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Update

Jury grants policyholder coverage to pay for waste site cleanup

DENVER—Broderick Investment Co. can tap its liability insurance policies from 1976 to 1983 to pay for a multimillion-dollar hazardous waste cleanup, a jury has ruled.

A federal jury found that Broderick is covered for cleanup of a site near Denver because it did not intend to pollute third-party property, even though the company admitted to intentionally putting contaminants into unlined basins. However, the jury ruled Broderick could

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Market turn imminent, insurance buyers told

By DOUGLAS McLEOD

NEW YORK—Commercial insurance buyers should expect rate increases when renewing property and casualty insurance policies in coming months, warn insurers, brokers and industry analysts.

Following three years of intense rate competition and an unprecedented string of catastrophes, several U.S. insurers either have announced plans to hike commercial insurance rates or have suggested that a turn in the market is imminent.

Many others stop short of predicting a widespread turnaround, but add they will be reviewing risks on a case-by-case basis and boosting premiums where necessary.

Insurers are now more afraid of the antitrust implications of a rapid, widespread market hardening, and this may be one reason why some refuse to discuss pricing goals, observers note.

Meanwhile, some insurance brokers say they have yet to see any signs of rising prices and, in many cases, still find insurers competing for business.

However, brokers add they are monitoring renewal negotiations and predict that while some buyers may be able to renew programs at expiring rates, others will be hit with 10% to 20% rate increases by January (see related story).

"The hard market is here," says analyst Thomas G. Rosencrants, senior vp and director of research for Interstate/Johnson Lane in Atlanta. "People now expect that the turn will come in casualty lines as well as property lines."

"Those (insurers) that we've talked to are going to take the opportunity on renewals to raise their rates," said Ira H. Malis, securities analyst for Alex Brown & Sons Inc. in Baltimore.

"Their own reinsurance rates are going up and they've also taken a hit on" Hurricane Hugo, the California earthquake and the Phillips Petroleum Co. plant explosion in Pasadena, Texas, he added.

Several large insurance companies have cited these catastrophe losses in publicly announcing plans to raise rates or predicting a market turnaround.

In reporting a third-quarter net loss of $17.1 million, USF&G Corp. Chairman Jack Moseley said he has ordered underwriters "to seek price increases on all business, exclusive of any increase in exposure."

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Rate hikes to boost brokers' 1990 results

By LINDA J. COLLINS

The financial performance of publicly held insurance brokers should rebound in 1990 after being mired in the doldrums during 1989.

Rate increases that some insurers already are ordering in response to recent underwriting losses from Hurricane Hugo, the San Francisco earthquake and the explosion at the Phillips Petroleum Co. plant in Texas should help boost brokers' revenues next year, most brokers and analysts anticipate (see related story).

"Instead of the market turn we were anticipating for some time in the first half of 1990, we believe that turn is happening now," said analyst Michael A. Smith, vp of Shearson Lehman Hutton Inc. in New York.

"Some underwriters get religion when they see death," he quipped.

"The hard market is here," said analyst Thomas G. Rosencrants, senior vp and director of research for Interstate/Johnson Lane in Atlanta.

"For 1990, I'm expecting substantial revenue and earnings acceleration for the brokers, and the outlook for their stocks is very positive," Mr. Rosencrants added.

Ira H. Malis, securities analyst for Alex. Brown & Sons Inc. in Baltimore, agreed that a market turn is imminent.

"We're seeing it, and it's happening sooner than we thought

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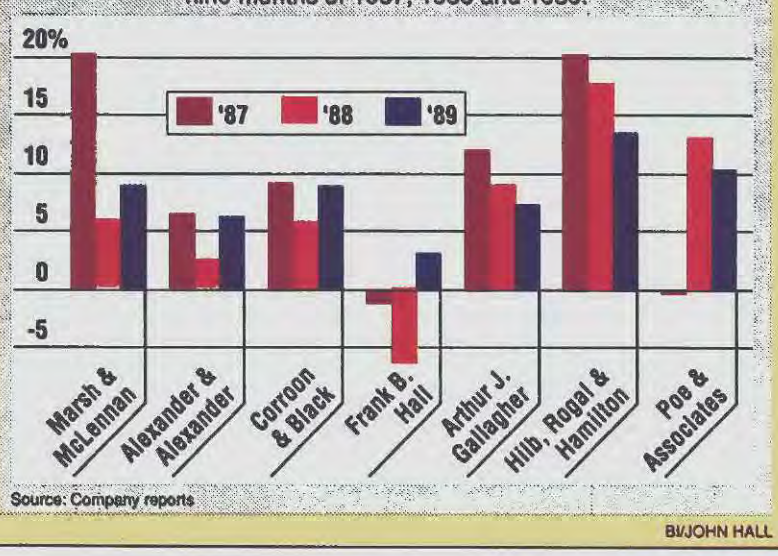
Brokers ready for rebound

Publicly held insurance brokers hope that rate hikes in 1990 will reverse their lackluster revenue gains. Figures are for the first nine months of 1987, 1988 and 1989.



Source: Company reports

BI/JOHN HALL

House, Senate deal final blow to Section 89

By JERRY GEISEL

WASHINGTON—Employers need no longer worry about complying with the dreaded Section 89 non-discrimination rules.

Last week, the House and Senate voted to repeal Section 89 of the Internal Revenue Code as part of legislation to raise the federal debt ceiling. President Bush's signature made the bill law last week.

The provision to repeal Section 89, undoubtedly the most despised benefits statute ever enacted by Congress, was shifted to the debt ceiling bill under an agreement reached earlier in the week by congressional leaders.

A provision to repeal Section 89 had been part of a mammoth budget reconciliation bill the House passed last month. However, the Senate later stripped Section 89 from its budget bill along with hundreds of other provisions not related to the budget bill's major purpose: reducing the federal deficit.

After weeks of negotiations, congressional leaders agreed last week to tack the repeal of Section 89 to the debt ceiling bill rather than try to include it in the slimmed-down budget reconciliation bill now being hammered out by a House-Senate conference committee.

Employers say the repeal came not a moment too soon. Section 89 originally was to have been effective Jan. 1, but was delayed several times by the Treasury Department and finally was scheduled to take effect Dec. 1.

Business leaders last week hailed the House and Senate votes to repeal Section 89.

"The long Section 89 nightmare is over. This was the biggest congressional folly ever in the employee benefit arena and at last Section 89 has met the end it deserved," said Howard Weizmann, executive director of the Assn. of Private Pension & Welfare Plans

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Allegedly inflated surplus

Grand Jury indicts ex-Transit official

By DOUGLAS McLEOD

JEFFERSON CITY, Mo.—Former Transit Casualty Co. President George P. Bowie is facing criminal charges that he falsely inflated Transit's surplus in an annual statement filed nine months before the insurer collapsed.

A one-count indictment by a state grand jury charges that Mr. Bowie intended to deceive the Missouri Insurance Division by concealing liabilities and other information in Transit's 1984 annual statement.

The annual statement was filed on April 1, 1985. Transit was ordered into liquidation in December 1985 and is now estimated to be insolvent by as much as $2.5 billion.

The Cole County, Mo., grand jury indicted Mr. Bowie on Sept. 28, though the indictment remained sealed until Nov. 2, when he surrendered to Missouri authorities.

In a hearing before Circuit Judge James McHenry, Mr. Bowie entered a plea of not guilty and was released on $250,000 bond. No trial date has been set.

The felony charge of filing a false financial statement carries a maximum penalty of up to five years in prison.

Mr. Bowie, who has resigned from the firm of Wilson, Elser, Moskowitz, Edelman & Dicker in Los Angeles, referred questions on the

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House allows states to impose unlimited liability for oil spills Page 2

Winter weather can produce costly damage for companies Page 3

EAP helps aircraft maker cut employee health care costs Page 3

Update

Jury grants firm cleanup cover

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not tap its 1984 liability insurance policy.

The jury was instructed by the judge that the pollution exclusion in comprehensive general liability policies bars coverage only if the policyholder expected or intended to pollute third-party property. The insurer, Hartford Accident & Indemnity Co., vigorously argued that the exclusion should bar all gradual pollution (*BI*, Oct. 16).

However, U.S. District Judge Zita L. Weinshienk is reviewing the jury's decision to resolve several unclear issues, including whether Broderick can stack the limits of its policies.

It also must be determined whether Hartford can offset the amount it owes Broderick by payments made by other insurers. Two banks with controlled trusts that have held Broderick since the early 1960s settled with their liability insurers over claims stemming from the cleanup.

From 1976 to 1983, Broderick had primary CGL limits ranging from $50,000 to $1 million per occurrence and umbrella limits ranging from $1 million to $2 million per occurrence.

Hazardous waste coverage litigation has gone before a jury only one other time. In that trial, which involved Houston-based Shell Oil Co., the jury found Shell knew it was polluting the environment and voided coverage (*BI*, Dec. 26, 1988).

Domestic partner benefits eyed

SAN FRANCISCO—A mayoral task force is studying the feasibility of extending health care benefits to unmarried domestic partners of city employees even though voters last week defeated a measure that would have given city workers involved in such relationships the same bereavement leave as married workers.

The ballot proposition, which was defeated by fewer than 2,000 votes, did not extend health care benefits to domestic partners.

Opponents of the measure actually worked to place the proposition on the ballot. The measure had been approved by the Board of Supervisors and was backed by Mayor Art Agnos.

Now, "the presumption" is that the task force, which is scheduled to meet this week, will pursue the feasibility of extending health care benefits for both homosexual and heterosexual domestic partners, said Randall Smith, executive director of the city's Health Service System.

If the task force reports to the mayor that the health care benefit extension is feasible, Mr. Agnos is expected to submit a recommendation to the seven-member Health Services Board, Mr. Smith said.

San Francisco's 32,000 active city workers and 13,000 retirees are covered either by a self-insured health care plan or one of four health maintenance organizations, the largest of which is Kaiser Permanente Medical Care program, Mr. Smith said.

Kaiser agreed to extend health care benefits to homosexual and heterosexual domestic partners of city workers in Berkeley, Calif., several years ago, said a Kaiser spokesman (*BI*, Feb. 25, 1985).

Outhwaite settles two policies

LONDON—Lloyd's of London underwriter Richard Outhwaite will be able to cap his liabilities under settlements with two Lloyd's syndicates for which he wrote runoff reinsurance policies.

Syndicate 90, managed by Merrett Holdings P.L.C. subsidiary Pulbrook Underwriting Management Ltd., and syndicate 484, managed by Methuen (Lloyd's Underwriting Agents) Ltd., both ceded past underwriting liabilities in the early 1980s to syndicate 317/661, managed by RHM Outhwaite (Underwriting Agencies) Ltd., through unlimited runoff reinsurance contracts.

But, under the settlements announced last week, both ceding syndicates have agreed to accept undisclosed limits of liability on the contracts.

Mr. Outhwaite estimates that his syndicate will likely be liable for about $60 million in losses under the settlements. However, his liabilities would be greater under the agreement if losses eventually exceed current estimates.

Both settlements were concluded with the help of lawyer Mark Littman, who was appointed by the Council of Lloyd's to act as a conciliator in such disputes (*BI*, June 19).

Mr. Outhwaite has reached similar settlements with several other Lloyd's syndicates and insurers for which he wrote runoff reinsurance. Mr. Outhwaite has disputed claims from more than one dozen of the approximately 50 runoff reinsurance policies he wrote.

IUD settlement cleared

WASHINGTON—The U.S. Supreme Court's refusal to hear two suits challenging the Dalkon Shield settlement clears the way for full-scale settlements between A.H. Robins Inc. and more than 100,000 women who claim they were injured by the intrauterine device.

Under its reorganization plan, Robins, which in 1985 filed for protection under Chapter 11 of the U.S. Bankruptcy Act, has set up a $2.6 billion trust fund to compensate the IUD claimants.

To date, the trust fund has been making only small settlements. The fund now is scheduled to be fully operational by Dec. 15.

"The road has been much longer and more difficult than we envisioned when we filed for reorganization," said a spokesman for Robins, which sold the IUD in the United States from 1970 to 1974 (*BI*, July 3; Aug. 26, 1985).

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Errors and omissions

- The chart that appears in the Nov. 6 Ask a Benefit Actuary column specifically refers to excess liability or workers compensation insurance losses. The chart was identified as referring to excess insurance losses in general.

- Kirkway International Ltd. was incorrectly identified in the Nov. 6 directory of reinsurance intermediaries.

Supreme Court ruling boon to comp insurers

U.S. courts can hear disputes

By LINDA J. COLLINS

WASHINGTON—Insurers nationwide are cheering a recent Supreme Court decision that allows an insurer disputing a workers compensation award to file suit in federal court.

The high court ruled in *Northbrook National Insurance Co. vs. Brewer* that a federal statute barring direct actions against insurers in cases not involving the policyholder from being heard in federal court does not apply when a work comp insurer initiates the lawsuit.

Insurer representatives, who say the decision also will benefit employers, contend that filing suit in federal court allows the insurer to obtain a more impartial hearing in work comp cases.

The Supreme Court's 8-1 decision involved a dispute between Northbrook National, a unit of Allstate Insurance Co. in Northbrook, Ill., and a Texas employee over a workers compensation award of about $56,000.

Northbrook objected to the award, which was issued by the Texas Industrial Accident Board. Texas law provides that any party dissatisfied with the board's ruling may bring civil suit to set aside the decision.

Northbrook filed its appeal in the U.S. District Court for the Eastern District of Texas, but the District Court dismissed the case, citing a lack of jurisdiction based on a federal statute.

That statute says: "In any direct action against the insurer of a policy or contract of liability insurance. . . .to which action the insured is not joined as a party-defendant, such insurer shall be deemed a citizen of the state of which the insured is a citizen."

Under federal civil procedure, a federal court can only hear cases involving federal issues or between citizens of different states.

Northbrook appealed to the 5th U.S. Circuit Court of Appeals in New Orleans, which affirmed the lower court's decision.However, the Supreme Court reversed the lower courts' rulings.

The high court ruled that the federal statute only applies when an employee files the lawsuit, not when the insurer files the lawsuit. The court stressed that the statute specifically refers to lawsuits filed against insurers, not those filed by insurers.

The court cited as precedent for its decision, *Horton vs. Liberty Mutual Insurance Co.*, which held: "We must take the intent of Congress with regard to the filing of diversity cases in federal district courts to be that which its language clearly sets forth."

Justice Thurgood Marshall, writing for the majority, said: "The language of the proviso could not be more clear. It applies only to actions against insurers; it does not mention actions by insurers."

Dissenting, Justice John Paul Stevens noted that regardless of which party files a lawsuit in workers compensation cases, in reality, the litigation represents a claim against an insurer.

"On the merits, three characteristics of the Texas scheme make it appropriate to characterize the judicial review of a compensation award as an action 'against' the insurance carrier, regardless of which

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House allows states to seek unlimited liability for oil spills

By ADRIENNE LOCKE

WASHINGTON—States will be allowed to continue to impose unlimited liability on ship and cargo owners involved in oil spills under legislation approved last week by the U.S. House.

The Senate already has passed similar legislation.

In a reversal of a long-held position, the House approved by a 375-5 vote an oil spill liability and compensation bill, H.R. 1465, that would allow states to impose limits of liability that exceed the federal standard on owners of tankers and cargo involved in an oil spill.

Bills passed by two House committees earlier this year would have pre-empted all state laws regarding oil spill liability, which in effect would have set a uniform federal limit on a ship or cargo owner's liability for an oil spill (*BI*, Aug. 14).

The House traditionally has supported pre-emption of state oil spill liability laws in favor of a federal standard, while the Senate has supported the right of states to set their own liability limits.

Currently, 20 coastal states hold tanker owners unlimitedly liable for pollution incidents.

Under the House bill, tanker and cargo owner's liability in an oil spill would be limited to $1,200 per ton of oil spilled unless this limit is superseded by state law. The bill also would set up a no-fault compensation system, under which damages that exceed the liability limit would be paid by an oil industry-sponsored pool.

"The states are the ones that are more directly affected by a spill," said a spokesman for Rep. George Miller, D-Calif., who co-sponsored the amendment—along with Rep. Garry E. Studds, D-Mass.—that restores the states' jurisdiction over oil spill liability.

The amendment was in keeping with other federal environmental programs, under which standards are established at the federal level, but the states have the option to impose tougher requirements, the spokesman added.

The Senate in August passed similar oil spill legislation, though the Senate bill would establish a federal liability limit of $1,000 per

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Deadline for inclusion in TPA directory near

The deadline is approaching for companies to return questionnaires to be listed in the annual directory of third-party claims administrators, adjusters and auditors.

The directory will appear in the Jan. 29, 1990, issue of *Business Insurance*, which will contain a spotlight report on trends in self-insurance.

If your company offers claims administration, adjusting or auditing services and you have not yet received a questionnaire, please request one by calling Sara Harty at 312-280-3195.

The deadline for returning completed questionnaires to *Business Insurance* is Dec. 11.

Inside

- A Unocal Corp. drilling ship that capsized last week is insured for $15 million. **PAGE 4**

- This week's editorial suggests ways to improve the effectiveness of HMOs. A second editorial says the Supreme Court should find LTV Corp.'s follow-on pension plans are an abuse of the PBGC system. **PAGE 8**

- In Speaking Out, broker William D. Bolton says flaws in the work comp system penalize employers who hire the handicapped. **PAGE 28**

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Names sue Lloyd's for breach of duty over PCW losses

By STACY SHAPIRO

LONDON—Five Lloyd's of London members who belonged to syndicates formerly managed by PCW Underwriting Agencies Ltd. are suing Lloyd's for unspecified damages for breach of its statutory duty as a market regulator.

The five members—who did not agree to a 1987 settlement negotiated by Lloyd's to end litigation over the PCW affair—also are suing PCW's parent, Minet Holdings P.L.C., and former Minet Chairman John Wallrock for their roles in the PCW affair.

The lawsuits, filed in late September in London's High Court, are the first by PCW syndicate members in the aftermath of hundreds of millions of dollars in losses at the PCW syndicates.

However, the litigation could end if the five plaintiffs agree to pay by the end of March their share of a 7.63 million pound ($12.1 million) payment to Lloyd's-owned Lioncover Insurance Co. Ltd., which was established to handle the runoff of the PCW syndicates.

Lloyd's earlier this month paid the 7.63 million pounds to close the PCW syndicate accounts on behalf of 10 PCW syndicate members who did not agree to the 1987 settlement and eight members who were not offered the opportunity to settle.

The 10 PCW members who did not agree to the settlement—including the five plaintiffs—could settle their outstanding share of the PCW liabilities once and for all by paying their portion of the 7.63 million pounds to Lioncover. The members have until the end of March to decide whether to accept the latest offer.

However, the five plaintiffs already have sought an injunction to stop Lloyd's from closing the PCW syndicates' accounts, although their suit was rejected by the High Court, said Robin G. Moore, a Chester, England-based private attorney representing four of the plaintiffs. They still could appeal the ruling, he noted.

Alternatively, the plaintiffs "could con-

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Heavy snowfall, if not removed promptly and properly, can cause roof collapses.

Cold weather catastrophes

Arctic blasts pose big risks

By MARK A. HOFMANN

While many risk managers now are focusing on programs to minimize property damage from a catastrophe like a hurricane or an earthquake, they also must take precautions against a much more common danger: cold weather.

Although most risk managers in Northern states generally are prepared for the cold, their Southern counterparts are especially vulnerable to occasional drastic temperature drops, loss control experts point out.

But risk managers can use the same identification and prevention techniques used to manage corporate risks yearround to prevent property damage during the winter, experts say.

Cold weather may lack the drama of a hurricane or earthquake, but it can be just as damaging to property, statistics show.

For example, until Hurricane Hugo battered the Southeast in September, causing an estimated $4 billion in insured damage, a 1983 winter weather system was the largest single catastrophe recorded by the Property Claims Services division of New York-based American Insurance Services Group.

Fierce winds, snow and bitter cold caused an estimated $800 million in insured damage to 41 states in late December 1983. The storm was dubbed Catastrophe No. 24 by Rahway, N.J.-based PCS.

Because risk managers with facilities in Northern areas are experienced with severe winter weather, their companies often do not suffer the most in extreme cold, said Stanley J. Couvillon, vp-loss prevention, for Hartford, Conn.-based Industrial Risk Insurers.

But damages from unexpected arctic blasts tend to hit states such as Oklahoma, Tennessee and the Carolinas particularly hard, he said.

In fact, complacency on the part of risk managers with little extreme winter experience contributed to the then-record damage in December 1983, Mr. Couvillon said.

"They felt this couldn't happen to them," he said, comparing the situation to Hurricane Hugo: People who believed they had nothing to fear because they were hundreds of miles from Charleston, S.C., when the hurricane struck woke up to find downed power lines, splintered trees and flooded basements.

The 1983 deep freeze shattered Southern complacency, said Joe Hankins, manager of Factory Mutual Research Corp.'s protection section in Norwood, Mass.

Factory Mutual clients nationwide reported about $75 million in insured damage from some 1,300 freeze-related inci-

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Piper Alpha explosion

Occidental files suit against rig's builders

By CAROLYN ALDRED

LONDON—Occidental Petroleum (Caledonia) Ltd., one of the four owners of the Piper Alpha North Sea oil platform, is suing several companies involved in the platform's design and operation as the public inquiry into the cause of the July 1988 explosion nears completion.

Occidental, a subsidiary of Occidental Petroleum Corp. of Los Angeles, seeks unspecified damages in suits that have been filed in the London High Court but have not yet been served.

By filing the suits, Occidental is protecting its legal position "in view of the fact that the public inquiry may continue into next spring," a spokesman said.

The inquiry into the explosion of the Piper Alpha, which also will examine future safety considerations, began in Aberdeen, Scotland, in January and likely will continue until early next year, said a spokesman for the investigators.

The 12-year-old Piper Alpha North Sea oil platform was destroyed in a July 1988 explosion. Total claims are expected to reach $1.4 billion, making it the largest man-made loss in history. Ninety-seven people died in the tragedy (*BI*, July 11, 1988).

The platform was jointly owned by Occidental; Texaco Britain Ltd., a subsidiary of White-Plains, N.Y.-based Texaco Inc.; Union Texas Petroleum Ltd., a subsidiary of United Texas Petroleum Holdings Inc.; and Thomson North Sea Ltd., a subsidiary of International Thomson P.L.C. of London.

Occidental, which had the largest ownership stake in the platform, also operated the Piper Alpha.

Insurers so far have paid out $1.1 billion in property, business interruption and liability losses to the four Piper Alpha owners, according to Derek Wills, chairman of Lloyd's of London Underwriters Assn.

Early loss estimates appear to have been on target, said Mr. Wills, predicting insured losses will total about $1.4 billion.

But, the loss likely will plague the London insurance market for many years, according to market sources.

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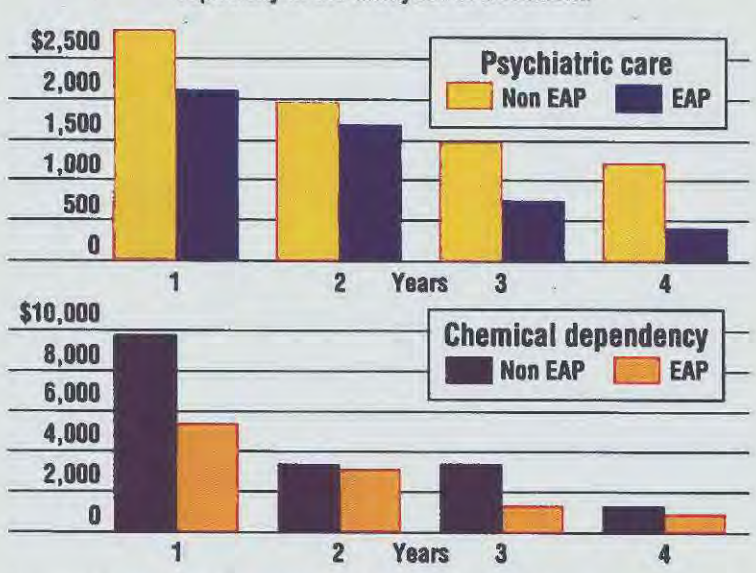
EAP savings at McDonnell Douglas

Psychiatric and chemical dependency patients in EAPs incurred lower medical costs than those outside the EAP. But both groups incurred significantly higher costs than the average employee, especially in the first year of treatment.



