.00	0.0	-3.5	1.59	2.67
United Health Services	OTC	8.88	0.0	97.3	0.00	0.00	504	0.00	0.0	3.9	2.59	3.43
United Medical Corp	AMEX	5.50	-6.5	4.8	6.75	5.13	10	0.00	0.0	1.7	4.11	1.34
U.S. Healthcare	OTC	11.75	-8.8	102.2	13.00	5.25	945	0.20	1.7	106.8	2.87	4.09
Western Health Plans Inc	AMEX	0.63	-16.0	-8.7	0.00	0.00	14	0.00	0.0	-0.3	0.82	0.77
HMOs	AVERAGE		-4.5	81.5					0.2	15.1		
ALL COMPANIES	AVERAGE		0.2	19.7					2.7	12.3		

System design: Communications Research Group

Who Covers Business Insurance From A to Z?



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