Source: McDonnell Douglas Corp. and Alexander & Alexander Consulting Group

BI/JOHN HALL

McDonnell Douglas EAP trims health care costs

By LOUISE KERTESZ

BRIDGETON, Mo.—McDonnell Douglas Corp.'s employee assistance program is drastically reducing health care costs for workers with chemical dependency and psychiatric problems, according to a new study being touted as the first of its kind.

Workers who received treatment for chemical dependency and psychiatric problems over a four-year period through the EAP available as part of the company's insured health care plan incurred $9,800 less in health care costs on average than workers who received treatment outside of the EAP, according to the study (see chart).

Overall, health care costs and costs associated with absenteeism and turnover for workers and dependents who were treated through the EAP were almost 45% lower than those for employees and dependents who received treatment outside the EAP, according to the study.

In addition, the absenteeism and turnover rate among McDonnell Douglas employees who received treatment through the EAP was significantly lower than that for employees who received treatment outside of the EAP.

However, the study found the indemnity plan EAP was far less effective in treating employees for drug dependency than in treating employees with drinking problems.

In addition, the study found that employees who received treatment for chemical dependency or a psychiatric disorder through an EAP offered by the company's health maintenance organizations are far more likely to lose their jobs than the employees treated by the EAP available through the indemnity plan.

The 300-page study, "McDonnell Douglas Corp. Employee Assistance Program Financial Offset Study 1985-1988," was conducted by the Health Strategies Group of Alexander Consulting Group Inc. in Westport, Conn., a unit of Alexander & Alexander Services Inc.

The study is the first to compare for statistical validation over an extended period of time the health care costs of a substantial number of workers in an EAP with a control group of workers without

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Unocal ship insured for $15 million

By STACY SHAPIRO

LONDON—A Unocal Corp. drilling ship that capsized last week during a typhoon in the Gulf of Thailand, killing more than 90 people, is insured for $15 million.

Wholly owned Unocal subsidiary Seacrest Drilling Co. in Bangkok, which owned the vessel, the Seacrest, also has at least $9 million in third-party liability insurance covering the vessel.

Only one crewman on board worked for Unocal.

Typhoon Gay wreaked havoc in the gulf and on the Thai mainland from Nov.3-Nov.7, killing more than 500 seaman and sinking 100 vessels, mostly fishing boats, reports say. Whole rubber tree and coconut plantations were flattened in Chumphon Province. As many as 71 people died on land.

More than 3,500 houses also were destroyed with more than 65,000 people affected by the storm.

Reports say Thai Interior Minister Pramarn Adireksan will ask the cabinet for $80 million in emergency aid for typhoon victims.

Los-Angeles-based Unocal's five Gulf of Thailand natural gas fields last week were producing less than half of their pre-storm daily volume of 540 million cubic feet, Unocal Thailand Ltd. in Bangkok stated last week.

However, the company said production would soon return to normal levels.

At least part of Unocal's global property and liability coverage—which includes the Seacrest—is placed in London under a special rig line slip administered by specialist energy broker Newman & Martin Ltd.

Newman & Martin, which has applied to be a Lloyd's broker, is working in the Lloyd's market under an umbrella arrangement with Lloyd's broker Steel Burrill Jones Ltd.

The line slip is led at Lloyd's by underwriters Peter Portman and Richard Wyatt, and in the London insurance company market by Prudential Corp. P.L.C., which is not related to Prudential Insurance Corp. of America.

The line slip provides up to $250 million in property coverage, but the Seacrest is insured for only $10.5 million in hull damage and $4.5 million in damage to other equipment on the drilling ship, according to London sources.

The company also purchases liability insurance covering the drilling ship through the line slip with limits of $9 million excess of $1 million, sources say, although they do not know whether the first $1 million is retained by Unocal or insured elsewhere.

Sources did not say whether Unocal purchases additional liability coverage for the ship.

Newman & Martin confirmed that it is the London broker for the ship, but would not comment on the coverage and referred all calls to Energy Insurance, Unocal's Houston-based broker, which also would not comment.

Senior Unocal officials, directed by John F. Imle Jr., senior vp-energy resources, and chairman of Unocal Thailand Ltd., traveled to Thailand last week to support the search effort and help restore production, the company said.

The "Seacrest," a 351-foot-long drilling ship built in 1977, was operated by Great Eastern Drilling & Services Inc. of Singapore.

Details of Great Eastern's insurance program were unavailable.

Unocal stated that of the 97 people on board, 77 were employees of Great Eastern, 19 were employees of various oilfield service companies and one employee was from Unocal.

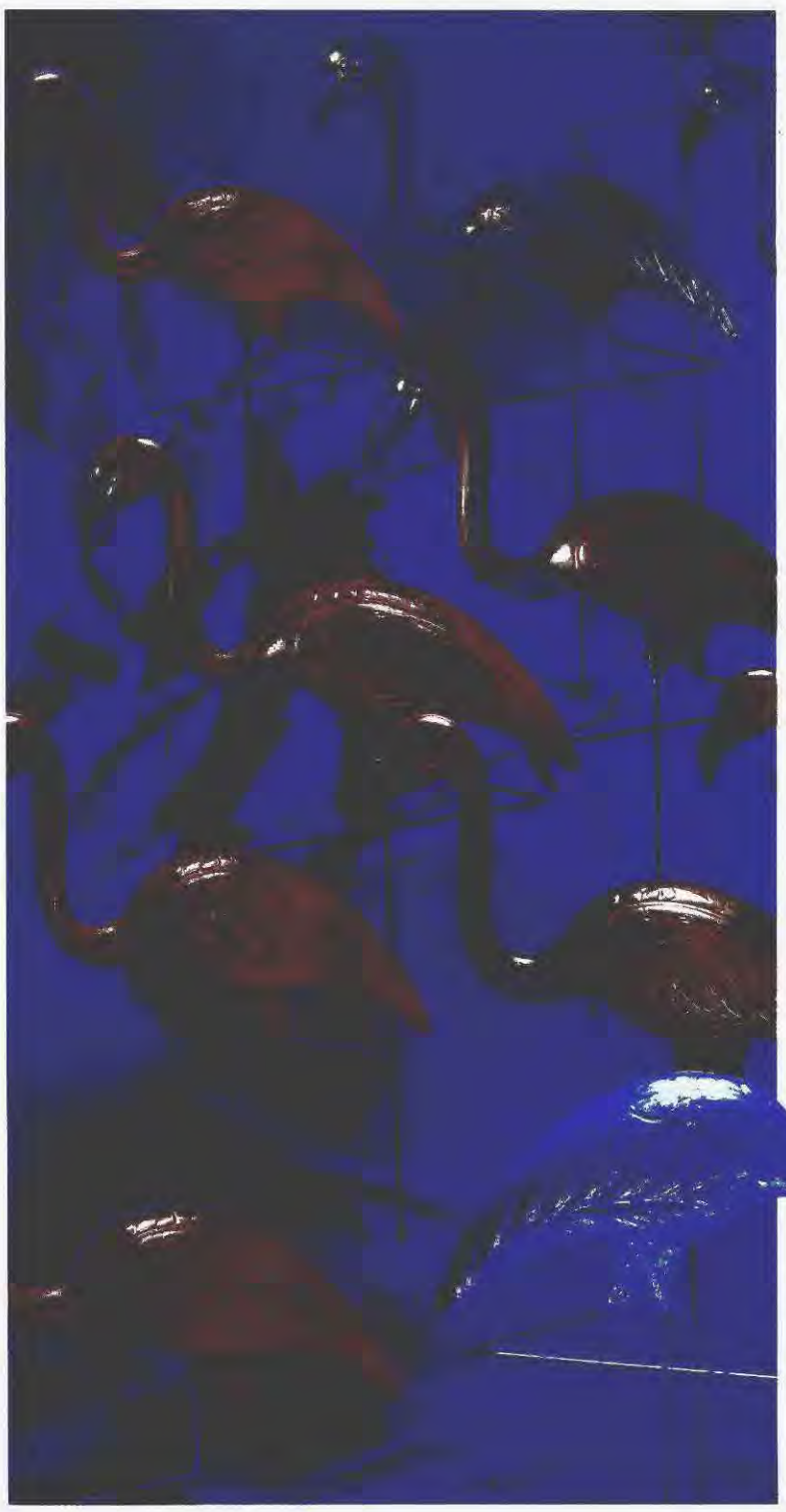
Among the 97, 64 were Thai nationals and 33 were non-Thais, including six U.S. citizens and others from Australia, Britain, Canada, West Germany, Denmark, Italy and New Zealand.

On the morning of Nov. 3—the height of the typhoon—Unocal reported that three drilling rigs had each lost some anchors. The Seacrest was hardest hit, losing seven of its eight anchors.

Unocal then went on full alert and set up an emergency communications center at its Bangkok office, the company reported. At the time, Unocal said it believed all crewmen were present and accounted for and all drilling units were secured.

However, by early afternoon on Nov. 3 Unocal lost contact with the Seacrest, and early the next morning, a company helicopter spotted the drilling ship overturned. An aircraft reported seeing an empty life raft in the vicinity. ■

When your exposure requires a coverage of a different color.



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Reporter, copy editor join BI staff

Louise Kertesz has joined *Business Insurance* as an associate editor in the Los Angeles bureau and Timothy Stanton has joined the staff as a copy editor in Chicago, Associate Publisher and Editor Kathryn J. McIntyre announced.

Ms. Kertesz, 50, most recently was labor and financial reporter at Automotive News, a weekly newsmagazine in Detroit which, like *Business Insurance*, is published by Crain Communications Inc.

Ms. Kertesz

Ms. Kertesz previously was a technical editor and writer in the Detroit area. She also worked as a researcher at Forbes magazine in New York and was a high school and college English teacher.

Ms. Kertesz received an master of arts degree in English from Columbia University in 1963 and a doctorate in English from the University of Illinois in Champaign-Urbana in 1970.

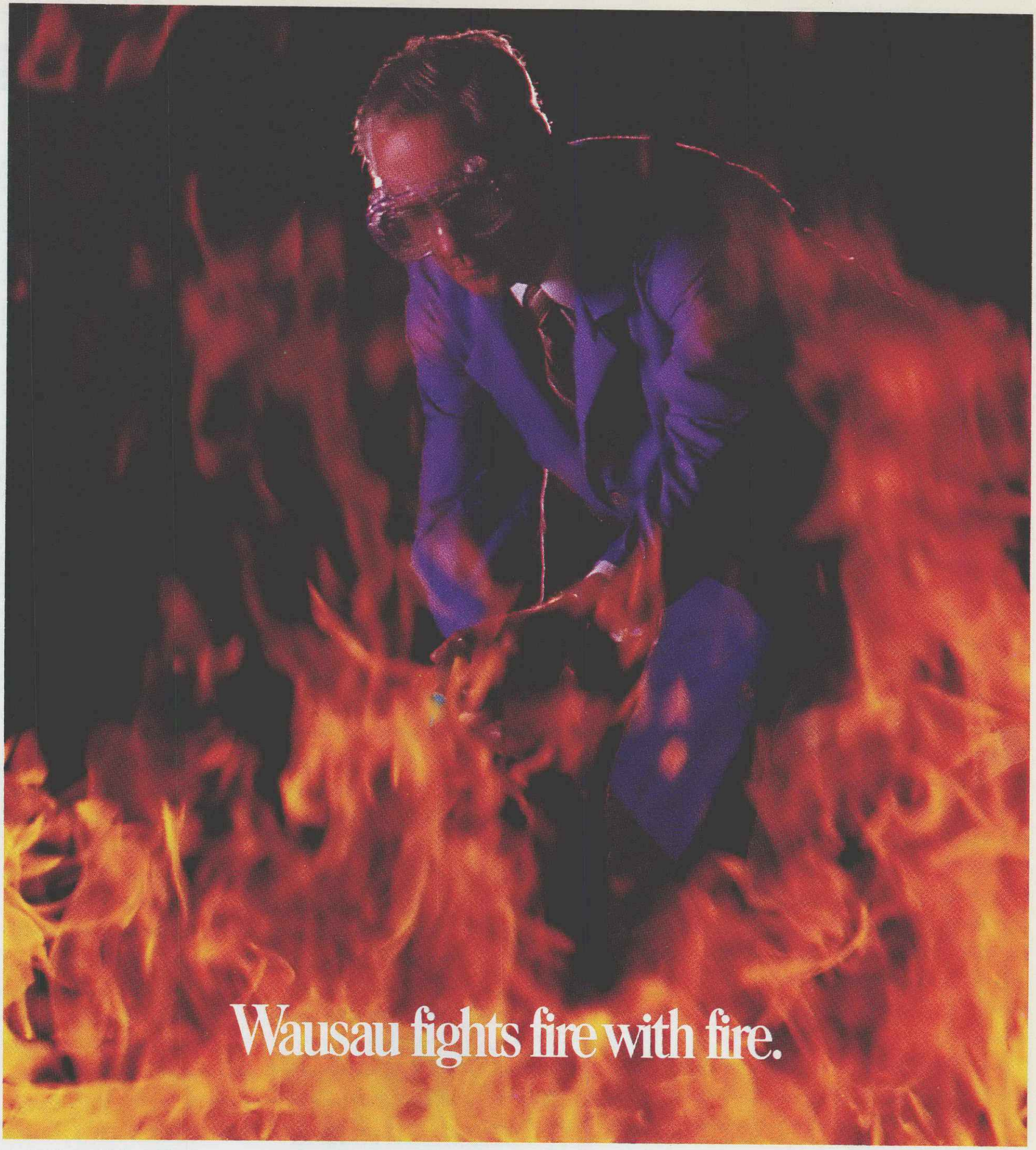
Ms. Kertesz reports on employee benefits and risk management issues. She can be reached at 213-651-3710.

Mr. Stanton, 24, had been a police and business reporter with the Waterloo Courier, a daily newspaper in Waterloo, Iowa. He also has worked for newspapers in Milwaukee and Madison, Wis.

Mr. Stanton

Mr. Stanton graduated in 1988 from the University of Wisconsin in Madison with a bachelor's degree in political science and journalism.

Mr. Stanton can be reached at 312-649-5440. ■



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Armstrong increases health cost shifting

By MICHAEL SCHACHNER

Unionized workers at Lancaster, Pa.-based Armstrong World Industries Inc. will pay a larger portion of their health care costs under a three-year labor agreement reached with the company last month.

In exchange for the cost-shifting, Armstrong agreed to improve dental benefits and establish a child care pretax reimbursement account.

However, the retiree health care plan for 1,600 Armstrong workers who are members of the United Rubber Workers of America will remain intact under the agreement.

And employees also can still elect to enroll in one of several health maintenance organizations, which do not require deductibles or copayments, according to a company spokesman.

Benefit beat

Under the labor agreement ratified Oct. 31, annual health care coverage deductibles under the company's self-insured indemnity plan will remain unchanged at $200 for individuals and $400 for families.

And after deductibles are met, Armstrong will continue to pay 80% of incurred expenses.

However, the annual out-of-pocket maximum that employees must pay for medical expenses was raised to $1,000 from $700 for individuals, and to $2,000 from $1,400 for families.

Armstrong also initiated a $2 million lifetime maximum for medical coverage. No lifetime maximum was set under the expired contract.

The new contract also sweetened employee dental benefits, increasing the annual maximum for family dental benefits to $1,200 from $1,000, and hiking the lifetime orthodontic benefit to $1,200 from $1,000.

A child care reimbursement account, into which employees can deposit up to $5,000 annually on a pretax basis, also will be instituted under the new contract.

During contract negotiations, Armstrong dropped its proposal to replace its union workers' retiree health care plan with an employee stock ownership plan.

Under the company's original plan, retired union members represented by Local 285 would have had the option of purchasing health care coverage available to the company's active workers with shares of stock from the ESOP.

Currently, 1,900 salaried nonunion Armstrong employees have this option.

However, responding to the union's complaint that ESOP proceeds available at retirement would not offset medical needs, Armstrong withdrew the ESOP proposal, called "Share in Success."

Under the contract, retired union members will still receive health care benefits under the company's self-insured health care plan.

Family leave

Some 1,300 full-time employees of Newark, N.J.-based Mutual Benefit Life Insurance Co. can now take up to 14 weeks of unpaid leave with full benefits to care for family members under a new family leave program.

Employees also have the option, with management's approval, of working part time for six months while caring for dependents.

Employees with at least one year of service who work in Mutual's Newark and Piscataway, N.J., and Ames, Iowa, offices are eligible for the program.

The insurer previously offered employees two weeks of unpaid leave to care for dependents.

Mutual expanded its unpaid leave benefit as "one response to the pressures employees face in trying to balance the responsibilities of home life and the workplace," explained Susan McElvogue, second vp of human resources in Newark.

Driver safety

More than 300 employees of Honeywell Inc. in Minneapolis are receiving personal auto insurance at reduced rates from NWNL General Insurance Co. after attending a driver safety education program.

The "Safe and Sound" program offers tips on safe driving and requires that participants seeking reduced auto rates pledge to wear seat belts and not drive while under the influence of alcohol.

"While auto safety is often overlooked in benefits planning, we know that wearing seat belts and driving sober saves lives," explained James R. Voeller, employee benefits manager with Honeywell.

Honeywell employees can receive $60 reductions on annual premiums for auto insurance written by NWNL General, a unit of Northwestern National Life Insurance Co. of Minneapolis.

Nearly 1,000 of 12,000 eligible Honeywell employees have participated in the course to date.

Health care study

A whopping 74% of a group of leading physicians believes that the United States will implement a national health care system during the 1990s, but only one-third of the physicians support the idea.

And, overall, 72% of the physicians predict profound changes in the U.S. health care system in the 1990s, according to New York-based Metropolitan Life Insurance Co.'s fall "Health Poll."

The 100 survey respondents consisted of prominent physicians, such as heads of government programs, directors of university medical research facilities and medical consultants.

Of the respondents, 71% are no longer involved in private practice, while 28% still are practicing.

The physicians, who were polled in August and September, represented all regions of the United States: 33% from the Midwest; 27% from the East; 22% from the West; and 18% from the South.

According to the survey, 49% of the respondents who predict a national health care system will be implemented in the United States within the next 10 years expect the system to be comparable to the current fee-for-service system with "minor modifications."

Thirty-nine percent of the respondents, though, anticipate that the system will be modeled after the Canadian universal health care system.

Continued on page 10

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Opinions

Restoring HMOs' luster

THERE'S A BIG chink in many employers' cost control armor.

For years, employee benefit managers and employee benefit consultants have touted health maintenance organizations as among the primary tools that employers can utilize in the fight against rising health care costs.

However, a new survey by benefit consultant A. Foster Higgins & Co. Inc. found that many employee benefit managers may not think that HMOs are all that worthwhile (*BI,* Nov. 6). According to the survey, 32% of benefit managers polled do not believe that HMOs are effective in controlling health care costs, while 35% of the employers are ambivalent about HMOs' potential. In addition, 54% said that their HMO rates are the same or higher than indemnity plan rates.

Obviously the promise that HMOs once held as a means to hold down health care costs is no longer being realized in the eyes of many benefit managers.

A first impulse is to the blame the HMOs. And there is much that HMOs can do to both approve their effectiveness in controlling health care costs and to improve the perception that employers have toward HMOs as a cost containment tool. Most notably, HMOs can increasingly share badly needed cost and utilization data with employers.

But there is a lot that employers can do to improve HMOs' effectiveness in controlling health care costs. Among them:

- Negotiating HMO premiums. Gone are the days when federal law allowed HMOs to only charge a premium based on community rating, or the experience of the entire community, rather than on the employer's own experience. Demand that HMO costs reflect your own experience.
- Weeding out the least effective HMOs among the plan options offered to employees.

Many employers are now examining the crazy-quilt selection of HMOs they offer and are paring down the options to a few select plans that offer the highest quality of care at the lowest cost to the employer. This cuts administrative costs and gives

an employer more clout in negotiating with the HMOs they do offer.

Some employers are following the lead of Allied Signal Inc. and are offering only one managed care plan to employees nationwide (*BI,* Feb. 22, 1988).

- Scrutinizing the financial solvency of the HMOs offered.
- Demanding detailed data from the HMO. As we've said before, employers cannot plot meaningful cost containment strategies without adequate data, both from their indemnity plan and their HMOs.
- Insisting on high quality of care standards. Employees will not use HMOs unless they deliver the best medicine possible.

We still believe that HMOs can lead to better control over health care costs. Although HMO premiums are rising almost as quickly as indemnity plan costs, HMOs still are often less costly than indemnity plans. However, to get the most from their HMOs employers must develop an all-encompassing HMO strategy.

The 'follow-on' foul-up

WE HOPE THE Supreme Court overturns a lower court ruling, which, unless reversed, could do grave damage to the nation's defined benefit pension plan system.

In a case involving three LTV Corp. pension plans with $2.3 billion in unfunded benefits, the justices will decide whether companies can establish new, low-cost "follow-on" programs after their underfunded pension plans are terminated and the liabilities are shifted to the federal Pension Benefit Guaranty Corp. (*BI,* Nov. 6).

For a company in financial difficulty, it makes perfect economic sense to get rid of existing underfunded pension plans and set up a new program. From the company's perspective, it can shed, at a very low cost, a pension debt that grew huge because it made inadequate contributions to the plan.

And, the company is not likely to get any complaints from workers and retirees. Through a combination of receiving benefits from the terminated plan—paid by the PBGC instead of the company—and from the new company-sponsored follow-on plans, workers and retirees will not suffer any financial loss and may actually come out ahead.

While a company and its pension plan participants may emerge as winners, the big losers are the PBGC and all employers with defined benefit pension plans that pay termination insurance premiums.

In fact, we believe follow-on pension plans are an abuse of the PBGC insurance program.

The PBGC was intended to be an insurer of last resort of participants' promised basic benefits when companies fail and their pension plans are inadequately funded to pay what was promised.

Congress, in passing the Employee Retirement Income Security Act, also made clear that an employer could terminate a pension plan if its continued existence and funding would bankrupt the company.

Clearly, though, before a company sets up a new pension plan, it must first fully fund its current pension program. To allow otherwise would mean, in effect, that the PBGC and ultimately other employers would be forced to subsidize a pension program that a company promised but chose not to properly fund.

Obviously, if the PBGC can't return the terminated plans to LTV, other companies also are likely to try to shed their underfunded pension programs onto the PBGC and then set up new plans.

Ultimately, that will send PBGC premiums skyrocketing. Companies that responsibly fund their pension plans will terminate them rather than subsidize pension promises of employers that abuse the system.

We hope the Supreme Court stops that scenario from developing.

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At issue

What is your employees' most pressing benefits concern?

Donald J. Winters
director-employee services
ConAgra Inc.,
Omaha, Neb.

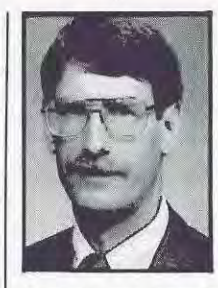
Our salaried employees are most concerned about the increased contributions resulting from the flexible benefits program we introduced in 1987. The program was touted as a method to control costs, but that is not the opinion of employees who've seen deductibles rise. As a result, we're looking to alternative methods, particularly managed care programs.

Patricia M. Nazemetz
director of benefits
Xerox Corp.,
Stamford, Conn.

The increased size of their share of medical bills through copayments and deductibles is a concern. And, the complexities of the health delivery system being put in place to control costs create a maze for employees who have to make choices.

Margaret M. Gagliardi
senior vp-compensation/benefits/staffing
American Express Travel Related Services Co.,
New York

The most pressing need is child care because of our predominantly female workforce. We see that benefit as a key tool for attracting and retaining an increasingly diverse population of employees.



Stuart Larimore
manager of compensation/benefits planning
Boise Cascade Corp.,
Boise, Idaho

Overall, our benefits are very adequate. But, the most pressing benefits issue to our employees is the continuation of their health care coverage in the event of termination, layoff or retirement. We, like other employers, have announced changes to our retiree medical program. Our employees are concerned about the affordability of outside health insurance.

Compiled by Christine Woolsey

After the Earthquake

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Dave Mathis

David B. Mathis
Chairman and
Chief Executive Officer

Kemper Re
Long Grove, IL 60049

Benefit beat

Continued from page 6

Each of Canada's 10 provinces and two territories individually determine how to finance health care expenses. Currently three different funding methods are in use: direct premiums from citizens, payroll taxes paid by employers and general tax revenues (*BI*, Feb. 20).

Three percent of the respondents predicted a fully nationalized system like Great Britain's National Health Service, under which doctors and hospitals are directly employed by the government.

Nine percent said they were not sure what direction the U.S. health care system may take.

But most of the respondents—61%—believe that employers should be responsible for providing health care coverage. Only 32% of the respondents supported a national health care delivery system.

In addition, 5% of the respondents said other parties should be responsible, and 2% were not sure.

Regarding the overall health care system, 72% of the survey respondents predicted "additional profound change" during the 1990s. Those changes include a continued movement away from fee-for-service health care coverage toward managed care; new, more limited physician fee schedules; and fewer private practitioners.

The remainder forecast "some" change.

Survey respondents also expect quality of health care to continue to improve in the next decade because of advanced technology, doctors' increased medical knowledge and increased standardization of health care delivery in the medical community.

But, some factors could cause the quality of health care to erode in the upcoming decade, including continued rising health care costs, survey respondents said.

Among the leading factors contributing to rising health care costs ranked by respondents were physicians, followed by hospitals, patients, the federal government, unions, health care insurers and employers and state and local governments.

Forty-seven percent of the respondents said managed care could help contain health care costs.

"Without managed care, we're never going to control inexorable rises in cost and never use our resources effectively or efficiently. We would never know what's worth spending money on," said one respondent.

Seventy-eight percent of the respondents said inpatient utilization review was either "very" or "somewhat" effective, while 65% said outpatient UR was effective; 74% said health maintenance organizations were effective; 73% said preferred provider networks were effective; 64% said case management was effective; and 45% said physician chart reviews were effective.

However, 38% of the respondents said managed care was ineffective in containing health care costs.

For example, one respondent said managed care "lowers the quality of care due to cost reduction"; its numerous "regulations limit health care and the services doctors provide"; and "third-party payers interfere too much with doctors' decisions and options."

Seventeen percent of the respondents were not sure how managed care would affect health care costs.

However, almost all survey respondents—98%—predict managed care will continue to remain a major element of health care plans.

Free copies of the "Health Poll" may be obtained by writing Stephanie Valeiko, Managed Care Services Group, Metropolitan Life Insurance Co., 276 Post Road West, Westport, Conn. 06880. ■

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Section 89

Continued from page 1

in Washington, D.C.

"We are delighted that Congress has dispensed with Section 89. This reflects an overwhelming sentiment in Congress and the business community to put those rules aside. This whole episode shows the legislative process does indeed work," added Dirk Van Dongen, president of the Washington, D.C.-based National Assn. of Wholesaler-Distributors.

Ironically, the legislation and its staggering complexity originated during the Reagan administration's drive in the mid-1980s to make the nation's tax laws simpler and fairer.

The first Reagan administration tax reform proposal, unveiled in May 1985, included a provision that would have taxed highly compensated employees on a portion of their health insurance benefits if their employers did not extend comparable coverage to lower-paid employees.

This first health care non-discrimination statute was drafted so that its effect largely would have been limited to companies offering different health care plans to various corporate lines of business or operating units.

The non-discrimination proposals subsequently grew increasingly complex as the proposals wended their way through Congress.

The final non-discrimination statute, which ultimately became Section 89, was put together by Treasury Department staffers during the summer of 1986. It was included in the Tax Reform Act of 1986, which was signed by then-President Reagan in October 1986.

During this roughly 18-month drafting period, no congressional hearings were held on Section 89 or its earlier versions. At the same time, neither congressional or administration staffers conducted any significant research to determine to what extent group health plans discriminated against lower-paid employees.

Indeed, Section 89 was frequently described as a solution in search of a problem.

After Section 89 was enacted, employers slowly discovered the unprecedented compliance burdens that it imposed.

Employers faced a slew of non-discrimination tests that they had to run on their health care and other welfare plans, including a "90%-50% test," a "75% average benefits test" and an "80% alternative coverage test."

Before an employer could run these tests, an immense amount of data—often difficult and expensive to obtain—had to be collected and analyzed. For many large employers, obtaining and analyzing this data meant tens of thousands of dollars in fees for employee benefit consultants.

And because each health care option offered by an employer, like individual vs. family coverage or health maintenance organization vs. indemnity plan coverage, was considered a separate health care plan under Section 89, some employers found that they had hundreds of plans for non-discrimination testing purposes.

No matter how much data they collected, some employers found it was impossible to pass Section 89. For example, Section 89 required employers to include employees working as few as 17.5 hours a week when running the benefit plan non-discrimination tests.

Since employers almost never extend health care coverage to employees working fewer than 20 hours a week, this 17.5-hour threshold virtually guaranteed that employers with many part-time employees could not pass Section 89's tests unless they made expensive adjustments to their plans.

Some benefit experts have cited this 17.5-hour threshold as an example of the ignorance or indifference of the Section 89 drafters to how employer-provided benefit plans are structured.

The drive to repeal Section 89 took off after the Internal Revenue Service issued rules in March to help employers comply with the law.

The rules were staggering in both their complexity and length. And, even though the rules comprised 154 pages, the IRS acknowledged that the rules did not deal with all Section 89 issues. The IRS said it would have to issue yet more rules, though it never did.

"The IRS regulations underscored the complexity of Section 89 and were perhaps the straw that broke the camel's back. After the regulations were published, employers felt that it would be virtually impossible to administer their plans in compliance with Section 89. At that point, a powerful wave of employer discontent began to overwhelm Congress," said Henry Saveth, a principal with A. Foster Higgins & Co. Inc. in New York.

"The massive nature of the IRS regulations confirmed what employers had been saying—that Section 89 was unbelievably difficult for employers, especially small firms, to comply with," said Frank McArdle, a consultant in the Washington, D.C., office of Hewitt Associates.

A repeal proposal introduced in January by House Small Business Committee Chairman John LaFalce, D-N.Y., which had initially attracted only modest congressional support, rapidly gained co-sponsors after the IRS rules were published (*BI*, Feb. 20).

> **'Section 89 was unbelievably difficult for employers. . .to comply with,' Mr. McArdle says.**

Ultimately, the LaFalce measure gained more than 300 co-sponsors.

That massive show of support for the LaFalce measure was the driving factor behind the decision of House Ways and Means Committee Chairman Daniel Rostenkowski, D-Ill., in April to direct his staff to draw up legislation to simplify Section 89. Rep. Rostenkowski, who was a champion of the concept of health care non-discrimination testing, feared that the House might adopt the LaFalce repeal measure unless he took action.

"The rapidly growing strength of the repeal movement focused Rep. Rostenkowski's attention on Section 89 in a dramatic fashion," Mr. Saveth said, noting the Illinois Democrat's prior resistance to Section 89 changes.

"When the LaFalce bill had amassed such a large number of co-sponsors, it became clear that the will of the House of Representatives would overcome Rep. Rostenkowski unless he did something" to counteract the repeal movement, said Hewitt's Mr. McArdle.

However, the Section 89 reform proposals later unveiled by Rep. Rostenkowski did very little to simplify Section 89. In fact, Rep. Rostenkowski's first Section 89 reform proposal would have been devastating for many types of flexible benefit plans (*BI*, April 24).

The Rostenkowski proposals, which were part of a slow-moving budget reconciliation bill the Ways and Means Committee was drafting, picked up virtually no employer support.

At the same time, a Section 89 reform proposal—put together by Senate Finance Committee Chairman Lloyd Bentsen, D-Texas, and passed by the Senate in July as part of a broader child care bill—also failed to garner significant employer support because of its complexity (*BI*, July 3).

Employers, especially smaller firms that were not mollified by either the Rostenkowski or Bentsenreform proposals, stepped up their lobbying efforts to repeal Section 89 during the August congressional recess.

By early September, it became

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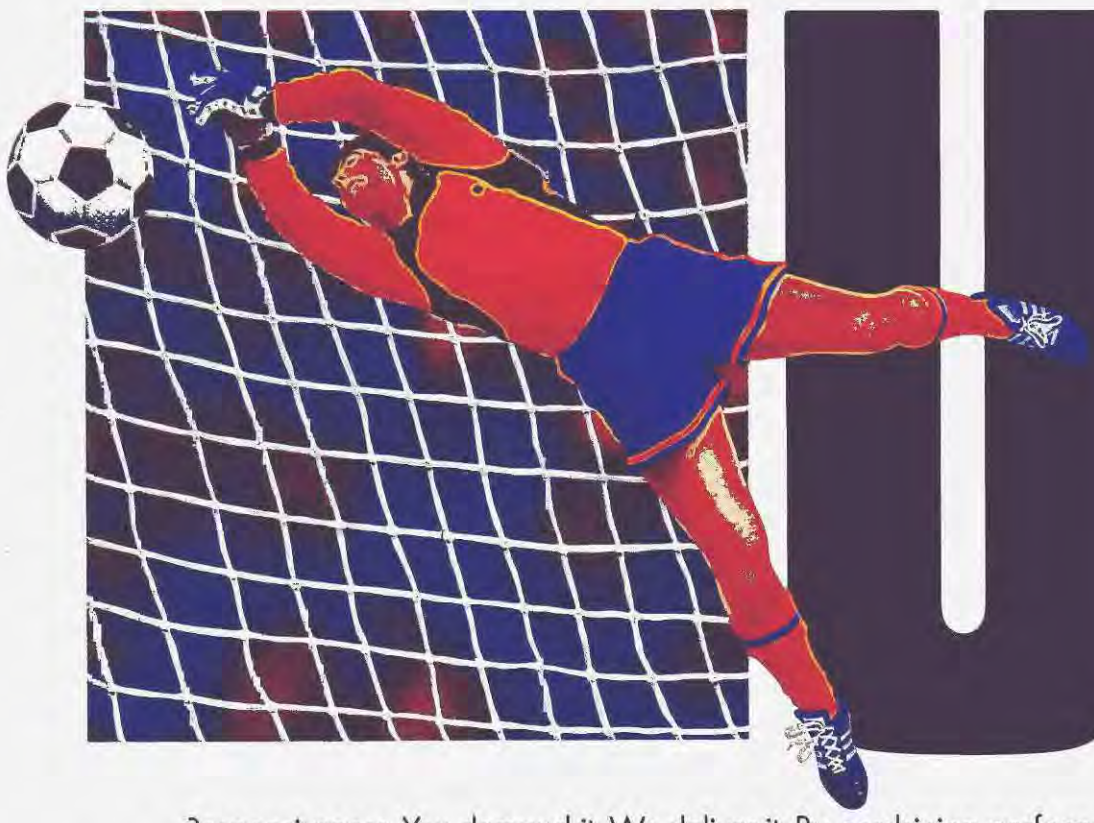

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Continued from previous page
clear that small employers had gotten the upper hand in their battle to repeal Section 89.

Desperate to avert repeal, Rep. Rostenkowski came up with a new Section 89 reform proposal that would have essentially scrapped Section 89 and replaced it with a new proposal intended to preclude so-called executive-only medical reimbursement plans (*BI*, Sept. 18).

But Rep. Rostenkowski's 11th-hour effort proved too late. By the time his third and last reform proposal was unveiled, few legislators wanted anything to do with Section 89.

"The political heat on Congress for Section 89 repeal became overwhelming," said Edward J. Davey, a principal with Foster Higgins.

In late September, the House voted 390-36 vote to add a Section 89 repeal amendment, proposed by Rep. Byron Dorgan, D-N.D., to a budget reconciliation bill (*BI*, Oct. 2). The entire budget reconciliation bill later was approved by the House.

Soon thereafter, the Senate Finance Committee approved a budget reconciliation bill with a Section 89 repeal provision. However, the Section 89 provision and hundreds of other provisions later were deleted from the bill as part of an agreement by Senate leaders to reduce the girth of the measure.

The repeal legislation remained in limbo until last week's agreement to add it to the debt ceiling legislation and the subsequent approval of that legislation.

However, the repeal of Section 89 cannot restore to employers hundreds of millions of dollars in compliance costs. But some believe the Section 89 debacle may have a silver lining: Legislators, embarrassed that they approved without discussion a proposal put together by mid-level Treasury Department staffers, are likely to pay closer attention to benefits-related legislation, observers say.

"Having been burnt on Section 89, legislators will be more cautious about voting on proposals that have not had extensive hearings," Mr. Saveth said.

In September, several representatives cited a lack of hearings in successfully urging rejection of an amendment to the budget reconciliation bill that would have required employers to share control of defined benefit and defined contribution pension plan assets with employees.

And, the victory on Section 89 is bringing new confidence to the employee benefit community, which scored a number of other decisive victories this year, including the defeat of the proposal to share control of pension assets and another much-assailed proposal that would have imposed stiff fees on companies filing federally required pension and welfare plan reports.

"It has been a watershed year in which employers said: 'We will not take it any more' and then employers prevailed. The employee benefits community has found its voice, and that voice is being heard in Washington," said Mr. Weizmann. ■

U.S. tort system is more expensive than other nations': Study

By JERRY GEISEL

SIMSBURY, Conn.—The cost of the U.S. tort system—as a percentage of gross national product—is more than triple that of tort systems in a dozen other industrial countries, a risk management consultant reports.

U.S. tort costs also are rising faster than those in the other nations, according to the report by the Tillinghast division of Towers, Perrin, Forster & Crosby Inc.

Tort costs—including claims payments by insurers and captives, administrative costs and attorneys' fees—were 2.6% of the U.S. gross national product in 1986 and 1987, the most recent years for which complete information is available.

By contrast, 1986 tort costs in only one of the 12 other industrialized countries exceeded 0.6% of GNP, according to "Tort Cost Trends: An International Perspective."

Among other surveyed countries, the highest 1986 tort costs as a portion of GNP were in Switzerland at 0.8% and the lowest in Australia at 0.3%.

Other nation's 1986 tort as a percentage of the gross national products were: Denmark, Japan and Spain, 0.4%; Italy and West Germany, 0.5%; and Austria, Canada and France, 0.6%.

In addition, tort costs as a percentage of GNP in Belgium and the United Kingdom were 0.5% in 1985, the last year for which complete information is available.

More extensive social welfare systems—such as national health insurance—in other industrial nations may account for some of the difference between the costs of the U.S. tort system and the tort systems in other nations, said Bob Sturgis, a managing principal of Tillinghast's property/casualty consulting division in Simsbury, Conn.

"There is presumption in other countries that the victim is being taken care of" and thus victims may not feel the need to sue, Mr. Sturgis said. And if there is a suit, the damage award likely will be lower, he said.

"If the victim is taken care of, he or she is less likely to feel like a victim," Mr. Sturgis added.

In addition, punitive damages and contingency fee arrangements, which some observers say drive up U.S. tort costs, are barred in many other countries, observers say.

While tort costs as a percentage of GNP generally have not varied in the 12 other nations by more than 0.1% since the mid-1960s, U.S. tort costs have risen steadily, according to the Tillinghast report.

For example, U.S. tort costs in 1965 amounted to $7.9 billion, or 1.1% of GNP, and then climbed in 1975 to $22.2 billion or 1.4% of GNP. In 1985, U.S. tort costs were $89.2 billion, or about 2.2% of GNP, while in 1986 costs rose to $108.4 billion, or about 2.6% of GNP.

In the final year studied, 1987, U.S. tort costs remained at 2.6% of GNP, though overall costs increased 7.9% to $117 billion in 1987 compared with 1986.

"Whereas tort costs in other countries have remained stable over the last 20 years, our costs have escalated," Mr. Sturgis said.

As a method of compensating accident victims for losses, the U.S. tort system "is both inefficient and unfair," according to the Tillinghast report.

For example, only 50% of total tort costs go to compensate actual economic losses and claimants' pain and suffering. The other half is consumed by insurers' administrative costs, claims handling expenses and plaintiff and defense attorneys' fees.

"Our tort system, as a system to compensate victims, is not working very well," Mr. Sturgis said. ●

A limited number of free copies of "Tort Cost Trends: An International Perspective" are available by writing Towers, Perrin, Forster & Crosby Inc., Marketing Services, 100 Summit Lake Drive, Valhalla, N.Y. 10595.

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PCW litigation

Continued from page 3

tinue their action" against Lloyd's, Minet and Mr. Wallrock, Mr. Moore said.

The PCW affair dates back to November 1982 when Lloyd's began investigating missing funds from the PCW syndicates, funds that were allegedly diverted by PCW Chairman Peter Dixon, former Chairman Peter Cameron-Webb and others.

Mr. Wallrock resigned as chairman of Minet shortly after the investigation began after admitting that he benefited financially from PCW reinsurance arrangements.

In June 1984, PCW members were called upon by Lloyd's to pay 38.9 million pounds ($61.6 million at current exchange rates) in losses from underwriting years 1979 to 1981. However, Minet and broker Alexander & Alexander Services Inc., which brokered some reinsurance for the PCW syndicates, offered to pay 38.2 million pounds ($60.5 million) of this amount. The amount included 25 million pounds ($39.6 million) recovered by Minet and A&A from Gibraltar companies allegedly controlled by Messrs. Dixon and Cameron-Webb.

The remainder was paid by Minet and A&A, in return for a pledge from PCW members not to sue certain parties. Most of the PCW members, including the plaintiffs in the recent action, accepted the offer.

In April 1985, PCW's successor agency, Richard Beckett Underwriting Agencies Ltd., announced that PCW members had to pay an additional cash call of 62 million pounds ($98.2 million) to meet Lloyd's solvency requirements.

Altogether, losses faced by the PCW syndicates totaled 130 million pounds ($205.9 million).

However, all PCW members refused to pay the losses after a report by accountant Price Waterhouse concluded that the PCW syndicates had overwritten their premium limits and entered into improper reinsurance transactions.

In November 1985, Lloyd's expelled Mr. Dixon and fined him a record 1 million pounds ($1.58 million) for his role in the misappropriation of syndicates funds. Five other Lloyd's members were also disciplined for their roles in the PCW affair.

Mr. Cameron-Webb, who later paid $1.5 million to Richard Beckett Underwriting Agencies, was accused by Lloyd's of contributing to the alleged fraud, but Lloyd's could take no action against him because he had resigned as a member in 1982.

Members of the PCW syndicates subsequently threatened to sue Lloyd's and 37 other parties to recover the losses.

In an attempt to avoid long litigation, Lloyd's in April 1987 offered to contribute 103 million pounds ($165.8 million)—financed by Lloyd's and other organizations including brokers and accounting firms—toward the PCW losses and give members immunity from any further losses.

In return, the 1,547 PCW members had to pay 34 million pounds ($54.7 million) toward the agreement and relinquish their rights to sue Lloyd's and other parties (*BI*, April 13, 1987).

However, the offer was not extended to Mr. Dixon and seven other members who allegedly participated in the fraud.

And, all but 10 members that were offered a chance to participate in the settlement agreed to the terms by the end of 1987, and until late September no litigation had been filed against Lloyd's or other parties over PCW losses.

Once the settlement agreement was made unconditional, a syndicate known as syndicate 9001 was set up in which all of the PCW syndicates' liabilities—except those of the 18 members not participating in the settlement—were transferred. In addition, the 137 million pounds ($217 million) contributed by Lloyd's, the other parties and the assenting PCW members was paid to the syndicate as a reinsurance-to-close premium from the PCW syndicates.

The new syndicate, managed by Additional Underwriting Agencies (No. 4) Ltd., then ceded all its business to a new Lloyd's subsidiary, known as Lioncover Insurance Co. Ltd. Lloyd's also formed a members' agency, Additional Underwriting Agencies (No. 5) Ltd., to manage the affairs of the 18 PCW members not participating in the settlement.

The settlement 'would bring a hefty liability' to the names," says Robin G. Moore.

A few months ago, AUA (No. 4) proposed collecting a 7.63 million pound reinsurance-to-close premium from the remaining 18 names who did not agree to or were not offered an opportunity to participate in the 1987 settlement, according to Mr. Moore, the plaintiffs' attorney.

That premium has since been paid by Lloyd's, which now is offering to cap the obligations of the 10 members who did not agree to the 1987 settlement in return for their share of the 7.63 million pounds and an agreement not to sue the parties to the 1987 settlement, including Lloyd's and Minet.

However, the eight members who were not allowed to participate in the 1987 settlement would still be liable for additional PCW losses, plus their share of the 7.63 million pounds.

The plaintiffs are balking at the Lloyd's offer.

The settlement "would bring a hefty liability to the non-consenting names," said Mr. Moore. In addition, his clients are questioning the accuracy of AUA (No. 4)'s accounts for the PCW syndicates, he added.

As a result, his clients and one other member filed two lawsuits in High Court in London to protect their interests, he explained.

Mr. Moore filed one of the suits on behalf of PCW members John Kethro Bindon, his wife Audrey Doreen Bindon, Frances Diana Bishop and Mitch Murray. A separate but similar action was filed by law firm White & McDevitt on behalf of former PCW member John Bremner, said Mr. Moore.

Continued on page 16

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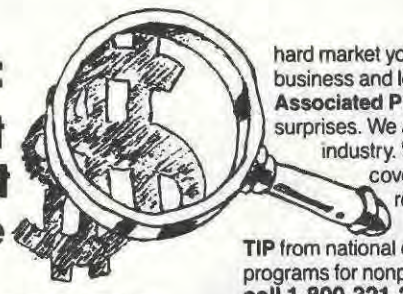

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PCW litigation

Continued from page 14

Attorneys at White & McDevitt did not return phone calls.

Mr. Moore's clients are seeking unspecified damages, plus interest, from the Society of Lloyd's under the Lloyd's Acts of 1871 and 1982 for "breach of statutory duty. . .and/or breach of fiduciary duty, negligence and/or breach of duty of care," the suit says.

The suit seeks damages from Minet for breach of fiduciary duty as PCW's parent and/or for negligent misrepresentations made orally or in writing in connection with the June 21, 1984, offer Minet made to PCW members.

Furthermore, the plaintiffs ask that the June 1984 agreement under which they pledged not to sue be rescinded.

The plaintiffs also want damages for "consequential loss and damage caused by a conspiracy to defraud" between the PCW agency, Minet, Mr. Wallrock and others, including Mr. Cameron-Webb and Mr. Dixon, the suit says.

The suit specifically accuses Mr. Wallrock of conspiracy to defraud "to make secret and improper profits" in the course of underwriting for the PCW syndicates.

The plaintiffs also seek damages from Sorim (1987) Ltd., the company set up by Minet to handle the runoff of Richard Beckett Underwriting Agency, for breach of underwriting agency contracts made between January 1968 and Dec. 31, 1984, for fraud and/or for breach of fiduciary duty.

The plaintiffs also demand in their action that the court declare that Sorim be recognized as the trustee for all PCW syndicate premiums "including the secret profits resulting therefrom."

In addition, the plaintiffs seek to force Sorim to "restore and pay to each of the plaintiffs their respective shares of the monies and profits."

The plaintiffs also want an indemnity from Sorim "in respect of any liability of each of the plaintiffs to tax, interest or penalties which may have fallen on the plaintiffs. . .which would not have done so or would not do so but for (Sorim's) conduct," according to the writ.

Lloyd's said it had received the lawsuits but could not respond until it receives points of claim, plaintiff's documents containing specific allegations.

However, a Lloyd's spokesman added that "should the lawsuit proceed, we will pursue it with the utmost vigor."

Minet's Chairman Ray Pettitt did not return phone calls. Mr. Wallrock, who lives in Hong Kong, could not be reached for comment.

Meanwhile, earlier this month the plaintiffs also applied to the High Court for an injunction to stop AUA (No. 4) from closing the PCW syndicate accounts, said Mr. Moore.

But, the High Court refused to grant the injunction, Mr. Moore and Lloyd's confirmed. ■

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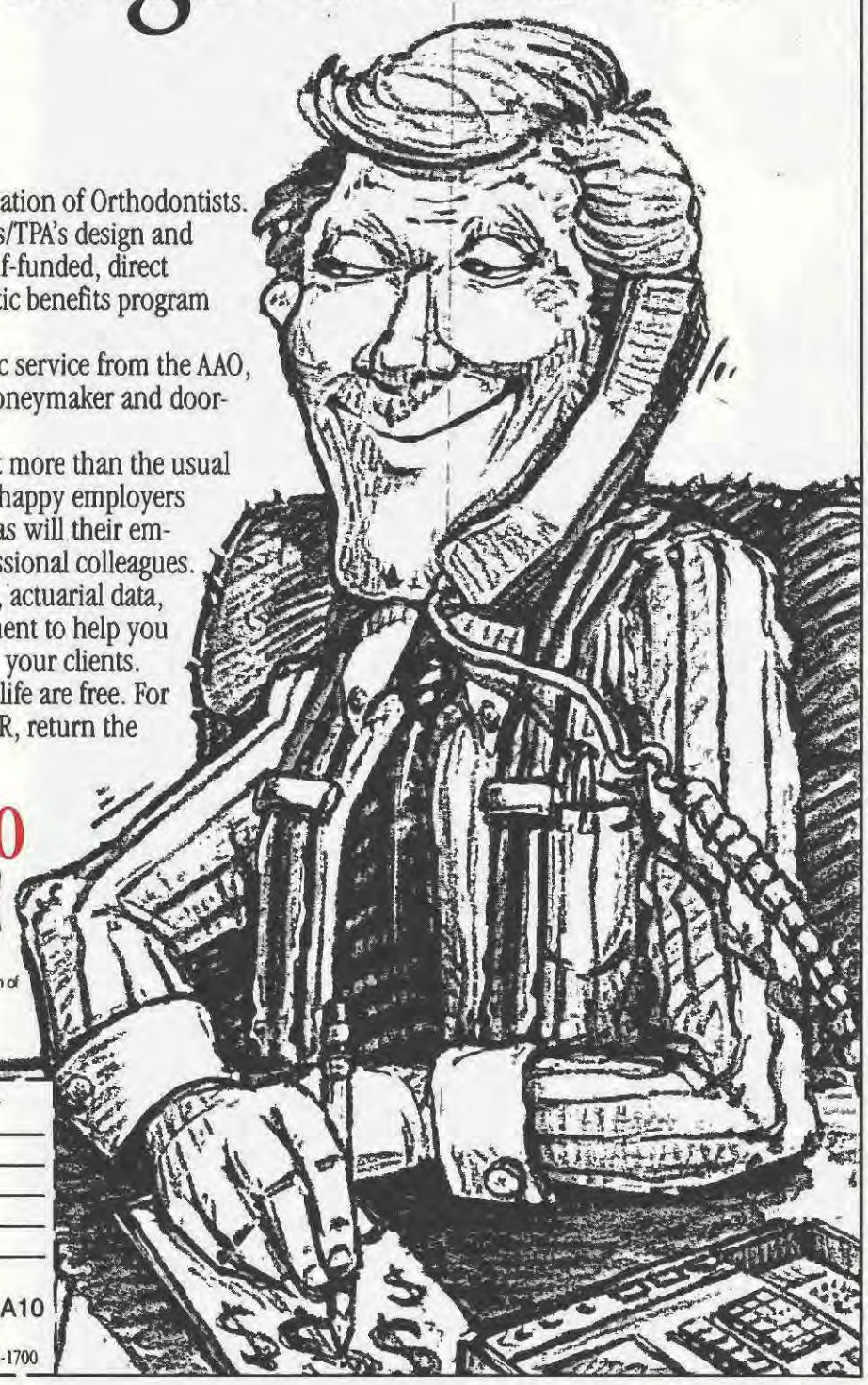

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Continental to buy surety operations

New York-based Continental Corp. has signed a letter of intent to purchase most of the surety operations of Transamerica Insurance Co. of Los Angeles.

Terms of the sale, which is expected to be completed by year-end, were not disclosed.

Continental plans to integrate the Transamerica surety operations with its existing surety business, which is written by its Continental Guaranty & Credit Corp. subsidiary.

CG&C markets surety and financial institution bond, commercial fidelity, credit and financial risk coverages.

Continental anticipates the proposed acquisition will add about $30 million to its surety premium writings next year, bringing combined 1990 gross surety premium writings to more than $110 million.

The purchase "not only represents a good fit with our existing operations, but also enhances our presence in select geographic areas and contributes several attractive new specialty programs within the surety line," said CG&C President Beverly B. Wadsworth.

Broker buys reinsurer

Lawrence Insurance Group Inc. of Albany, N.Y., has purchased Houston-based reinsurer United Republic Reinsurance Co. for $28 million as part of Lawrence's plan to diversify and increase its presence in the Southwest.

United Republic will continue to write its existing business.

United Republic had $32.9 million in capital and surplus as of Sept. 30, up $2.3 million from $30.6 million at year-end 1988, according to A. Wayne Peterson, president.

United Republic had written $10.85 million in net premiums as of Sept. 30, he said. It reported net premiums of $17.5 million for 1988.

Lawrence Insurance Group is a publicly held subsidiary of Lawrence Group Inc., parent of privately held Lawrence Agency Corp., the 20th-largest U.S. broker based on 1988 gross revenues of nearly $27 million.

Lawrence Agency plans to place with United Republic approximately $30 million of the reinsurance business it previously placed with other markets.

United Republic, which was established in 1986, is an admitted reinsurer in 27 states and is applying for admission in the remaining states.

Hafnia buys captive

The Hafnia Group of Copenhagen, Denmark, has purchased captive insurance company Forenede Assurandorer A/S from FLS Industries A/S in Denmark for 325 million Danish krone ($45.5 million).

Forenede, however, will continue to underwrite FLS Group's insurance, according to a public statement.

"Hafnia's acquisition of the company should be seen as the first step of a long-term insurance cooperation between Hafnia and FLS Group," the statement said.

Hafnia said Forenede is "known internationally as advisers in respect of captive insurance and risk management" and has "healthy Danish and international expertise in this important field of industrial insurance."

In a single European market, "heavy demands will be made on the expertise of the insurance companies regarding captive management, risk management and quality management," said Hafnia President Per Villum Hansen. "Through the purchase of Forenede Assurandorer A/S, Hafnia will be in a position to satisfy the requests and demands of such clients."

Hafnia Managing Director Hans Henrik Koefoed will assume the same title at Forenede.

Beginning next year, Forenede General Manager Jens Erik Ladelund will concentrate on the development of Forenede subsidiary Risk Research & Captive Services A/S, which provides risk management and quality management consulting services and captive insurance company consulting and management services.

Forenede, which has 38 employees, reported gross premiums in 1988 of 131.5 million Danish krone ($18.4 million) and a profit of 13 million Danish krone ($1.8 million).

Forenede also owns an insurance broker, which concentrates on placing captive reinsurance.

Markets

Lockton merger

The Lockton Insurance Agency Inc. of Prairie Village, Kan., merged with Denver-based agency J.H. Silversmith Inc. on Nov. 1 and will now be known as Lockton Silversmith Inc.

Terms of the merger were not disclosed.

The newly formed company and its 70 employees will move to new headquarters in Denver and will place a broad base of commercial property/casualty insurance coverages.

"This merger will thrust us into the Top 5 brokers in Denver," said Joshua Band, Lockton Silversmith chief operating officer. "Our goal is to double our revenues in five years," Mr. Band said.

Bill O'Connell, former president of Lockton, was named president of Lockton Silversmith, and J.H. Silversmith Jr., former president of his agency in Denver, was appointed chairman of the new company.

Lockton is the 30th-largest U.S. insurance broker based on 1988 revenues of $20 million. Silversmith reported 1988 gross revenues of $3.8 million.

For more information, call Joshua Band, chief operating officer, Lockton Silversmith Inc.; 303-751-5702 or 303-698-1221.

Claims management

Risk management consultant J.H. Albert International Insurance Advisors Inc. of Needham Heights, Mass., recently formed a new unit to provide casualty claims management services for self-insurers and insured clients.

J.H. Albert Claims Management Services, based in Needham Heights, Mass., will provide program development, case management, claim auditing and reserve analysis and employer training

Continued on next page

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services.

For more information, contact William Quinn Jr., Director, J.H. Albert Claims Management Services, 72 River Park, Needham Heights, Mass. 02194-2631; 617-449-2866.

HMOs acquired

EQUICOR Inc. has agreed to acquire Total Health Systems Inc., which operates health maintenance organizations in New York and New Jersey with approximately 115,000 enrollees.

"The acquisition of Total Health will give EQUICOR the capability to offer a quality managed care option to our employee benefit clients in New York and New Jersey," said Roger Jones, president of EQUICOR's Northeast region.

Great Neck, N.Y.-based Total Health reported revenues of $67.4 million in 1988 and $51.8 million in the first six months of 1989.

EQUICOR, based in Nashville, Tenn., is a joint venture of Equitable Life Assurance Society of the United States and Hospital Corp. of America. EQUICOR now manages HMOs in more than 30 markets.

The acquisition is subject to approval by regulators and by Total Health's shareholders.

New ABI unit

San Francisco-based broker American Business Insurance Inc. has established a new division to offer a full range of insurance services to the U.S. units of foreign-owned companies.

ABI International will be headed by Henri Monjauze, formerly executive vp and chief operating officer of CSE Insurance Group in San Francisco.

In addition to designing insurance programs for the U.S. units of foreign corporations, ABI International will provide opportunities for European and U.S. insurers to establish joint ventures or partnerships that will provide coverage and service to each other's policyholders or to new clients, according to Mr. Monjauze.

American Business Insurance Inc. is the 13th-largest U.S. broker based on 1988 gross revenues of $38.5 million.

For more information, contact Henri Monjauze, President, ABI International, 160 Spear St., Suite 1540, San Francisco, Calif. 94105-1547; 415-541-7898.

Benefit consultant

Pittsburgh-based Bigler-Ketchum Group recently formed a new employee benefits consulting subsidiary.

Benefit Consultants Inc. will provide consulting, planning and insurance brokerage services for public and private organizations and professional and trade associations.

For more information, contact Richard Galardini, President and Chief Operating Officer, Bigler-Ketchum Benefit Consultants Inc., 1030 Fifth Ave., Pittsburgh, Pa. 15219; 412-391-5525.

Additional service

The Tampa, Fla., office of New York-based Atlantic Mutual Insurance Co. is expanding its operations to provide commercial insurance underwriting services in addition to claims handling and inspection services.

The creation of a "full-service marketing center" is spurred by "the growth of the Florida economy and the expansion of our business in the region," explained Mark S. Brown, resident vp of the South-Central Region.

Atlantic Mutual's Tampa office is located at 5300 W. Cypress St., Suite 120, Cypress Commons, Tampa, Fla. 33609-0467; 813-289-6899.

Mergers/acquisitions

Tampa, Fla.-based broker **Poe & Associates Inc.** has acquired **Insurance Administration Center Inc.** in Park Ridge, Ill., an insurance consultant and plan administrator for the National Assn. of Wholesaler-Distributors and its member associations.

In addition, Poe, the 15th-largest U.S. broker with 1988 revenues of $35 million, plans to acquire **Marlar, Johnson & Allen Insurance Inc.** in Phoenix, Ariz. The company, which has 12 employees, will merge with Dean S. Davidson Insurance Agency Inc., Poe's Phoenix subsidiary.

Alexander & Alexander Benefits Services Inc., the health care and benefits brokerage unit of Alexander & Alexander Consulting Group Inc., has acquired Denver-based **Rocky Mountain Insurance Brokers**, which will now become part of the Denver office of A&A Benefit Services.

Hilb, Rogal & Hamilton Co. of Richmond, Va., the 12th-largest U.S. insurance broker with 1988 gross revenues totaling $49 million, announced an affiliation agreement with **Robert D. White**, an insurance agent in Dallas. Mr. White will now operate his business out of Hilb Rogal's Dallas office.

In addition, Hilb, Rogal is merging with **McEldowney, McWilliams, Deardeuff & Journey Inc.**, an Oklahoma City insurance agency. Terms were not disclosed. The agency will become Hilb, Rogal's Oklahoma subsidiary.

Switzerland Insurance Holding USA Inc., a member of the Swiss Re Group, has acquired **Bertschmann & Maloy Inc.**, a managing general agent in New York. The company, renamed **Switzerland Marine Managers Inc.**, will underwrite ocean marine insurance and provide claims management and other services. For more information, contact Robert Farulla, head of Switzerland Marine Managers Inc., 116 John St., New York, N.Y. 10017; 212-233-6560.

Citation Insurance Services, a newly formed subsidiary of Citation Insurance Group of San Jose, Calif., has acquired San Francisco-based **Navigators Insurance Services**, an underwriting affiliate of The Navigators Group Inc. of New York. Terms of the sale were not disclosed.

New offices

Underwriting manager and broker **Burns & Wilcox Ltd.** of Southfield, Mich., has opened a new office at 4330 Auburn Blvd., Suite 1300, Sacramento, Calif. 95841; 916-485-9595.

Rollins Burdick Hunter Co. of Chicago has opened a new office in Cincinnati. The new office is located at 250 E. Fifth St., Suite 1500, Cincinnati, Ohio 45202; 513-621-0130.

Van Beurden & Associates, a commercial insurance brokerage firm based in Kingsburg, Calif., is beginning construction of a new corporate headquarters. The two-story building should be completed by mid-1990. The new address will be 1600 Draper St., Kingsburg, Calif. 93631.

Edward H. Pine Insurance Agency Inc., a Fort Worth, Texas-based agency specializing in insurance for governmental entities, public housing authorities and schools, has moved. The new address is 5020 Collinwood, Suite 100, P.O. Box 901003, Fort Worth, Texas 76101; 817-732-6153.

Name changes

Risk management consultant **Applied Risk Associates** in Irvine, Calif., has been renamed Allon Greene & Associates. ■

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Brookings proposes to cut civil case backlog

By ADRIENNE C. LOCKE and JERRY GEISEL

Washington

WASHINGTON—A tracking system based on case complexity could relieve the civil case backlog in federal courts, a new study says.

The system could be used to resolve simpler cases more quickly, while reserving more time for complex cases, according to the Washington, D.C.-based Brookings Institution.

"The proposals recognize that the same set of generic procedures need not, and indeed should not, apply to all types of cases," says the report, "Justice for All: Reducing Costs and Delays in Civil Litigation."

For example, a proposed Track 1 would be for "expedited" cases that can be resolved quickly and fairly with little or no pre-trial judicial intervention.

Track 2 would be for "complex" cases needing early and intense judicial involvement.

And Track 3 would be reserved for "standard" cases that do not fall into the other categories, the study said.

The tracking system is the brainchild of a Brookings task force convened between September 1988 and June 1989 at the suggestion of Sen. Joseph R. Biden Jr., D-Del., to develop recommendations to cut court costs and delays.

The task force was composed of defense and plaintiffs' attorneys, civil and women's rights lawyers, attorneys representing consumers and environmental groups, insurance industry representatives, corporate counsel, former judges and law professors.

The panel also recommended the courts adopt certain time limits and set early, firm trial dates, depending on the track.

"Time limits can go a long way toward improving overall case management by attorneys and judges, reducing discovery abuse, and lowering litigation transactions costs," the panel said.

Abuse of the discovery process was cited as the chief cause of litigation cost overruns and delays by the majority of respondents to a survey of more than 1,000 civil justice system participants conducted by the task force.

The task force suggested limiting discovery to: 50-100 days in expedited cases, 100-200 days in standard cases and six to eight months in complex cases.

In all but the simplest cases, trial dates should be set at a mandatory hearing within 45 days of the first responsive pleading to a complaint, the report said.

Judges in complex cases should set trial dates about four months into the discovery period, according to the report.

To reduce extensions and continuances, the report said, courts should narrowly define the "good cause" needed to extend trial or discovery deadlines.

Each federal court should develop its own reforms for case tracking and time limits based on its own needs, the report said.

For example, each district court plan should ensure that magistrates do not have duties better left to judges, the report said. "Magistrates can and do fulfill a valuable function in alleviating judges' workload by performing many critical non-judicial tasks, especially for routine litigation. At the same time, however, the task force believes that a number of federal district courts are relying too heavily on magistrates in civil cases to conduct certain tasks that are properly reserved to judges."

District judges should monitor the number of items pending before each magistrate and the length of time each item has been pending, the report said.

The report also calls for more resources for district courts, including computers to bring administration "into the modern age."

The task force also recommended higher salaries for judges, the immediate filling of judicial vacancies and additional positions in districts with substantial backlogs.

Copies of the report are available for $5.95 from the Brookings Institution, 1775 Massachusetts Ave. N.W., 20036; 202-797-6258.

OSHA rules delayed

The Occupational Safety and Health Administration will delay implementation of its new lockout/tagout requirements until Jan. 2 in response to employer complaints that they lacked time to prepare for the order.

The National Assn. of Manufacturers sued to halt the measure Oct. 31, citing inadequate time to respond to changes and an "unrealistic" economic impact estimate.

OSHA voluntarily pushed the deadline back after NAM filed suit last month in the District of Columbia Circuit Court of Appeals. However, NAM officials said they would not drop the suit.

OSHA failed to give "adequate notice or opportunity to comment on the final standard, which was substantially different from OSHA's original proposal," said Jerry Jasinowski, newly elected NAM president. And the agency "seriously understates the economic impact on those industries affected," he said.

Some provisions are unnecessarily broad and underestimate compliance and training costs, he said.

The lockout/tagout rule requires employers to lock or identify by tags machinery being repaired or serviced so it won't be accidentally turned on (*BI*, Sept. 11).

Cargill fined

The Labor Department has cited Cargill Inc. of Minneapolis for 113 alleged violations of federal health and safety standards and proposed fines of $242,000 at its Buena Vista, Ga., chicken processing plant.

The workers' union had complained about employees' exposure to cumulative trauma disorders, caused by repeated awkward or forceful hand and arm actions.

According to the Occupational Safety and Health Administration, 111 of the alleged violations involve failure to implement administrative and engineering controls to reduce ergonomic or work environment hazards.

OSHA estimates the ailments affect two-thirds of the plant's 500 employees.

The company also was cited for not having an overall effective ergonomic program and for failing to provide employee medical records to union representatives. ■

MARKET REPORT:
EMPLOYEE BENEFITS
December 18, 1989

BI editors will evaluate market conditions affecting group health and managed care, forecast how much group health care costs will rise, and examine other benefits including dental plans and long-term disability plans. Plus editors will rank and profile the 10 largest consulting firms in our annual Directory of Benefit Consultants. This issue will provide executives with a clear picture of how to plan and implement their strategies for the coming year.

AD CLOSING: DECEMBER 5

THE YEAR IN REVIEW
December 25, 1989

BI editors will recap the events of the past 12 months — how these events have shaped the commercial insurance industry at home and abroad. The Year In Review serves as a barometer tracking news and trends: legislation and regulation; tort reform; section 89; prop 103; pollution liability; and the dramatic impact of the Valdez oil spill, hurricane Hugo and the San Francisco earthquake. This recap issue will provide readers with details of events and trends that will help shape the future.

AD CLOSING: DECEMBER 12

MARKET REPORT:
RISK MANAGEMENT
January 1, 1990

BI editors will look at where property/casualty insurance rates are heading during year-end renewals. Will the spate of disasters that occurred in 1989 mean higher insurance prices as we enter the '90's? Editors will talk to insurers, brokers, reinsurers, surplus lines market executives, London market officials and risk managers for their views. To take the pulse of the property/casualty insurance marketplace readers turn to BI.

AD CLOSING: DECEMBER 18

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Loss control vital in cutting comp costs

By COLLIN NASH

NEW YORK—Companies can control the destiny of their workers compensation insurance costs by making loss control an integral component of their operations, says a risk management expert.

Risk managers cannot control the casualty insurance market cycle, and "there is no question that the market will tighten" soon, said Harry P. Mirijanian, president of risk management consultant Applied Risk Control Corp. of Orangeburg, N.Y.

But, risk managers can protect their companies against the vagaries of the inevitable shift toward a tighter market by controlling their workers comp losses, Mr. Mirijanian said.

The company that can prove to underwriters that its losses are largely predictable will be able to obtain affordable insurance as workers comp insurance rates rise, he asserted.

"Clearly, if you cut losses you control your destiny," Mr. Mirijanian told risk managers at a Risk & Insurance Management Society Inc. breakfast seminar, "Casualty Loss Control—How to Prevent the Loss," in New York last month.

Risk managers have to recognize predictable accidents, Mr. Mirijanian said.

Conceding that loss recognition is difficult, Mr. Mirijanian suggested that risk manages first review the company's loss history and make sure that loss information is readily available.

Loss runs have been known to end up "in the bottom of managers' file draws," Mr. Mirijanian noted. "If no one sees it, no one does anything to it," he said.

Mr. Mirijanian suggested that risk managers establish a two-pronged loss control program consisting of pre- and post-accident phases.

In addition, he suggested that risk managers further segment the pre-accident phase of the program.

One phase should be devoted to the safety of operations, he said. For example, risk managers should implement controls to ensure that protective guards are maintained on equipment, that adequate caution signs are posted in dangerous work areas, that work stations are adequately lit and organized and that proper temperatures are maintained in work areas.

Anther segment of the pre-accident phase of a loss control program should be devoted to the human element of workplace accidents, he said.

For example, in assessing the effectiveness of a training programs, risk managers should be particularly careful that employees who speak English as a second language understand instructions, Mr. Mirijanian pointed out.

Companies also should be mindful of messages they convey to employees during orientation, he said.

To illustrate his point, Mr. Mirijanian recounted a case in which a company president told his new employees during orientation: "If you become financially distressed, we've purchased on your behalf workers comp insurance."

What employees are told and how they are told is of "paramount" importance to the success of a loss control program, Mr. Mirijanian asserted.

Risk managers also should consider conducting personality and heredity profiles of workers in an effort to eliminate losses, Mr. Mirijanian suggested.

"Personality profiles detect people who are psychologically bent on beating the system," and heredity profiles predict whether someone will eventually develop certain diseases such as cancer, he noted.

"I'm not advocating these" alternatives, he added. But, he advised risk managers to use the tests if the tests would be helpful.

Risk managers also must have a clear idea about what employees like and dislike about the company and what they believe are a company's most dangerous areas.

"It's absolutely paramount to get a handle on employees' perception of their jobs and the company, because no safety program will work if your employees are out to get you," he explained.

Realistically, risk managers cannot totally eliminate accidents, but there is much they can do after one to control future losses, Mr. Mirijanian stressed.

For instance, if risk managers can identify the events leading to the an accident, they can "control future losses," he said.

After an accident, risk managers should make a checklist of loss control mechanisms that might have mitigated the losses from the accident, Mr. Mirijanian suggested.

For example, a well-stocked first-aid kit and making sure employees have taken cardiopulmonary resuscitation training are good loss control mechanisms, he said.

Effective claims management is the final line of defense in controlling losses, he said. Risk managers should make sure the pertinent insurance claim forms are filled out correctly and promptly forwarded to adjusters.

But a loss control program can be effective only if top management is committed to it, and top management has to see the program's potential impact on insurance costs and profits, pointed out Angelo J. Anello, director of risk management for Instrument Systems Corp. of Jericho, N.Y.

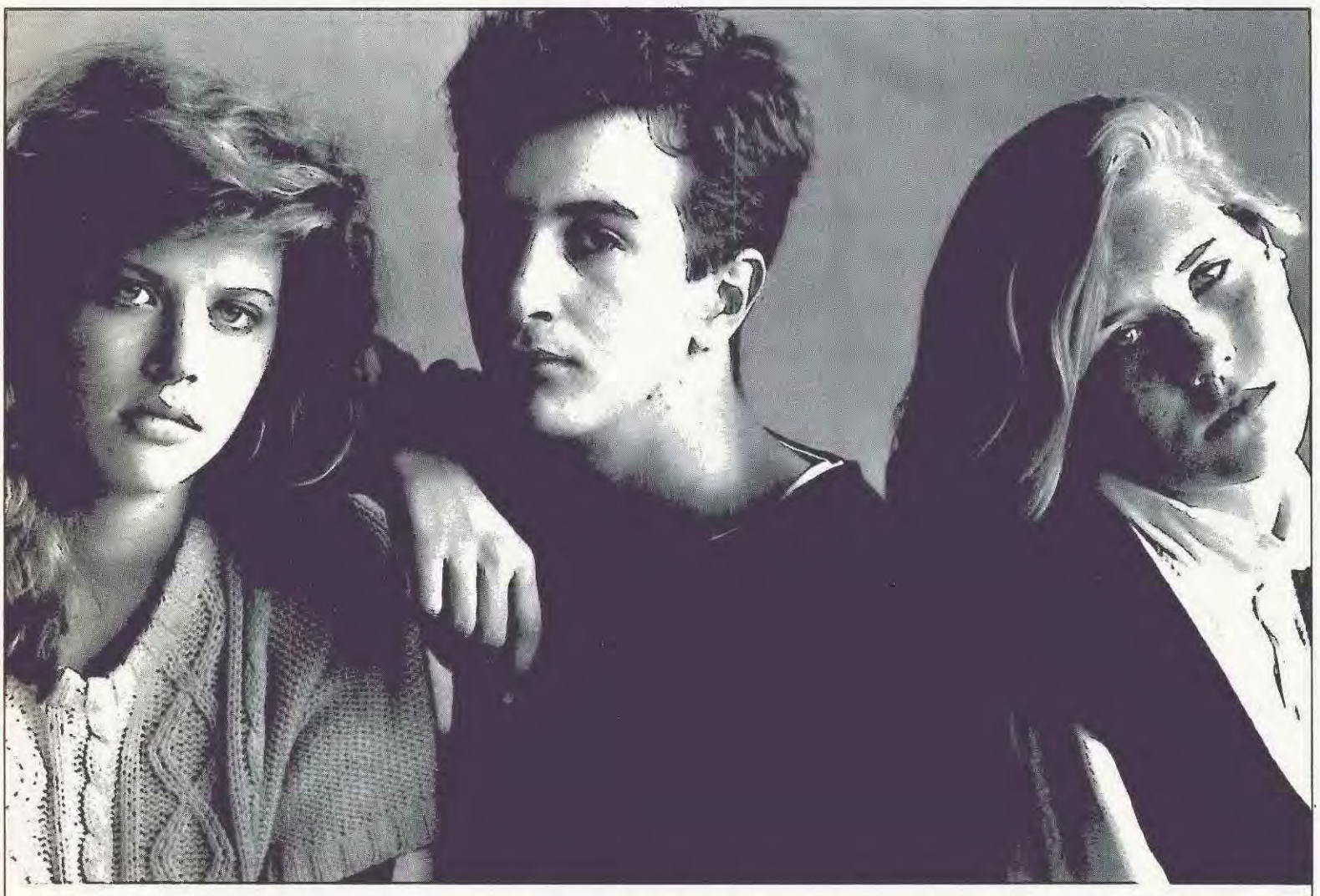
Risk managers also should point out how an ineffective loss control program, or the lack of one, may ultimately hurt executives' own pocketbooks, he said. Mr. Anello explained that many executives and managers are eligible for bonuses for exceeding production goals and revenues, which can be difficult to meet if there are excessive accidents.

Mr. Anello suggested that risk managers break down their companies' loss experience by divisions, subsidiaries or locations. With this data in hand, risk managers can then "give management a target to shoot for" in controlling future losses, he said.

Show company executives what expected losses are for the next year, and "you'll see some eyes light up," he said.

The importance of loss control also must be stressed with line supervisors, he said. "Make loss control and safety part of line supervisors' overall responsibility. It should be discussed with them at their annual (performance) review. Compare them with peers within the plant," Mr. Anello said.

"The only things that evolve by themselves in an organization are disorder, friction and malperformance," Mr. Mirijanian quipped. Risk managers must show management that without a well-thought-out loss control program, "they won't have a business." ■



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Agent/Broker Topics

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Nader takes pulpit on insurance issues

Industry leaders respond at PIA meeting

By LAURA MAZZUCA

LAS VEGAS, Nev.—The insurance industry's support for no-fault auto insurance is just the first step in an industry-wide conspiracy to deprive consumers of their right to collect pain and suffering damages, says consumer activist Ralph Nader.

"We all know that the insurance companies would like total no-fault, and partial no-fault through a verbal threshold is just the first step toward this," said Mr. Nader, founder of the Washington, D.C.-based Public Citizen consumer organization and a longtime insurance industry critic.

The insurance industry is "trying to ease in to eliminate the civil jury system altogether," he charged.

Mr. Nader discussed no-fault insurance and problems in the industry overall as part of a panel discussion during the 58th annual convention of the National Assn. of Professional Insurance Agents, held Oct. 29-Nov. 1 in Las Vegas, Nev.

The panel's title, "Consumers and Insurance: In Search of the Win-Win Strategy," proved to be overly optimistic in light of the discussion that ensued, as Mr. Nader and a panel of insurance industry representatives agreed to disagree during most of the discussion.

Patrick Buchanan, syndicated newspaper columnist, host of the Cable News Network's "Crossfire" program, and a former official in the Nixon and Reagan administrations, presided over the rancorous session as Mr. Nader and the panelists jousted over industry topics such as territorial rating, the McCarran-Ferguson Act, the public's perception of insurers and agent commission rebating.

However, Mr. Nader and the industry panelists eventually did find some common ground in the area of improving industry lobbying efforts, implementing loss prevention and education programs to lower the high cost of auto insurance premiums, and finding new ways in which insurers can communicate with the public.

Throughout the two-hour panel discussion, Mr. Nader was particularly outspoken on the subject of no-fault auto insurance.

Unlike his fellow consumer activist J. Robert Hunter, president of the National Insurance Consumer Organization in Alexandria, Va., Mr. Nader is opposed to the concept of no-fault insurance because a plaintiff cannot be compensated for pain and suffering under most no-fault laws, and "a person who is injured is treated as so much damaged goods," he said.

Because it's impossible to collect damages for pain and suffering under most no-fault laws, "it hits elderly people, housewives and children harder because they don't have a wage loss," said Mr. Nader.

Even Mr. Hunter, who is closely linked with Mr. Nader but who supports the concept of no-fault auto insurance, does not believe that no-fault will lower auto insurance rates, added Mr. Nader.

Furthermore, the no-fault concept has not worked in Michigan, Florida or New York, so it should not be considered elsewhere, he stated.

However, panelist Michael F. Conners, president of Conners & Reddy Insurance Inc., an agency in Cohoes, N.Y., disagreed that no-fault laws fail to adequately compensate victims, noting that auto accident victims can collect substantial amounts.

And, since New York's no-fault law was passed in 1973, the state's auto insurance rates have increased 73%, compared with the 146% increase in auto insurance rates in the rest of the country during the same period, said Mr. Conners.

The New York no-fault system allows claims processing to move more quickly as well, with injured parties collecting medical expenses within an average of 30 days after filing a claim, compared with the average of seven or eight years it takes to collect court awards under the tort system, Mr. Conners said.

He added that auto insurance was still "fairly affordable" in New York City as a result of

Continued on next page

From left, columnist Patrick Buchanan moderates a panel discussion featuring consumer activist Ralph Nader, Kemper Group's Peter T. Standbridge and Michael F. Conners of Conners & Reddy Insurance Inc.

Nader

Continued from previous page

the no-fault law, though he conceded that auto insurance rates are still significantly higher in the city than in the suburbs.

Other panelists suggested that problems with the no-fault system lie more with trial lawyers than with the insurance industry or the no-fault laws themselves.

But, while Mr. Nader agreed that there are problems with "storefront legal operations that crank the system," he pointed out that these problems should not be corrected by taking away the legal rights of the public through no-fault's "tort deform." If that occurs, "you're going to buy an incredible backlash," he advised.

The tort system has helped spur actions that have been taken for the good of society, like asbestos removal and product safety campaigns, he explained.

In addition, individual plaintiffs who filed product liability lawsuits against large corporations that manufacture asbestos products or defective intrauterine birth control devices would have never been able to afford legal recourse if attorneys did not operate on a contingency fee basis, he said.

But although Mr. Nader is adamantly opposed to no-fault, he believes that other insurance industry practices can be changed for the better.

Mr. Nader said his concept of the ideal insurance system for the year 2000 is one that operates in a "competitive framework," without antitrust protection, advisory rates from the Insurance Services Office Inc. or anti-rebate restrictions for agents.

Insurers operating in this Utopia would "act as underwriters and not simply cash cows" by developing their own research divisions, which would operate safety laboratories, proving grounds and other auto improvement experiments, the fruits of which would help hold down auto insurance costs, Mr. Nader explained.

He cited a prototype "safety car" developed by Liberty Mutual Insurance Co. of Boston in the 1950s as an excellent example of how insurers could work with manufacturers in developing safer automobiles.

And, Mr. Nader's ideal insurance industry also would allow agents and insurers to work together to prevent automobile accidents by establishing government safety standards that would mandate that auto manufacturers improve their products.

This "engineering strategy" includes the restoration of the 55-mph speed limit, a regulation that automobile bumpers must withstand a 5-mph crash without damage, a mandatory motorcycle helmet law, mandatory installation of air bags in new cars and side impact standards for automobiles.

The consumer would play a more active role as well, taking advantage of a system in which insurers "disclose, update and justify their rates" in order to allow policyholders to compare rates in order to purchase the most competitive policies, he said.

Mr. Nader also attacked territorial automobile insurance rating, saying that where a driver lives has been "exaggerated" in the rating process "simply to increase insurer revenues." Instead, criteria such as the person's driving record and the number of years he or she has been behind the wheel, should be given more weight when rates are set.

But while the other panelists agreed with some of Mr. Nader's more general ideas for safety programs and better communication with consumers, they strongly disagreed with his criticisms of the insurance industry.

"Anybody who's been in this business for any period of time knows that there is more competition than most of us can handle already," said Peter T. Standbridge, executive vp of Long Grove, Ill.-based Kemper Group, referring to Mr. Nader's opinion that ISO advi

Continued on page 22D

This issue of *Agent/Broker Topics* is being published the second week of the month to include coverage of the National Assn. of Professional Insurance Agents conference held earlier this month. The December *Agent/Broker Topics* issue will appear Dec. 4.

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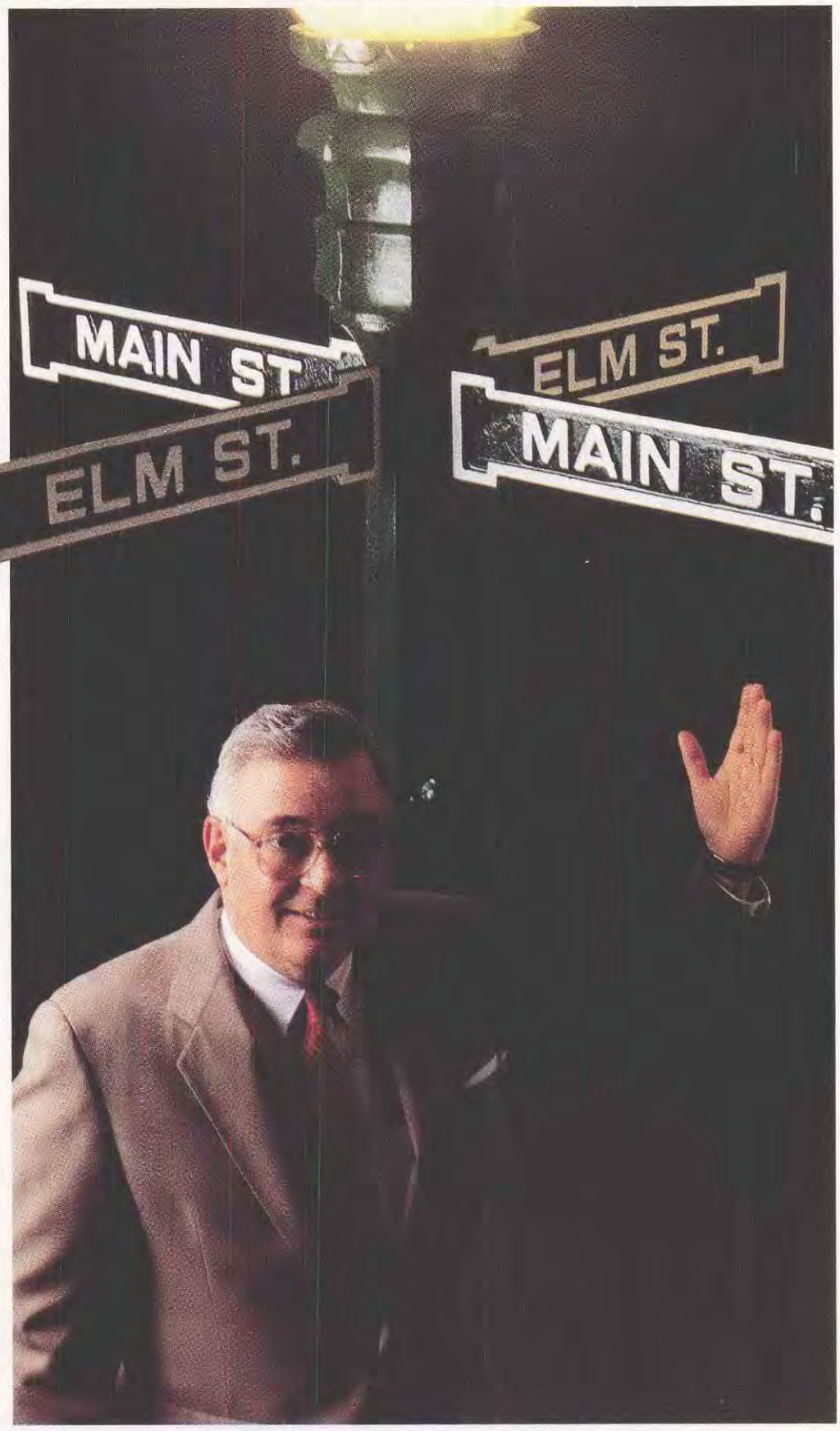

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Agent/Broker Topics

Nader appearance draws mixed reaction

By LAURA MAZZUCA

LAS VEGAS, Nev.—Consumer activist Ralph Nader drew resentment —with at least one conference participant calling him the "enemy"—as well as curiosity when he spoke at the 58th annual National Assn. of Professional Insurance Agents conference.

But most agents were interested in hearing out Mr. Nader.

Marshall Rubenstein's sentiment represented that of many conference attendees when he said: "Mr. Nader's crusade for safety is like motherhood and apple pie, but his facts are incorrect."

Mr. Rubenstein is president of the Margold Agency Inc. in Hicksville, N.Y.

But consumerism and consumerists did rankle some. Officials from one insurer—Baltimore-based United States Fidelity & Guaranty—did not attend the convention because J. Robert Hunter and Mr. Nader were to appear.

"We are very concerned about the tendency in the insurance industry to pay people who are critical of us speaking fees," said USF&G Senior Vp W. Minor Carter. As a matter of company policy, he said, USF&G does not attend industry gatherings where outspoken critics appear.

Mr. Hunter, president of the National Insurance Consumer Organization, was to speak at a panel discussion with Mr. Nader, but canceled to provide consultation to the North Carolina Insurance Department, said a PIA spokesman.

And the association itself was criticized by some agents for its proactive consumer stance.

However, in his State of the Association address, outgoing President David L. Ream said the PIA's consumer outreach program is "unmatched in the industry. It has become our best vehicle for building a better business climate."

In addition, during his year-long tenure as PIA president, only a "minority" of the 27 insurers he visited had taken negative views of the program, Mr. Ream said.

And, newly installed PIA National President Richard Yingling promised to continue the consumer outreach efforts through the association's Consumer Insurance Interest Group and Agents & Communities Together program.

CIIG gathers public opinion on insurance industry issues in an effort to improve consumer relations. ACT, introduced last year, trains and encourages agents to make the industry's case through outreach programs, speeches to community groups and acting as sources for local news stories.

"It seems like some insurance companies don't want to listen to consumers because they may have to give up something to achieve customer satisfaction," said Mr. Yingling. "But the only way things are going to improve is if we initiate action."

The CIIG and PIA jointly developed a consumers' "bill of rights," including the right to protection, to be informed, to choose, to be heard, to redress, and to be treated with dignity, honesty and fairness.

Regardless of what prompted agents to hear Mr. Nader, his presence helped boost attendance about 40% over 1988, said a PIA spokesman.

"I don't like him, but I respect him," said Lyle D. Roth, vp of the insurance division of Koelbel & Co. in Denver and chairman of PIA's national company relations committee.

Others charged that Mr. Nader lacked knowledge about the insurance industry.

"He's pretty much able to ride on how bright he is and how uninformed others are," said Michael F. Conners, president of Conners & Reddy Insurance, an agency in Cohoes, N.Y. Mr. Conners, who appeared on the panel with Mr. Nader and several others, added that his "media star" status ensured that the panel would be well-attended.

Most agents attending the panel discussion "went out of a combination of curiosity, celebrity, and hostility factor," said a PIA spokesman.

"But you can't hide your head in the sand," remarked Mr. Rubenstein of the Margold Agency. "You have to know what your competition is thinking. If we could sit down with him and show him some of the facts, we might make some headway." ■

Nader

Continued from page 22B

sory rates and the industry's limited immunity from federal antitrust laws under the McCarran-Ferguson Act be eliminated.

"If it (McCarran-Ferguson) is repealed, it wouldn't change the way Aetna does business," said John Martin, president of the personal and financial security division of Aetna Life & Casualty Co. of Hartford, Conn.

However, some of the insurer's market niches might be hurt by a lack of ISO ratings, which could result in withdrawal from markets, he added.

And, since many small regional insurers use ISO rates because they do not have the actuarial ability to develop rates themselves, the elimination of ISO could put them out of business, said Mr. Conners. This would be disastrous if large insurers, like Aetna or Kemper, pulled out of a market or region, since agents depend on regional insurers to fill such a gap, he added.

Mr. Conners also took issue with Mr. Nader's views on rebating, which he said "illustrate a lack of understanding of how the system really works."

He pointed out that excessively competitive rebating led to insurer insolvencies earlier this century. He added that the small policyholder stands to lose if rebating is allowed, since most agents will not offer rebates to clients with small premiums or who file many claims.

And, while agreeing with Mr. Nader's opinion that where a driver lives is sometimes overemphasized in auto insurance rating, Mr. Martin pointed out that, overall, current rating practices create incentives for good driving records. However, to make rating really equitable, insurers need more accurate motor vehicle information and more consistent law enforcement. "And those are the areas where you and we should work more closely together," he told Mr. Nader.

Continued on next page

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Continued from previous page

Other panelists defended the need for territorial rating.

"I sell insurance for a living, as do most of the people out there," countered Mr. Conners. "And there is a big difference, whether you like it or not, if you park your BMW in New York City or Watertown."

"Boston and Detroit have 2,700 thefts per 100,000 cars; Chicago and Baltimore have 1,300. That's the difference" that is taken into account in territorial ratings, added Mr. Standbridge of Kemper.

There were other areas of agreement too.

For instance, both Mr. Nader and insurance industry representatives concurred that the industry had lost the confidence of the public.

"We sell a high-priced product that you have to buy but you can't use unless you're in trouble," said Mr. Standbridge of Kemper. Although this has always been been the case, "the price keeps getting higher," which only adds to the public's negative opinion of the industry, he explained.

Mr. Conners noted that the insurance system is too complicated for the general public to understand, and that "we've got to dumb it down" to make it understood.

"Why don't you just say 'clarify?' " asked Mr. Nader. "I don't think being obtuse is particularly 'dumbing up.' "

Mr. Nader said he believes that the reason the insurance industry has such a bad reputation with consumers is because insurers increase rates and cancel policies arbitrarily without informing their policyholders why they are doing so, citing as an example the commercial property/casualty insurance market of 1985-1986.

"It's the lack of explanation which you should fulfill," he said.

If the insurance industry truly wants to improve its image, agents should position themselves as "the sentinels of auto safety" by pushing for mandatory safety devices in new cars. If they do, "they (consumers) will flock to you as their supporters," said Mr. Nader.

Mr. Martin of Aetna pointed out that individual insurers have taken steps toward public education and auto safety programs. For instance, Aetna recently donated video cameras to the Houston police in order to track drunk drivers.

"I like to think that we are all consumer advocates," said Mr. Martin.

"Maybe we haven't done as much as we could, as quick as we could, but it's kind of hard to respond to a situation when you and some of your colleagues have your heels at our throats. . . If we make a step toward you, you call it a diversion," Mr. Martin told Mr. Nader.

"But I want you to take more than one step—I want you to fulfill your potential," Mr. Nader replied.

While he commended the PIA on its consumer outreach program (see story, page 22D), he did not believe such programs are effective, since the insurance industry failed to push legislation through Congress that would have reinstated the 55-mph speed limit or established the 5-mph bumper requirement.

"Those two trademarks of the test of loss prevention in the industry would have been won for the consumer, with billions of dollars saved," said Mr. Nader. "All of you have your favorite members of Congress; you have dinners with them. You meet with them more often than we would ever dream of meeting them. . .what do you do to use a fraction of your political muscle?"

Mr. Standbridge of Kemper agreed that while industry lobbyists worked hard on these issues, "collectively we didn't work together, and that's been a problem of this industry for many, many years."

"We can't agree on anything," he said. "That's why all the opposition against McCarran-Ferguson is a little questionable," he noted, referring to the fact that insurers seldom act in concert.

"The system should be driven by you; if you don't do it, it will create a vacuum that might be filled by someone you don't agree with," agreed Sen. Randolph J. Townsend, D-Nev., who also participated in the panel discussion.

Mr. Nader and the panelists also agreed that while California's Proposition 103 is a threat to the insurance industry, it also can be an opportunity for the industry to address its communication problems with the public.

Mr. Martin called Proposition 103 a "wake-up call" for the industry to improve its relationship with the public.

"I think we have a tremendous challenge within our families, our work groups and our church groups," he said. "We need to make people better understand the options that they have to spend their premium dollars." ■

PIA conference sets record for attendance

LAS VEGAS, Nev.—More than 3,000 agents and guests from across the country packed their bags and headed for the slots, shows and sun of Las Vegas for the 58th annual convention of the National Assn. of Professional Insurance Agents, held Oct. 29-Nov. 1 at Bally's Casino Resort.

Though Lady Luck may have treated the agents with an impartial hand at the gaming tables, Mother Nature was less than cooperative. Guests from chillier climes were disappointed by the unseasonably cool Las Vegas temperatures, which were in the 50s.

And, although conventioneers were entertained by the Smothers Brothers comedy team and performer Jim Stafford on Monday, a musicians' strike shut down other stars, like Rodney Dangerfield, who were slated to appear at Bally's.

Despite the disappointments, the convention set an attendance record, said a PIA spokesman.

The keynote speaker, oil baron and takeover king T. Boone Pickens Jr., addressed agents on the entrepreneurial spirit and America's trade relations with other countries. In addition, consumer activist Ralph Nader raised the dander of some agents with his outspoken criticism of the insurance industry (see story, page 22A).

Sixteen continuing education workshops, including sessions on how to start an agency, how to motivate frustrating employees and how to develop consulting expertise, were offered.

And more than 100 exhibitors—including insurers, computer software vendors and third-party administrators—offered attendees a sample of their wares.

The 1990 PIA convention is scheduled for Nov. 11-14 at the Marriott Marquis in Atlanta.

For more information contact the PIA at 400 N. Washington St., Alexandria, Va. 22314; 703-836-9340.

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Agent/Broker Topics

Agents aid quake victims with loans and a hot line

By LAURA MAZZUCA

LAS VEGAS—The Professional Insurance Agents of California & Nevada is pitching in to help member agents and the general public who suffered damages in the earthquake that hit the San Francisco Bay Area last month.

The group is offering a total of $200,000 in loans to member agents in the Bay Area who sustained damage to computers and other equipment, furniture and supplies, said Mark A. Fukui, president of the Van Nuys, Calif.-based chapter of the National Assn. of Professional Insurance Agents

One-year loans of up to $5,000 per agency are available at 9% interest, according to Mr. Fukui, who also is executive vp of the Finney & Brown Inc. agency in Sacramento, Calif.

The PIA of California & Nevada started the loan fund with a $100,000 contribution, which the national PIA in Alexandria, Va., matched dollar for dollar, Mr. Fukui said.

"A good percentage" of the 200 Bay Area member agents "had some sort of damage," and about a dozen have requested loans, according to a PIA spokesman.

However, most of San Francisco Bay Area agents who registered for the PIA's 58th annual convention held Oct. 29-Nov. 1 in Las Vegas were able to attend the conference, Mr. Fukui noted.

To qualify for a loan, member agents must submit proof of damages and applications by Dec. 15.

Some agents still are assessing their total damages.

"We're just not sure where we're at yet" regarding damage, noted Tim Welch, a principal with Rittenhouse Insurance Center in Santa Cruz, Calif.

The 100-year-old building that housed the Rittenhouse agency suffered major structural damage and may be demolished, according to Mr. Welch. The agency's staff was allowed to retrieve some files and computer equipment from the building after the quake, but it is too hazardous to try to remove such items such as office furniture and copiers, he noted.

The agency's staff currently is "working out of cardboard boxes" in rented office space in Santa Cruz, he said.

Rittenhouse has applied for a loan through another source and may supplement this with a PIA loan if necessary, according to Mr. Welch.

In addition, some PIA agents who emerged from the quake unscathed pledged extra office equipment, supplies and the use of telephones and office space to other agents who were not as lucky.

"We got offers from agents as far away as Santa Rosa, just offering to help us dig out," recounted Karen Pitkin, president of Healy Insurance Marketing Services in San Mateo, Calif.

Ms. Pitkin's agency was closed for eight days after the quake because its building was declared unsafe. The quake detached the office's interior walls from its bearing walls, which sent furniture, file cabinets and computer terminals whipping around the office, Ms. Pitkin noted.

Other agents offered Ms. Pitkin's agency use of equipment and office space, but she did not have to take advantage of those offers because of the "incredible job" the agency's insurers did of contacting clients while the office was closed, Ms. Pitkin said.

As a result of the insurers' efforts, serious business interruption was prevented and the agency will not need a PIA loan, she said.

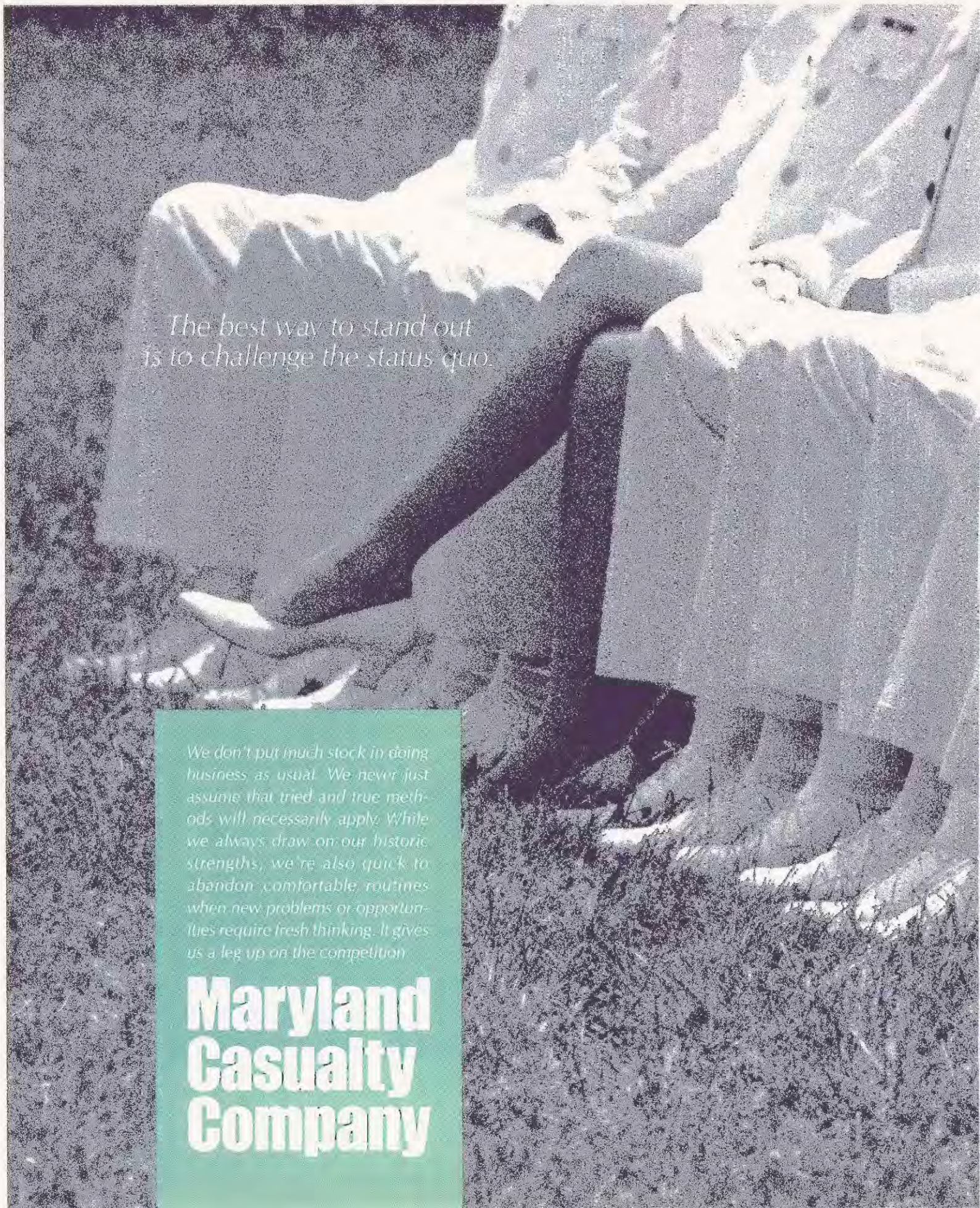
However, Ms. Pitkin is referring clients with "esoteric" quake-coverage questions to PIA of California & Nevada's toll-free "Earthquake Hotline": 800-448-0300.

The PIA chapter established the service shortly after the quake when phone lines were still down in the bay area. The California & Nevada PIA publicized the toll-free number nationwide and made the service available to relatives and friends outside the state trying to reach quake-stricken Californians.

The PIA chapter also has donated about $5,000 to the American Red Cross' earthquake relief fund, according to Rodney B. Leavitt, national director of the PIA and president of Leavitt Insurance in Las Vegas. ■

Bright lights, sin city

The National Assn. of Professional Insurance Agents convention, held Oct. 29-Nov.1, drew record crowds to Bally's Casino Resort in Las Vegas.



Business Insurance, November 13, 1989 / 22G

Business survival top priority for agents

By LAURA MAZZUCA

LAS VEGAS, Nev.—Although most agents agree that it is important to improve communications between policyholders and the insurance industry, they say that more immediate problems make it difficult to pursue public relations efforts.

Agents at the 58th annual National Assn. of Professional Insurance Agents convention in Las Vegas, Nev., this month said they were more concerned about insurers' increasing demands for premium volume and the lack of coverage availability in specific markets than they were with improving public relations.

"We try to talk to our people (clients), but many of them are in a hurry and aren't interested," said Rolf Ullrich, principal with the Bush Agency Inc. in Catskill, N.Y.

Because the agency operates in a rural area of New York state and its personal lines business is not highly specialized, its biggest problem is the continuing competitive market.

In nearby New Jersey, the state's malfunctioning joint underwriting association for auto coverage "has consumed us this year," said William G. Vowteras, principal at Fraser Brothers Inc. in Edison, N.J.

He explained that legislative changes this year have required insurers writing auto insurance in the state to reassume some business that had been underwritten by the JUA.

That meant that Mr. Vowteras' agency has had to convert many of its JUA policyholders to voluntary market policyholders. So far 400 policies have been switched over, Mr. Vowteras said, and the agency is only halfway done.

In addition, the JUA switched to new servicing insurers, forcing the agency to work with unfamiliar companies.

The double whammy, he said, is "wrecking the office."

The soft commercial property/casualty insurance market also has hindered the agency. However, Mr. Vowteras predicted that the California earthquake and Hurricane Hugo, coupled with the inevitability of a market hardening, will cause insurers to start raising rates.

Some agency principals are preoccupied with increasing volume to satisfy insurer demands.

"Our goal is just to go out there and sell, sell, sell," said Rudolph H. Franklin, president of Cycle Insurance Agency Inc. in Philadelphia.

Cycle places coverage for owners of motorcycles, recreational vehicles, snowmobiles and campers. Business is brisk and the agency has recently upgraded its 15-year-old automation system to meet demands, said Mr. Franklin.

At the Quality Insurance Service agency in St. Paul, Minn., agents hope to spur internal growth by increasing use of the agency's automation system and adding bookkeeping capabilities, said Norm Linnell, a principal.

Ashok Kumar, owner of Ashora Insurance Agency in San Francisco, also wants to grow by automation, specifically by adding an agency automation system next year.

About a year ago, Mr. Kumar started his one-man agency, which is about 70% commercial lines and specializes in hotel-motel coverage. He plans to step up marketing and hopes to hit $2 million in premium volume next year.

However, some agents have set communication with the public as a priority.

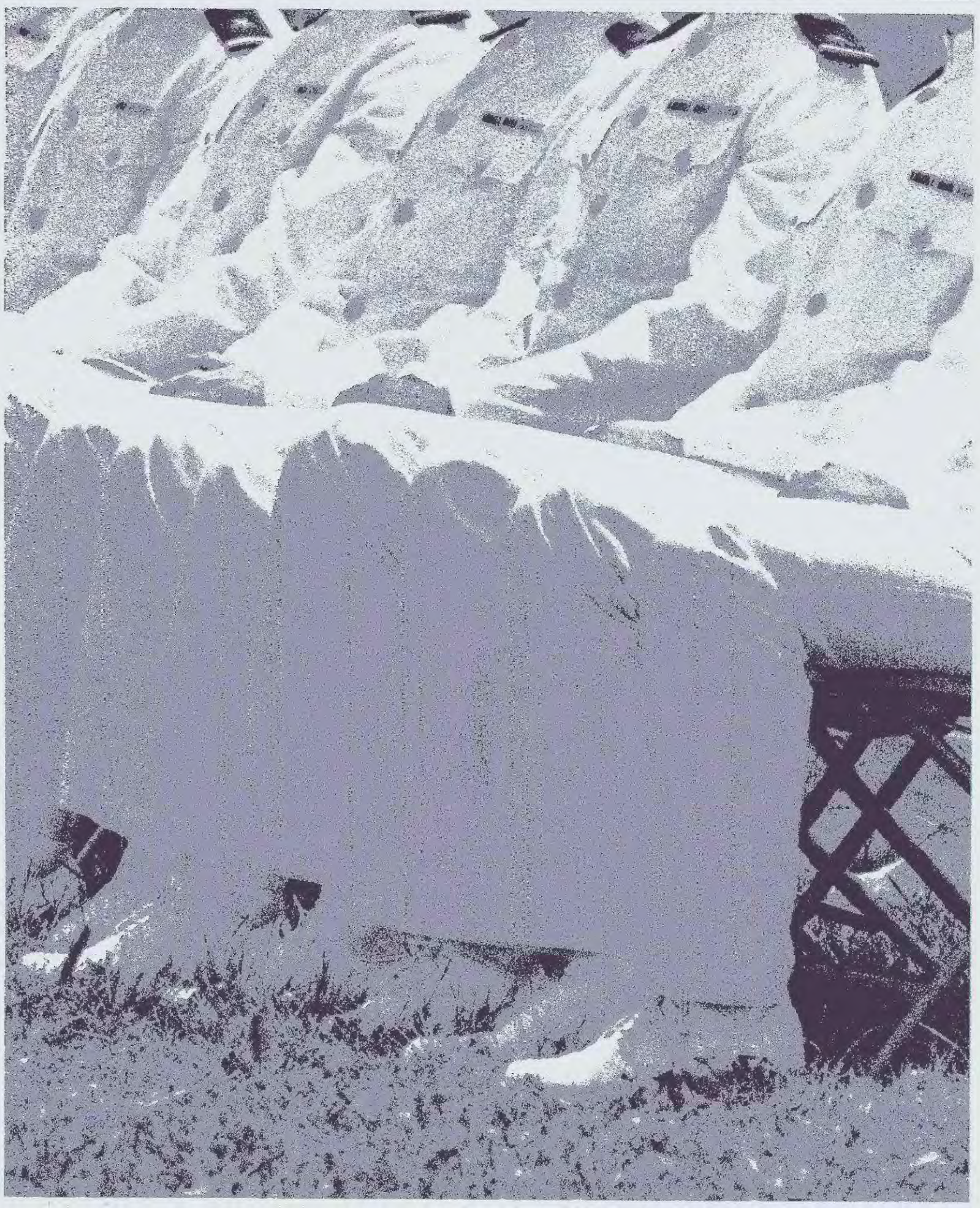
In 1990, we have "to get the message across to the public and the companies that the insurance agent is consumer-oriented. Without consumers, we have no one to do business with," said Marshall Rubenstein, president of the Margold Agency Inc. in Hicksville, N.Y.

Toward that end, Mr. Rubenstein, who is president-elect of the PIA in New York, speaks to college groups about insurance issues.

Independent agents must convince the public that "we're really representing them more than the insurer," said Dean Krueger, president of Krueger Insurance Management Inc. in Newton, Kan.

Mr. Krueger's agency tries to convey that message through regular newspaper advertisements. He was also instrumental in introducing PIA's Agents & Communities Together, or ACT, program in Kansas last year. Through this program, agents receive PIA information to help prepare them for appearances before community groups and schools and to act as sources for the local media.

Mr. Krueger's son and partner regularly addresses high school students about insurance, he said. ■



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Agent/Broker Topics

Study urges agents to size up insurers

By LAURA MAZZUCA

Agents should take the lead from insurers and use formal compatibility and performance evaluations to determine whether an insurer is a "good fit" with the agency, according to a recent study by the National Assn. of Professional Insurance Agents based in Alexandria, Va.

In a two-part project, "Evaluating Company-Agency Relationships," the PIA and its advisory council of 78 insurance companies polled insurers on what they seek from agents. Then, the PIA used this information to develop a formal evaluation format that agents can use to evaluate insurance companies.

Insurers seek the same things in agents that agents seek in insurers, the PIA concluded.

Consequently, the company evaluation forms developed by the PIA's agency company relations committee include checklists and evaluation forms to help agents determine the suitability of an insurer. These include tips on how to determine an insurer's financial stability, and how to assess its support services, personnel and products.

The PIA's original survey on what companies look for in agents was sent to 75 insurers and branch offices, of which 31 responded.

Virtually all responding insurers say they formally evaluate agents. A majority—58%—reported performing annual evaluations, while 25% said they evaluated agents semiannually and 17% quarterly.

According to one insurer in a post-survey agency/company focus group, "Companies have realized that they must better allocate their shrinking resources to ensure a better return on their investment."

An agency's loss ratios, volume commitment and financial stability are the primary factors considered in evaluations, said responding insurers.

Overall professionalism, automation capabilities, underwriting authority and internal and external business strategies and marketing programs were cited as less important by participants.

For instance, 84% of responding insurers said premium volume commitment was a very important factor in selecting an agency.

"Better than average loss ratios" were cited as very important by 19 insurers, or 61%. However, seven insurers, or 23%, said average loss ratios were "less important" and one insurer ranked them as "unimportant."

Also, 18 insurers, or 58%, said an "excellent credit rating" as a sign of financial stability was very important, though eight, or 26%, ranked it as less important.

Insurers responding to the survey were presented with five areas of agency operation—business strategy, marketing, underwriting, agency profile, and automation—and were asked to rate the importance of each.

In the area of business strategy, insurers were primarily concerned with an agency's commitment to volume requirements and an ability to meet growth goals, both for initial appointments and in subsequent performance evaluations.

In the marketing category, the survey found insurers primarily concerned about carefully targeting growth areas.

Twenty-eight of the 31 respondents agreed that an agency's ability to market to areas with potential and profitability is "very important." The other three respondents did not answer the question.

In addition, 19, or 61%, of the responding insurers considered the sale of life insurance products as "very important" in the agency marketing mix.

Respondents said they also carefully considered an agency's adherence to the insurer's underwriting procedures when evaluating its potential.

A majority, 58%, ranked "follows company underwriting/claim procedures" as "very important." Only 10% said it was "less important."

Insurers also expect their agencies to demonstrate loyalty by placing a substantial amount of business with them, the survey found. Three-quarters of respondents considered it "very important" for the insurers to be either first, second or third in terms of an agency's annual sales volume.

The insurers consider an agency's professional development crucial as well, with three-quarters of respondents saying an agency's commitment to professional growth is "very important."

Insurers polled appeared ambivalent about agency automation, with 39% believing it "very important," 19% "less important," and 10% "unimportant" for agencies to use computers for more than just rating. For nearly a quarter of respondents, automation was "not the primary issue of concern."

With these findings in mind, the PIA agency company relations committee then called on agent-insurer focus groups to develop guidelines for agents to use in selecting and retaining insurers.

While the committee cautioned that agency diversity makes it impossible to recommend any specific criteria, it suggested agencies examine potential and current insurers in these broad areas:

- Financial stability. Agents should use A.M. Best Co. and Standard & Poor's Corp. ratings, a company's annual reports, and other information to assess an insurer's financial stability.
- Support services. Agencies should consider "perks" offered by insurers such as automation financing, training and development help, advertising, and acquisition/financing consulting when selecting markets.
- Personnel. The insurer's personnel should show stability, expertise, education and good communication skills.
- Products. Insurers should provide the agency with training on the coverage provided by certain products, product stability and competitive pricing.
- Claims. Agency and insurer should have similar philosophies on timeliness, reserving, and claims adjusting. In addition, underwriting authority—whether through the agent, branch office or home office—must be determined up front.
- Automation. Agents should consider interface availability, whether the insurer will train agency employees, billing and collection methods, and whether the insurer offers automation-driven marketing assistance.
- Contracts and compensation. Areas of concern are the structure of the insurer's commission program as well as the clarity, completeness and equity of the agency-insurer contract.
- Underwriting. The agent should consider the insurer's capacity, reinsurance capabilities, expertise and loss control programs.

To help the agent determine the insurer's qualifications, the PIA/CAC survey includes rating grids for both personal and commercial lines insurers, as well as a checklist for agency/company agreements.

•

Copies of "Evaluating Company-Agency Relationships" are available at $10 each for PIA members and CAC member insurers and $25 for non-members from PIA/CAC, 400 N. Washington St., Alexandria, Va. 22314; 703-836-9340.

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Premium volume focus hurts small agent: Panel

By LAURA MAZZUCA

LAS VEGAS, Nev.—Small agencies eventually may be squeezed out of the insurance distribution system if insurers continue to seek relationships only with agents that can produce a large volume of business, some agency executives say.

In addition, insurers' home offices are out of touch with their branch offices and with agents' needs, some agency executives say.

Insurers and agents discussed trends in what they look for when forming relationships with each other during a panel discussion at the 58th annual convention of the National Assn. of Professional Insurance Agents, held Oct. 29-Nov. 1 in Las Vegas, Nev.

The panelists used the results of a PIA survey as a springboard for a feisty discussion, during which they alternately blamed each other and themselves for the demise of the small-town agency and the bloated bureaucracy of the modern insurance distribution system.

The PIA survey, "Evaluating Company-Agency Relationships," found that insurers rank volume considerations high on their list of criteria in seeking relationships with agencies. The survey found that insurers seeking agent appointments are looking for, in order of importance, business that will produce good loss ratios, a volume commitment, professionalism, financial stability, automation capabilities, the ability to properly write and service business, compatible internal business strategies and compatible external market/sales programs.

The survey showed that agents are seeking from insurers, in order of importance, financial stability, support services, professional personnel, products, compatible claims philosophy, automation, contracts and compensation and a compatible underwriting philosophy (see story above).

However, the small, independent insurance agent is "going the way of the mom and pop store, the small farmer and the small bank," as large insurers offer preferred contracts to large agencies, said said Ronald I. Knouse, chairman of PIA's company advisory council and vp of Pennsylvania Millers Mutual Insurance Co. in Wilkes-Barre, Pa.

Overemphasizing volume has given insurers "a myopic and very self-serving view of the world" said Charles E. Crowley Jr., president of Hemingway-Lewis Insurance Associates in Cheshire, Conn.

But, both agents and insurers overemphasize volume at the expense of other considerations, said Michael E. Hogue, president of Providence Washington Insurance Co. in Providence, R.I. "Many agents just book it (the business) and forget it," he said.

With consumer dissatisfaction running so high, though, such a cavalier attitude toward policyholders is ill-advised, he warned.

And, with increasing competition from self-insurance programs, direct writers and exclusive agents, the narrow concerns emphasized in many selection criteria are "self-indulgent—like picking members for the Last Supper," Mr. Hogue observed.

Agents and insurers instead should be looking for partners with "true business" sense, because that is the real key to a successful relationship, asserted John J. Birmingham, senior vp of Great American Insurance Co. in Cincinnati.

"If we are both reasonable businessmen, all these criteria are kind of ridiculous," he said.

Mr. Hogue of Providence Washington also complained that many of the major insurers are "inefficient" because they have lost touch with local offices. Because of the sheer size of their organizations, they have established a "bureaucratic legacy," he said.

As a result, they are too selective about what lines they want to write and are unrealistic about the actual needs of policyholders, he said.

Mr. Hogue said insurance company home offices have lost touch with the small agency.

However, he predicted that insurers will be decentralized within 10 years, which will lead to closer and longer relationships between insurers and agents. In turn, that will give agents a more thorough knowledge of the insurer's portfolio of products, he said. And, as a result, agents will be able to better match products and policyholders, which ultimately could bring down the price of the product, Mr. Hogue said.

But, in the meantime, major national insurers' alienation from branch offices and their volume demand is causing the small agency system in the "hinterlands" to fail because they are not willing to appoint agents in remote areas, charged Carl J. Frilling, founder of the Insurance Exchange agency in Albuquerque, N.M.

Mr. Frilling noted that his

Continued on next page

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volume, of $150 in commissions.

The "planned action" sheet would note producers by name and set target dates.

In addition, principals may back

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agency conducts a year-long evaluation of an insurer before agreeing to a contract. The Insurance Exchange's clients include bowling centers, restaurants and dentists, he said.

Most importantly, "we're looking for an insurer with a commitment to the agency system," Mr. Frilling concluded.

But, Great American's Mr. Birmingham responded that commitment is a two-way street and that both insurers and agents must adhere to contracts.

"Less than 1% of agents live up to the commitments made to the company, but they think the company is accountable to them for everything," he charged.

Agents in remote areas can turn to regional insurers because those insurers are more likely to look for agents in less populated areas than the major national companies are, said Mr. Knouse of Pennsylvania Millers.

"Everyone started out small," he said, referring to agencies. "We're looking for the small agency that wants to become a large agency."

But Mr. Frilling said that even regional insurers are not willing to appoint agents in remote areas of New Mexico.

As a result, small independent agents in the state "take on anybody (insurers) they can get for survival" and sometimes end up with insurers that are not financially stable, Mr. Frilling said.

Hemingway-Lewis' Mr. Crowley complained that when his staff inquires about specific financial information from an insurer's headquarters or branch office, the insurer's personnel often are unfamiliar with the data.

His agency will not consider contracting with an insurer unless it can provide financial data so that its performance can be measured against other insurers.

But, Mr. Birmingham of Great American said that many agents are weak in the area of evaluating financial information.

Although insurers' emphasis on urban markets may ultimately be detrimental to the small agency system, small agencies must recognize that an insurer's profitability is "tied to the volume level," said Mr. Crowley of Hemingway-Lewis.

If a smaller agency cannot lure an insurer with volume, then it must try to deliver policyholders for a particular line of business that the insurer wants to expand, he added.

Failing this, small, independent agents might prosper by forging limited affiliations with direct writing insurers, Mr. Crowley suggested.

Mr. Crowley, who has been appointed as a limited agent for an Allstate Insurance Co. unit, contended that direct-writing insurers with limited affiliations with agents can service policyholders more efficiently than insurers that rely on independent agents to produce most of their business, he said.

Mr. Frilling of the Insurance Exchange said that Allstate has recognized an opportunity in New Mexico.

Allstate has appointed 18 agents on a limited basis in New Mexico, said an Allstate spokesman.

"And, the agents are making Allstate a profit," he said, adding that he does not understand why other insurers "can't do that" for the smaller agencies.

In addition to evaluating how well an insurer will serve his agency, Mr. Frilling said the Insurance Exchange does carefully consider compensation and contingency fees, because it is "in the business to make a profit."

Because of the diverse needs of agents and insurers, the distribution system will change dramatically in the next decade, the panelists agreed.

For example, policyholders' expectations of service have changed radically during the past 10 years, which will require agents and insurers to work together through both service and economic commitments to give policyholders what they expect, said Mr. Crowley of Hemingway-Lewis.

Policyholders are concerned about product, pricing, prompt delivery and the prompt settlement of claims, and they will settle for nothing less, he added.

In addition, Mr. Birmingham of Great American predicted that mergers and acquisitions, which have whittled away at the number of insurers and agencies over the last 10 years, will continue.

However, Mr. Frilling predicted there will always be room in the picture for the small independent agent, as long as he is willing to roll with the changes.

"The guys who don't want to change won't survive," Mr. Frilling observed.

The panel was moderated by Lyle D. Roth, chairman of the PIA's national company relations committee. Mr. Roth is the president of Koelbel & Co., a Denver-based agency. ■

Alabama agent wins PIA honor

LAS VEGAS, Nev.—Alabama agent Victor D. McCarley Sr. won the PIA's 1989 "Professional Agent of the Year" award for his contributions to the insurance industry and his community.

Mr. McCarley received the award at the 58th annual convention of the National Assn. of Professional Insurance Agents, held earlier this month in Las Vegas, Nev.

Mr. McCarley, who is vp and general manager of the Gurley Insurance Agency in Tarrant, Ala., is president of PIA of Alabama. He has served on the board of directors of the state association since 1982.

As a member of the Insurance Services Office Inc.'s producer liaison committee, he has advised ISO on its state filings since 1982.

In addition, he teaches a monthly insurance course for the state association, and has recruited 31 agents into the PIA.

Mr. McCarley's work in the community includes an annual safe driving program presented to high school groups, as well as fundraising for the Boy Scouts of America.

In addition to Mr. McCarley's award from the national PIA, 36 other independent agents were honored by their state or regional PIA associations as "Professional Agent of the Year."

Honored were: Carl Frilling of Albuquerque, N.M., by Sun States Assn. of PIA; Tom Bowman of Phoenix, Ariz. by Sun States Assn. of PIA; Philip H. Merry Jr. of Fort Smith, Ark., by PIA of Arkansas; Lynn A. Choate of San Bernardino, Calif., by PIA of California & Nevada; and Paul A. Hoover III of Raleigh, N.C., by Carolinas Assn. of PIA.

Also honored were: Lee Braddock of Estes Park, Colo., by PIA of Colorado; Gerald E. Park of Boca Raton, Fla., by PIA of Florida; Sheryl Smith Crawford of Carrollton, Ga., by PIA of Georgia; George E. Miley of Hailey, Idaho, by PIA of Idaho; Sharon K. Heaton of Pontiac, Ill., by Illinois Assn. of PIA; Gary A. Cleveland of Greenwood, Ind., by PIA of Indiana; Paul D. Anema of Sanborn, Iowa, by PIA of Iowa; David Butler of Dodge City, Kan., by PIA of Kansas; William J. Detherage of Louisville, Ky., by PIA of Kentucky; J. Glenn Gremillion of Church Point, La., by PIA of Louisiana; Frank H. Rollwagen of Saginaw, Mich., by Michigan Assn. of PIA; Neil C. Hammer of Buffalo, Minn., by Minnesota Assn of PIA; and Thomas E. Brown of Oxford, Miss., by PIA Assn. of Mississippi.

Also: William V. Cundiff of Kirksville, Mo., by Missouri Assn. of PIA; John N. Watson of Great Falls, Mont., by PIA of Montana; Yvonne L. Deyle of Kearney, Neb., by PIA of Nebraska; Donald W. Leavitt of Stoneham, Mass., by PIA of New England; Marshall Ruben-

Continued on next page

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Agent/Broker Topics

Education requirement reciprocity urged

By LAURA MAZZUCA

LAS VEGAS, Nev.—John T. Guldan of the Aetna Life & Casualty Co. in Denver was honored as the 1989 "Company Representative of the Year" at the 58th annual convention of the National Assn. of Professional Insurance Agents in Las Vegas, Nev.

Mr. Guldan, regional vp and general manager of Aetna's commercial division in Denver, has worked closely with agents on programs dealing with perpetuation, mergers and acquisitions.

While president-elect of Western Guaranty Fund Services, which administers five state guaranty funds, Mr. Guldan lobbied Colorado's Legislature and helped win passage of an amendment that allows agents to receive limited coverage from Colorado's guaranty fund. As a result, the fund will reimburse agents for up to $10,000 in unearned commissions in the event of an insurer insolvency.

Mr. Guldan currently is chairman of the Colorado Insurance Guaranty Assn. and holds the Chartered Property & Casualty Underwriter designation.

In addition to Mr. Guldan, 33 other insurer representatives were honored at the convention. They were chosen by state PIA organizations based on their assistance to agents, standing as insurance professionals, and participation in community affairs.

Honored were: Lowell V. Ashby of Hanover Insurance Co. in Sacramento, Calif.; Judy Arnold of Citizens Insurance Co. of America in Okemos, Mich.; Jeanie Beadles of Employers Mutual Casualty Co. in Wichita, Kan.; Rose Bickford of Crum & Forster Insurance Co. in Boca Raton, Fla.; Dana Bowers of State Automobile Mutual Insurance Co. in Columbus, Ohio; Gene C. Carpenter of SECURA Insurance, A Mutual Co., in Appleton, Wis.; Bill W. Ezell of Silvey Cos. in Arkadelphia, Ark.; Melvin R. Faas of United Fire & Casualty Co. in Lincoln, Neb.; Kenneth H. Fort of Pinnacle Insurance Co. in Carrollton, Ga.; Robert B. Fryer Sr. of American Universal Insurance Co. in Gray, Maine; and Keith R. Gordon of Citizens Security Mutual Insurance Co. in Red Wing, Minn.

Also honored were: Larry D. Jacobs of United Fire & Casualty Co. in Watertown, S.D.; Ralph M. Jones of Employers Mutual Casualty Co. in Charlotte, N.C.; Douglas C. Hardin of North Pacific Insurance Co. in Boise, Idaho; Richard J. Henke Jr. of Pekin Insurance Co. in Pekin, Ill.; Kenneth J. Kim of First Insurance Co. of Hawaii Ltd. in Honolulu; Gregory C. Loyda of West Bend Mutual Insurance Co. in West Bend, Wis.; R. Wayne Martin of First of Georgia Insurance Co. in Richmond, Va.; James H. Masonbrink of Celina Mutual Insurance Co. in Celina, Ohio; Jeff McCarty of General Accident Insurance Co. of America in Albuquerque, N.M.; and Walter R. Mesick of Frankenmuth Mutual Insurance Co. in Fort Wayne, Ind.

Also: Terry Nuti of The Hartford Insurance Co. in Seattle; Bobby R. Partin of Grange Mutual Casualty Co. in Lexington, Ky.; Rudy H. Paulsen of American West Insurance Co. in Grand Forks, N.D.; Joey D. Perkins of Employers Mutual Casualty Co. in Jackson, Miss.; John W. Powers of Standard Mutual Insurance Co. in Springfield, Ill.; Woodrow Reeder of Aetna Life & Casualty Co. in Metairie, La.; Dennis P. Rozario of American States Insurance Co. in Tulsa, Okla.; Lisa Tepper of Aetna Life & Casualty Co. in Albany, N.Y.; Gene Spruce of Allied General Agency Inc. in Scottsdale, Ariz.; Lois Van Hofwegen of Tri-State Insurance Co. of Minnesota in Luverne, Minn.; and John P. Wells Jr. of Dodson Insurance Group in Kansas City, Mo.

In addition, Travelers Corp. won the PIA's 1989 "Company Award of Excellence" for its commitment to senior citizens programs.

Joseph Brophy, senior vp of employee benefits for the Hartford, Conn.-based insurer, received the award at the PIA convention.

Travelers was lauded for, among other things, its "Older Americans Program," launched in 1979, which promotes economic security and affordable health care for the country's aging population.

The program "demonstrates that solutions to societal concerns can be addressed through the action of the private sector," said outgoing PIA President David L. Ream. "People over 65 years old are the fastest-growing segment of our population. It's essential to recognize and respond to the changes created by this population trend."

Travelers offered the first employer-sponsored group long-term care insurance plan in 1986. ■

Aetna vp named 'representative of year'

By LAURA MAZZUCA

The National Assn. of Insurance Brokers and the agent licensing task force of the National Assn. of Insurance Commissioners are encouraging reciprocity among states requiring continuing education for agents.

An NAIB resolution supported reciprocal education requirements for agents licensed in one state who want to sell in another, and an NAIC agent/broker advisory committee has been assigned to clarify the rules in existing model acts.

Agent and broker associations are concerned that language in the NAIC's current continuing education model act discriminates against smaller agencies. For example, some states such as Minnesota and New Jersey require that non-resident agents take continuing education courses at in-state schools, said Wayne Gordon, vp of Pictorial Inc., a financial services industry publisher in Indianapolis.

Under the current NAIC model act, a producer must satisfy the continuing education requirements in other states in order to sell insurance there, even if no continuing education requirements exist in his or her home state.

However under a proposed amendment to the NAIC model law, licensed, non-resident agents who comply with their home state's continuing education requirements would be exempted from the requirements of other states, as long as the home state accords the same privilege to non-resident agents.

The amendment will be presented to the NAIC at its December meeting in Las Vegas, Nev. If approved, it will be included in the NAIC model continuing education statute, the single licensing producers model act and the agent/broker licensing model act, effective immediately.

Although large insurance brokerages with producers in every state can meet individual state continuing education requirements without reciprocity, smaller agencies and brokerages could have problems sending people out-of-state to obtain licenses, said Robert L. Sanford, president of Smyth, Sanford & Gerard Inc., a New York brokerage. Mr. Sanford is also on the board of trustees of The College of Insurance in New York, which provides continuing education for agents.

The college is concerned that education requirements differ from state to state, and backs the proposed amendment to the NAIC's model law as a sign that the industry seeks "some standards to make continuing education more consistent," said Charles Edinger, a college vp.

In addition, some states require continuing education only for the first several years after initial licensing, making a reciprocal continuing education requirement difficult to apply for states that require continuing education for a longer period of time, noted Patricia A. Borowski, vp of government and industry affairs for the National Assn. of Professional Insurance Agents in Alexandria, Va. She also serves as chairwoman of the NAIC's agent/broker advisory committee.

Meanwhile, observers are concerned that states adding continuing education requirements will adopt the existing model act's wording, which does not provide for reciprocity, said Mr. Sanford.

About 21 states require continuing education for property/casualty and life/health agents, and regulations vary widely, Ms. Borowski said.

Ten states—Delaware, Georgia, Idaho, Illinois, Iowa, Kansas, Massachusetts, North Dakota, Oklahoma and Texas—have reciprocity arrangements exempting non-resident agents from their continuing education requirements as long as they meet the requirements of their home states, said Pictorial's Mr. Gordon. ■

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Business Insurance

Agent awards

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stein of Hicksville, N.Y., by PIA of New York; Dan M. Armburst of Fargo, N.D., by PIA of North Dakota; Larry N. Beardsley of Warren, Ohio, by PIA Assn. of Ohio; Ronald H. Crawford of Eugene, Ore., by Oregon PIA; and John T. Abram of Oreland, Pa., by PIA Assn. of Pennsylvania, Maryland and Delaware.

Also honored were: R. Alfonso Lozada Jr. of San Juan, Puerto Rico, by PIA of Puerto Rico and the Caribbean; Penn Williams of Pierre, S.D., by PIA of South Dakota; Charles E. Gardner of Morristown, Tenn., by PIA of Tennessee; Carl W. Bell of Irving, Texas, by PIA of Texas; Charles J. Cayias of Salt Lake City, by PIA of Utah; Scott Martin Harwood of Farmville, Va., by PIA Assn. of Virginia & District of Columbia; John A. Luetgen of Vancouver, Wash., by PIA of Washington & Alaska; Clifford R. Mauck of Niagara, Wis., by PIA of Wisconsin; and Stan Campbell of Powell, Wyo., by PIA of Wyoming.

—By Laura Mazzuca

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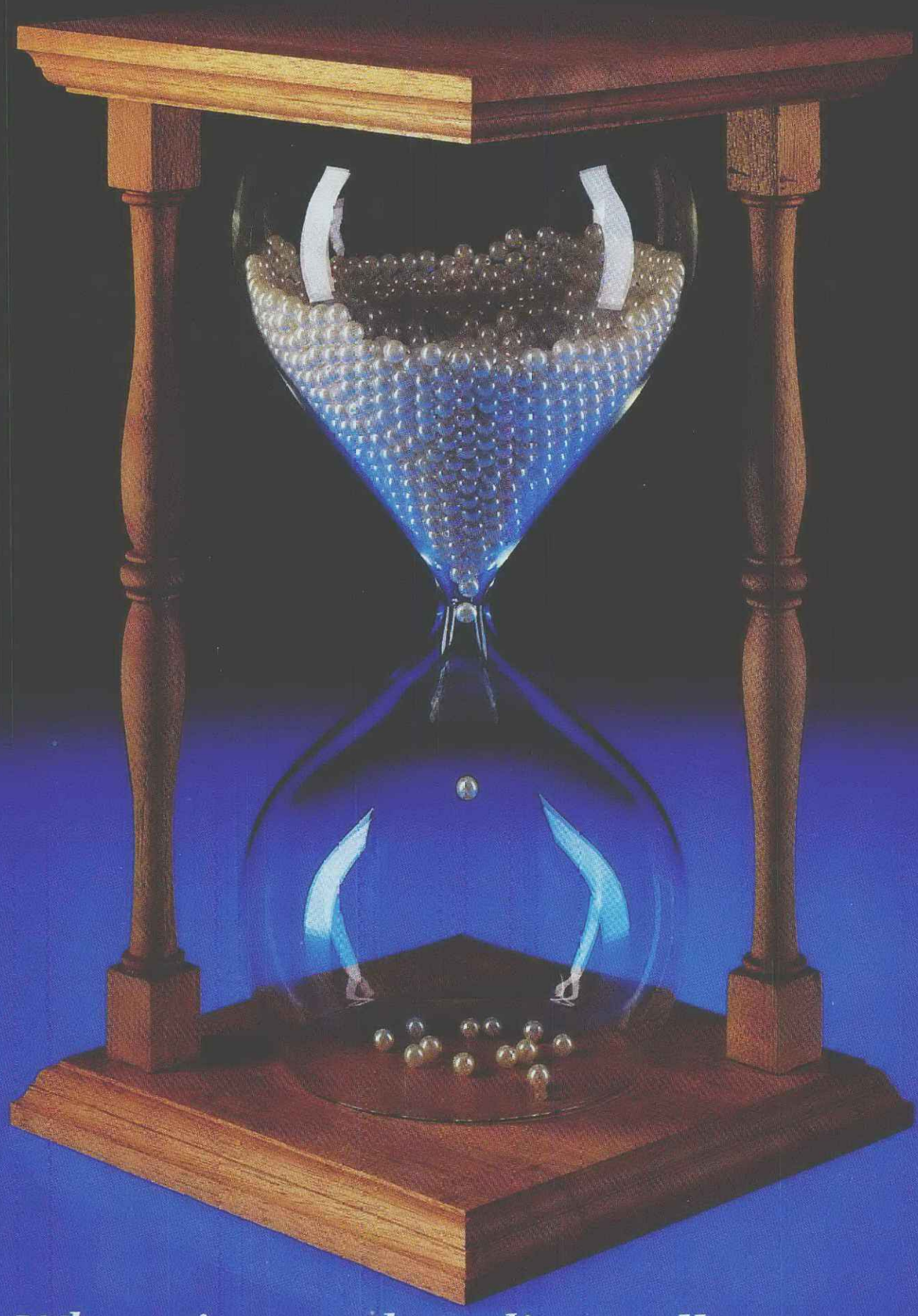

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ASK A BENEFIT MANAGER

Managing health costs requires many actions

Q **With health care cost trends for indemnity plans in the 20% area over the last couple of years and with no relief in sight, what approaches would you suggest to reduce health care costs?**

A Each company should review how its program is working, compare its health care costs with those of similar companies and the trends being reported for fee-for-service indemnity plans and managed health care plans.

Also look at managed health care trends by type of plan. For example, look at all health maintenance organization models, including staff, group or individual practice association, or any combination. Also examine HMO financial models like salaried physicians, capitation arrangements and discounted fee-for-service plans.

Also review preferred provider organization trends by financial model: fee-for-service plans or the newer scheduled payment programs.

This comparison will allow you to determine how you are doing and may also indicate possible opportunities for improvement. Be sure when making these comparisons you include both absolute per capita cost and cost increases. I have heard many people indicate that their companies did not have the kind of health care cost increases being reported in the press—only to find that on both a per-capita and percent-of-payroll basis their costs were considerably higher than the norm. This would indicate to me that they have a health care cost problem, but it is not clearly understood by their management.

Flexible benefit programs may be effective in reducing employer costs for a while, but they really do not control health care costs. You may only be cost shifting to employees. Over an extended period of time, these plans will not be as viable if health care cost increases continue in the 20%-26% range, as it appears they will in the future. A company in this situation should consider offering more cost-effective health care arrangements so as to not use too many of its benefit dollars for increases in health care costs.

There are managed care programs that are experiencing increases at about one-half of fee-for-service indemnity plans. It may make sense for companies with flexible benefit programs to consider replacing the fee-for-service indemnity plans with some type of HMO or PPO point-of-service plan that encourages employees and dependents to use managed care networks.

Another approach is to add options like a health maintenance plan or preferred provider point-of-service plan and structure the employee's costs in such a way as to provide an incentive to move into these programs. If structured properly, it may be able to move employees to managed health care plans over a period of time. Benefits from the latter approach will take longer to see.

After you have completed your review, based on your findings, I would recommend that you propose to your management a corporate health care objective. We have been good at setting objectives in other parts of our businesses but we have never felt comfortable or capable of setting a health care benefits objective. The size of health care costs, as a percent of payroll and charge to earnings, is now so large that we can no longer be passive payers of the health care bill. We must begin to manage health care as other parts of our business and eliminate inappropriate and unnecessary costs.

A number of studies have indicated that approximately 25% of health care costs fall in this category. The objective should, in effect, be your game plan to manage health care costs and should include staffing needs, timing and strategy for implementation, plan design and support.

The following will outline some ways to slow down the rate of health care cost increases:

- **Indemnity plans.** Basically, do what was done by most companies in the early 1980s: increase deductibles and out-of-pocket limits, and require greater employee and dependents contributions. Work at improving utilization review for both inpatient and outpatient services. Review the cost of mental and substance abuse claims and prescription drug programs and determine if any of the newer forms of cost control for these programs will be cost effective for your company.

Also, review financial arrangements with the HMO you are offering to be sure that you are not paying them more than you should for the risk they are assuming. It is important to "precision price" your HMOs based on age and sex of those using them.

Review the way your plan coordinates benefits with other plans and consider whether to change your company's commitment on the level of benefits and the amount you contribute for dependent coverage.

These actions would be classified as sticking to the cost containment activities of the past. If a company carries out these programs well, it should, at least for a while, have somewhat lower trends than other companies with indemnity plans that are not monitoring their programs.

On the negative side, indemnity plans are not able to handle cost shifting from the government—both federal and state—and from providers that participate in managed health care plans and provide either discounts for their services or have a fixed level of income. Physicians and other providers often use indemnity plans as payer of last resort to make up for any shortfall in their income objectives.

Another negative for indemnity plans is the delivery system. You continue to be more of a passive payer of the health care bills. Although indemnity plans provide broad access to medical care, this is offset by higher medical costs. You are not working at eliminating the unnecessary and inappropriate care costs in the system.

On balance, sticking to the past cost containment activities will not provide the desired results over a longer term. The bottom line is that you have not changed the delivery system that provides incentives to the providers to generate more, not fewer, services because higher utilization is the way they make more money.

- **Managed health care.** When we talk of managed health care, it means different things to different people. It means HMOs—which could be staff model, individual practice association, group practice model or some combination—and PPOs, where preferred providers discount their usual charges in return for patient volume.

The HMO might have financial arrangements similar to a PPO, or it could be a capitated model, in which the primary care physician is prepaid monthly or given a budget to provide health care services for those people that have selected him. In addition, in many staff model HMOs, the physicians are salaried. With this as a brief background, I will review some observations on managed health care:

✔ Staff model and capitated HMOs seem to be the most cost-effective. Generally, the hospital bed days, admissions and lengths of hospital stay are lower than in other forms of managed care. Because of their financial incentives, they seem better able to monitor health care and eliminate unnecessary and inappropriate care.

✔ The results for PPOs generally have been disappointing. The providers seem to make up on volume what they give away in discounts. Clearly there are some PPOs around the country that have done a better job at controlling costs than others.

I think it is important to measure the results of a PPO regularly to determine how well it is doing compared with other managed care approaches. You can't assume that price discounts will result in cost effectiveness.

Also, I understand the PPO trend is moving away from discounts toward negotiated fee schedules for physicians and to a per diem basis or other fixed arrangements for hospitals. This may provide PPOs with a more competitive arrangement.

✔ Point-of-service choice plans make the transition to a managed health care plan more possible. Point-of-service choice plans permit employees and dependents to choose a managed care network provider and receive a higher level of benefits or go out of the network and generally receive a lower level of benefits. Without the ability to go out of network for services, it would be difficult for employers to adopt a managed health care plan in a big way.

✔ Discounted fee-for-service HMOs generally have stronger controls on utilization than do PPOs, but financial incentives to providers are similar to PPOs. The jury is still out on whether they are cost-effective.

There is a large movement by employers to managed health care as it seems like the only and maybe the last opportunity available to slow down the rate of health care cost increases under our present health care system.

The competition in managed health care between health care companies, insurance companies, companies building their own networks of providers and in-house medical centers is heating up. They all have their advantages and disadvantages in the present marketplace. It will be interesting to see who will be the winners.

It is important to understand that we no longer can afford to just pay the bills with a blank check. We must understand and educate ourselves with what is available and how we can use it in our companies to our financial advantage. Many companies are so frustrated with the present health care cost situation that they are saying we need national health insurance. It could be dangerous for companies that sit and wait for this and any other "silver bullet."

I do not see any magic cure from above any time soon and I suggest we get to work in solving the problem for our companies, employees and dependents.

Would you like advice from an experienced colleague on a risk management, benefits management or actuarial problem? Four features in the Perspective section of Business Insurance can give you some answers.

Ask A Benefit Manager, Ask A Risk Manager, Ask A Casualty Actuary and Ask A Benefit Actuary answer written questions from readers on risk and benefits management issues and actuarial problems.

Mr. Duva

This month's column on employee benefits issues is written by Joseph W. Duva, director of employee benefits at Allied-Signal Inc. in Morristown, N.J. Susan M. Werner, director of risk management at Hardee's Food Systems Inc. in Rocky Mount, N.C., answers risk management questions. William J. Miner, an actuary with The Wyatt Co. in Chicago, answers actuarial questions on benefits issues. Richard E. Sherman, a principal with Coopers & Lybrand in San Francisco, answers actuarial questions in the casualty field.

Mr. Duva's and Ms. Werner's columns appear alternately on the second Monday of each month. Mr. Miner's and Mr. Sherman's columns appear alternately on the first Monday of each month. Mr. Duva's next column will appear in January.

Address your questions to ASK, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611. Please give us your name, title and employer; however, Business Insurance will consider unsigned letters.

Employers liability in Ireland

High costs hurt employers

International issues

By Douglas N. Smith

ALTHOUGH MANY U.S. multinationals have been enjoying "tax holidays" in the Emerald Isle, industrial accidents continue to injure insurance budgets and erode the profits generated by generous grants and capital allowances. In fact, with the average employers liability insurance premium estimated at 2.5% of a company's payroll, there is little doubt that the cost of employers liability insurance has become a burden for manufacturing companies in Ireland.

Needless to say, high insurance premiums hurt business in Ireland because they add to the cost of locally produced goods, making them uncompetitive with goods from other European Community nations.

Despite the Confederation of Irish Industry's recent call for a 30% to 40% reduction in employers liability insurance rates, the absence of competition among insurers writing this line of coverage will probably keep premiums high. Irish insurers may also resist reductions for fear that imprudent underwriting practices will tarnish their image within the EC as they gear up to provide cross-frontier services in July 1990, as prescribed by the Single European Act.

Who wins and who loses? The answer is complex.

To begin, the Irish government has been encouraging foreign investment to create new jobs and to develop its unskilled industrial infrastructure. As an offset, financial incentives granted to foreign investors include:

- 100% training grants.
- Tax relief on manufacturing profits through Dec. 31, 2000.
- Repatriation of tax-free profits without restriction.
- 100% tax depreciation.

No U.S. multinational or any other foreign investor can be expected to transplant urban habits to rural Ireland without some friction. In this instance, the friction comes from the employees and the common law liability that arises from the obligation each person has to exercise care in his or her actions in order to prevent bodily injury or damage to others.

Under common law, employees are entitled to damages only if an accident was caused by an employer's personal negligence. Workers have no claim against an employer merely because they met with an accident while employed.

However, as Irish trade unions over the years have increased in strength, the notion of personal liability has diminished. The employee credo has become "them against us" or, "if I get hurt, somebody has to pay." A successful claim in any large company often will spawn a number of similar claims.

Without doubt, the bureaucratic structure of Irish labor unions has helped to centralize the legal process in Ireland. One solicitor often facilitates a large number of minor claims by handling them as one job lot. This tends to encourage small claims; indeed, it is sometimes alleged that workers deliberately inflict minor injuries on themselves to jump on this bandwagon. More importantly, employers risk a strike by workers if they dismiss employees who are suspected of injuring themselves deliberately.

The fault of the system does not lie solely with the workers. Another major reason for high employers liability insurance premiums in Ireland is that employers there have not been as attuned to health and safety loss control procedures as U.S. companies.

Most companies are in business to make profits, not to promote health and safety. Records show that the vast majority of work accidents in Ireland result from a failure to guard machines or from slips, trips, falls and internal transport accidents. These accidents occur in Ireland with greater frequency than elsewhere, and although employees know about preventive measures, such measures are not always instituted.

While many U.S. multinational subsidiaries in Ireland strictly follow health and safety guidelines, a large number of Irish managers and employers fail to discharge their legal duties. This failure, which leaves the law of chance as the only barrier between employees and an accident, adds to high-frequency claims experience and helps to drive up insurance premiums.

Currently, only 30% of Irish employees—principally industrial workers—are protected by the Safety in Industry Acts of 1955 and 1980, which prescribe legal standards for employers. But this main body of legislation was superceded—effective Nov. 1—by the Safety Health and Welfare Act of 1988, so that all employees in Ireland, including agricultural and clerical workers are covered by workplace safety statutes.

The new legislation, which is modeled after the European Commission's Directive 80/1107/EEC, will continue to impose liability on the employer for securing the health, safety and welfare of employees. The new law also will allow for criminal liability of managers.

An employer's duties will continue to include training employees, guarding machinery, lighting, ventilation and protection against falls, chemical exposures and noise. As in the past, employers also will be required to establish a safety committee.

In addition, employers in Ireland will still be obliged to draw up a safety statement detailing the provisions made by the company to safeguard the safety and health of the workforce, the extent of cooperation required from employees, the availability of safety training facilities and the measures taken to guard against specific hazards that are present in the workplace. The statement must also detail the duties of a safety officer, when one is maintained on the staff. Complying with this aspect of the law makes employers, insurers and corporate legal counsel nervous that the statements may serve as a blueprint for employees who sue for negligence.

In addition to legislation, all employers in Ireland are subject to common law, as mentioned above. Common law underpins the rights of workers to a healthy and safe workplace. Unfortunately, common law principles are often used by employees to support a claim "after the fact," rather than by employers as a code of good practice in order to avoid accidents.

In common law, all employers in Ireland must provide their employees with:

- A safe system of work.
- Safe plants and equipment.
- Competent fellow employees.

The broadest of employers' common law duties is a safe working place. This duty encompasses proper instruction, effective supervision and safe work methods. Employers must ensure that the place of work is safe and that employees are afforded a safe means of access and egress.

Furthermore, the common-law duty of safe plants and equipment obliges an employer to provide and maintain proper machinery, plant appliances and works needed to do the job.

Common law also requires an employer to select properly skilled people to manage and superintend the business. If employees are not judged competent, the employer can be held vicariously liable for the acts or omissions of any employee that result in the injury of another worker. But, regardless of how well trained or safety conscious a worker may be, accidents will happen.

For example, statistics show that the human failure rate for routine production operations is about one in 1,000. This rises to one in 100 for workers in stressful conditions. As these figures indicate, employers would be wise to emphasize the "safe place" approach to claims control rather than rely on a "safe person" approach.

While these measures may be construed as loss control procedures, they often are the cause of high liability claims experience.

When courts are allowed to define negligence, it is not enough for employers to try to fit machines with guards, instruct the workers in their use or have supervisors watching to prevent accidents. Instead, the legal doctrine of the unsafe system of work has resulted in negligence "rewards" for accidents that are truly incidental to the nature of an employee's work.

In most EC member nations, these occurrences would be compensated by the state as social welfare accidents, rather than through an employer's liability insurer.

However, unlike other EC member nations, compensation for claims in Ireland's High Court traditionally have been assessed by a jury, while lesser cases—i.e., those where awards are limited—have been adjudicated in lower courts without jury involvement.

Understandably, most claimants have preferred to have their cases tried in the high courts, since the unpredictability of a jury usually meant greater compensation. For this reason, insurers often settled small cases out of court because they feared large jury awards.

But Ireland's Courts Act, which took effect April 1, has removed juries from hearing compensation cases for personal injury arising from automobile or employers liability hazards. These cases are now heard by a judge.

Although the removal of the jury was expected to result in greater stability and conformity in the amount of awards, the short-term experience has not shown any reduction in the value of awards by judges sitting alone. The considered view among insurers is that while awards will not drop in the immediate future, they probably will flatten out at existing levels. Another expected benefit is a decrease in the erratic settlements that occur when two courts sit in different parts of the country.

From a long-term perspective, employers liability insurance premiums are expected to remain high because of huge defense costs, which are provided outside of policy limits. But neither the insurance industry nor employers can be expected to single-handedly change an inefficient system.

In an ideal world, no employees would suffer on-the-job injuries, insurers would pay no claims and employers would not have to pay liability insurance premiums. In the real world, however, all employers can try to control the frequency and severity of accidents.

While on-the-job safety is the responsibility of both management and workers, management should play a major role. Do the remedies cost money? Yes, they do. Will the remedies save money? Yes, they certainly can.

Companies with Irish operations must examine what their subsidiaries can do to help solve the employers liability insurance crisis in Ireland? After all, the only thing worse than a staggering employers liability

Douglas N. Smith is vp and manager of the International Department of Johnson & Higgins in New York. His column appears the first Monday of every month.

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Comp system hurts the handicapped

By William D. Bolton

DON'T HIRE THE HANDICAPPED.

That is a message sent loud and clear to employers in states throughout the nation. These states don't print banners or fliers asking employers not to hire handicapped workers. Rather, they allow a workers compensation system to exist and thrive that places employers at additional financial risk by hiring the handicapped.

While the workers compensation system pays a minimum amount to everyone, major work injuries are becoming true financial catastrophes for employers because the benefits are so grossly inadequate. Fraud is so prevalent that the system is functioning only slightly better than a terminally ill patient.

For example, in comparing the cost of California's workers compensation system to others in the nation before recent work comp reforms were passed by the state Legislature (*BI,* Oct. 2; Sept. 25), California ranked third in the nation in work comp premiums collected, but 43rd in terms of benefits paid. And, of these benefits, 49 cents of every claim dollar went to doctors and lawyers.

Although the workers compensation system originally was designed to avoid litigation, today 40% of the total work comp caseload in California, for example, is litigated. In addition, insurers report an increasing percentage of their first notices of injury come via attorneys.

Why are employers paying high work comp premiums? Why are states "telling" employers not to hire the handicapped? It's because of the system.

What created these overwhelming challenges? First, an industrial revolution around the turn of the century changed, among other things, the methodology in treating on-the-job injuries. Because most injuries cannot be attributed to anyone in particular, a no-fault system was adopted. This was viewed as the most expedient and advantageous system to both the employer and the employee.

In 1917, such a law was enacted in California, eliminating the need for litigation in approximately 95% of the cases.

For those cases that did end in dispute, there was an appeals board and a standard procedure that allowed for quick decisions. As the California Constitution indicates, the purpose of the workers compensation system is to "accomplish substantial justice in all cases expeditiously, inexpensively and without encumbrance of any character." It further states that employees are to receive reasonable compensation.

In concept this sounds like a reasonable goal. The workers compensation system is designed to rehabilitate, not to indemnify. The permanent disability benefit for the loss of an arm is designed to allow that employee adequate funds to rehabilitate himself into another industry, not to pay pain and suffering costs.

It is designed to return a worker to a productive life. Pain and suffering has never been a part of any workers compensation program. The employee is given medical benefits "necessary to cure and relieve the effects of the injury."

In addition, while unable to continue work, the employee is entitled to temporary disability benefits. Also, a permanent disability benefit for permanent injuries exists.

Originally intended as a rehabilitation benefit to allow for a period of retraining into a new occupation, this benefit unfortunately has become more of a "pain and suffering" award.

But the real problem in the system started with an innocuous provision entitled the "liberal construction" rule. Because the no-fault system is contrary to common law rules of negligence, any such program is, by law, to be interpreted conservatively. Recognizing this conservative construction to be a problem, legislators inserted a clause that the system shall be interpreted liberally. Over the years, the courts have so whittled away at the conservative aspects that the system has become ultraliberal.

Today, the injured employee has to prove very little.

Speaking out

No reason of proof or even shred of evidence is required to establish the fact that an injury did or did not occur on the job. Unfortunately, the burden now falls on the employer to prove conclusively that it was not an on-the-job injury. This is not only difficult, but in most cases is impossible to prove without corroborating witnesses. Injuries such as weekend back strains, knee injuries from sports activities and even fights are reported in what has come to be known as the Monday morning injury.

Almost every injury that occurs results in permanent disability. We know that injuries that occur away from work rarely result in a permanent disability. However, in industrial situations, it is entirely different. The claimant knows the more he complains of permanency or pain, the more money he will be awarded. Thus, the problem is in proving that no permanency exists.

And, even in the face of substantial medical evidence, appeals boards are all too agreeable. More often than not, these boards will accept someone's word if he or she "aches" and grant benefits to the claimant. Under the system, everyone gets a little bit, but unfortunately the severely injured are not properly compensated. The system doesn't do what it is supposed to do.

Another area that has contributed to the breakdown is rehabilitation benefits. Originally designed to supplement the permanent disability benefit as an award that could provide retraining for the injured person, it has become a windfall for lawyers. Unfortunately, today, everyone applies for rehabilitation, regardless of the extent of the injury. Obviously, the primary motivation is simply to access more monetary awards, not just retraining.

In litigated cases, it has become a convenient method for high school dropouts and undocumented workers to gain job skills at the expense of a former employer. Training for these individuals is certainly necessary, but should be considered part of the state social system. Rehabilitation benefits should be reserved for injured workers who actually require retraining in order to move to another position.

So, why does the system break down, and who actually pays? Let's take an actual case and see why the system is telling employers: "Don't hire the handicapped."

John is a 37-year-old construction estimator suffering from muscular dystrophy, a disease in which the muscles slowly waste away. John's mind and motivation were excellent, but he had extreme difficulty in walking. Nevertheless, his employer decided to hire John as a handicapped worker. During the course of his work, he slipped and fell over a threshold sustaining a broken leg.

This injury, had John not been handicapped, would most likely not have created any serious or debilitating problems. However, in John's case, because of the requirement for casting and immobilization of the leg, further deterioration took place. The prognosis indicated that he would now be permanently confined to a wheelchair—an event that would have occurred naturally in a few years.

The insurer paid in excess of $30,000 for John's medical care, when a non-handicapped individual in the same accident would have fully recovered at a cost of about $2,000.

In addition, the contractor suffered as well. This was evident in the increase in his experience rating plus the probable loss of his dividend, which could have been several thousand dollars.

This case points out one of the major reforms needed in our workers compensation system. It has become more liberal than necessary and frequently we end up indemnifying for a pre-existing condition as well as for the injury. A minor back injury may well end up as a spinal fusion. From a compensation standpoint, no apportionment will be allowed for any existing condition unless it can be proven that there was a pre-existing disability. And, in most cases this is impossible to prove.

What employer is going to hire a handicapped individual or an individual with a pre-existing condition if an injury results in a costly increase in his already expensive workers compensation premium? Employers cannot be insensitive to the importance of providing employment opportunities for handicapped individuals who are qualified, in need of work and willing to do the job well.

Yet, in considering whether to hire a handicapped individual, the employer may hesitate because of the potential cost to his firm and his insurance company due to liberally compensated injuries.

Is it fair to overlook the pre-existing conditions and ask the employer to pay for something over which he has no control? Somehow our system of justice has become distorted. There are a few very serious quirks in the law that allow some individuals to collect for non-industrial conditions under an industrial accident insurance policy. It defeats the original purpose of the act and overcompensates those who are morally not entitled to payment. This is further complicated by the amount of fraudulent claims in the system.

By spreading the compensation costs over a broad spectrum of injuries, there is not enough money to properly compensate those who legitimately suffer serious workplace injuries and illnesses.

Litigation was never contemplated as a part of the system. It was always known that certain disputes would arise and quick, easy remedies were devised to minimize delays caused by litigation. But, we must remember this is a no-fault insurance system where benefits are prescribed by a formula. Theoretically, there should be no litigation. However, there is all too much and unfortunately the loser is ultimately the injured employee.

In litigated cases, factors other than the quality of care enter into the medical decisions that must be made—factors that may prove detrimental to the ultimate results. One must consider if this is the best possible physician for the case? Can he or she write a proper medical-legal report? And, what weight will he or she carry with the board?

Physicians privately say that injured employees involved in the workers compensation system become overly concerned with litigation and the "pot of gold at the end of the rainbow." When the applicant's attorney sends his client to a "liberal" doctor for evaluation, the defense is then forced to send the injured employee to a "conservative" doctor for an opinion. What results is two, three or even more exams on either side, with each costing $1,000. Obviously, millions of dollars have been wasted in the system as it exists today.

The truly injured worker needs to receive more equitable benefits. However, employers alone cannot possibly pay these increased costs. For the system to work as it was intended, litigation must be reduced and fewer medical reports and evaluations must be required.

In addition, insurers must deal more equitably with claimants in a non-litigious and non-adversarial environment.

Minor injuries with minor results, if any, must be eliminated from the system altogether. The person with the broken leg, whose injury heals fine should not be entitled to a benefit simply because he has an attorney or claims some residual pain.

The workers compensation concept is basically sound. But its interpretation has become much too liberal. The goals need to be redefined to allow adequate and fair compensation for those who sustain real injuries.

Handicapped and disabled people must be able to receive the kind of employment they need and employers should be able to do this without fear.

William D. Bolton is chairman and chief executive officer of Bolton & Co., a Pasadena, Calif.-based insurance brokerage.

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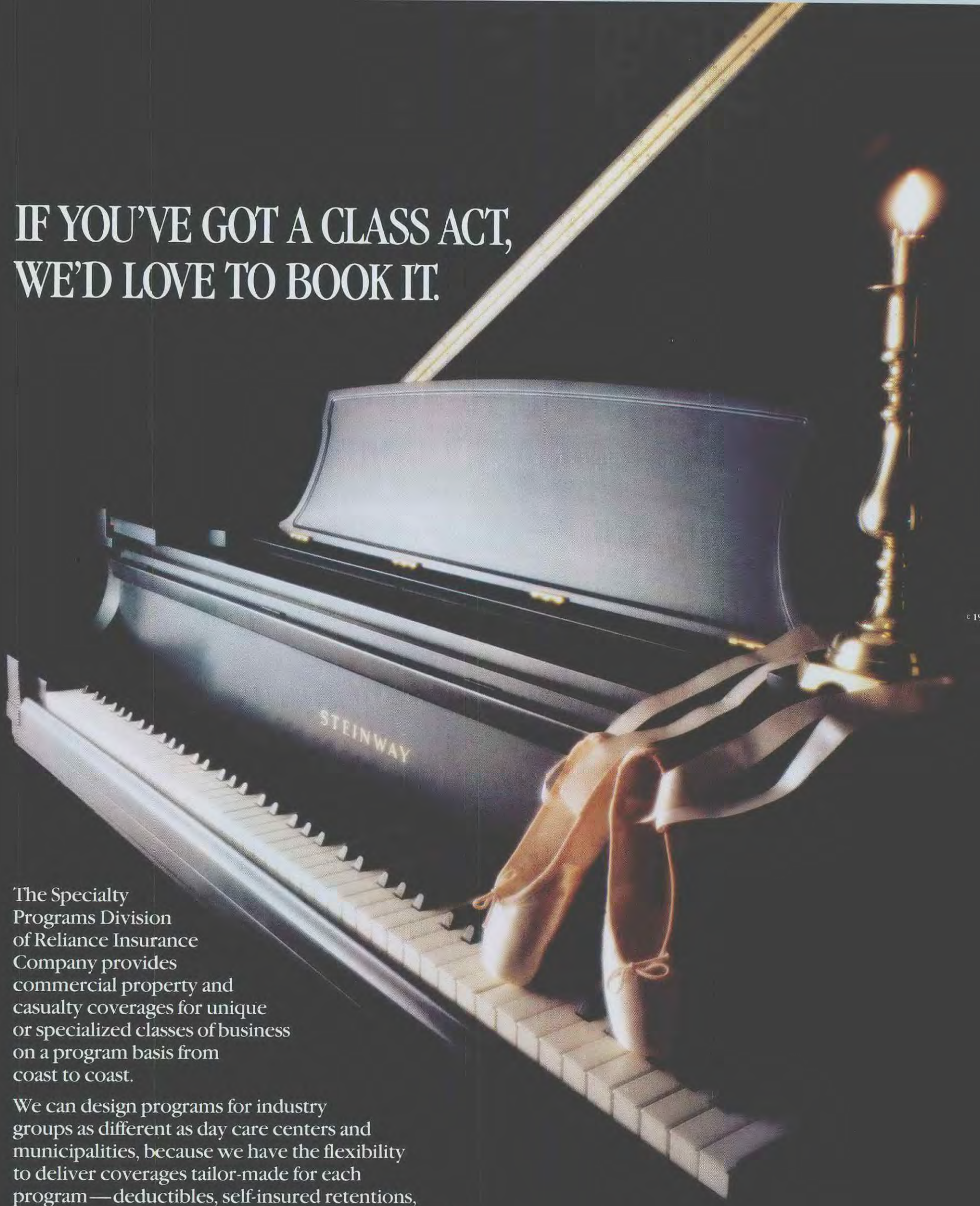

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Australian product liability reforms

Insurers say proposals are impractical

By KATE McILWAINE

BRISBANE, Australia—Product liability reform proposals by the Australian Law Reform Commission are totally impractical and out of step with product liability laws in Europe and the United Kingdom, critics say.

The reforms, which insurance industry representatives claim are too heavily weighted in favor of plaintiffs, would wind up costing consumers, since product manufacturers would have to increase the price of their goods to pay higher insurance costs.

The ALRC, at the request of Australian Attorney General Lionel Bowen, has recommended major changes in how Australians should be compensated for injury or damage caused by unsafe or defective goods. The changes, which would not require plaintiffs to prove that defendants were negligent, have not yet been adopted by the Australian government.

Jack Goldring, chairman of the ALRC, said product liability reform is necessary because of the uncertainty in current contract and negligence laws. For example, he noted it is difficult for plaintiffs to prove negligence because it is necessary to establish a duty of care on the part of the defendant, a breach of that duty and a causal relationship between the plaintiff's injury or loss and that breach.

Mr. Goldring was one of the participants in a panel discussion on product liability changes in Australia at the seventh annual National Insurance Brokers' Assn. convention, held last month in Brisbane, Queensland.

The ALRC has proposed a package of proposals that rest on the principle that manufacturers should be liable for any injury and/or damages that occur as a result of the way goods "act," but that manufacturers also should have a series of defenses available to reduce compensation payable.

The defenses include:

- Whether the claimant's knowledge of the product would lead a reasonable person to appreciate the risk of using the product.
- Whether the product "acted" as it did to comply with a legal standard. In such a case, the government entity that set the standard would be responsible for the injury or damage.
- Whether the defect in the product could have been discovered or anticipated by scientific means at the time the product was manufactured, or the so-called state-of-the-art defense.

Mr. Goldring said the defenses included in the proposal, including the state-of-the-art defense, would be absolute. If the defendant could establish any of the defenses, no compensation would be payable.

In addition, depending on the circumstances, compensation could be reduced by up to 100% to reflect the degree to which a plaintiff's own action—or the action of a third party not involved in the manufacture or distribution of the product—contributed to the injury or damage, Mr. Goldring said.

A manufacturer's liability also would be reduced in cases in which a supplier failed to elicit essential information or provide necessary instructions to a consumer. For example, Mr. Goldring referred to cases in which a doctor or pharmacist prescribes a drug that he or she knows to be dangerous during pregnancy without obtaining information from the patient on whether she is pregnant.

"We have suggested that the rights we propose (to recover product liability damages) be exclusive of all other rights, except where the loss or damage is a personal injury occurring at the place of work," he said.

Mr. Goldring said that the recommendation was based on an economic assessment that showed the Australian economy could not afford the burden of shifting workplace injuries from the current workers compensations systems—the majority of which are run by state governments—to liability insurers.

And he suggested that making the remedies exclusive would reduce litigation.

"Before any court action starts, we suggest that the claimant must give a written statement to the defendant, detailing the circumstances of the loss. We hope that will discourage litigation by putting people on notice of what they might expect," he said.

However, insurance industry panelists criticized the ALRC proposal.

Frank Hoffman, a lawyer with Hoffman Consultants in Sydney and a past president of the New South Wales Insurance Institute and the Australian Insurance Law Assn., says he is concerned about the unintended consequences of the proposed legislation.

The ALRC's proposals, if adopted, would unnecessarily complicate business, he said.

Another speaker, Paul Miller, managing director of the Reinsurance Co. of Australia Ltd., questioned whether the proposals were affordable.

Current Australian product liability laws are a patchwork that need "harmonizing," Mr. Miller said, adding that he appreciated that the ALRC was attempting to improve the level of justice provided to citizens and improve product safety standards.

However, he added that the Australian insurance industry already has suffered large underwriting losses and could not be expected to pay even more. Therefore, any increase in costs to insurers due to the reforms will have to be reflected in higher insurance premiums.

"The cost is passed on to the manufacturer and, thus, the consumer, he said.

"That's simple logic. If there's an expansion of the law, premiums will have to go up. The insurance industry has a return of something like 4% or 5% on shareholders' funds aftertax, a very ordinary performance," he said.

"The ALRC is saying that manufacturers enjoy all the advantages of manufacturing goods and should enjoy all the responsibility" for the safety of those goods, he said. "But there's an emphasis here that has been missed. The consumer must be getting some benefit or he would not buy (the product). We need to see a balance," he added.

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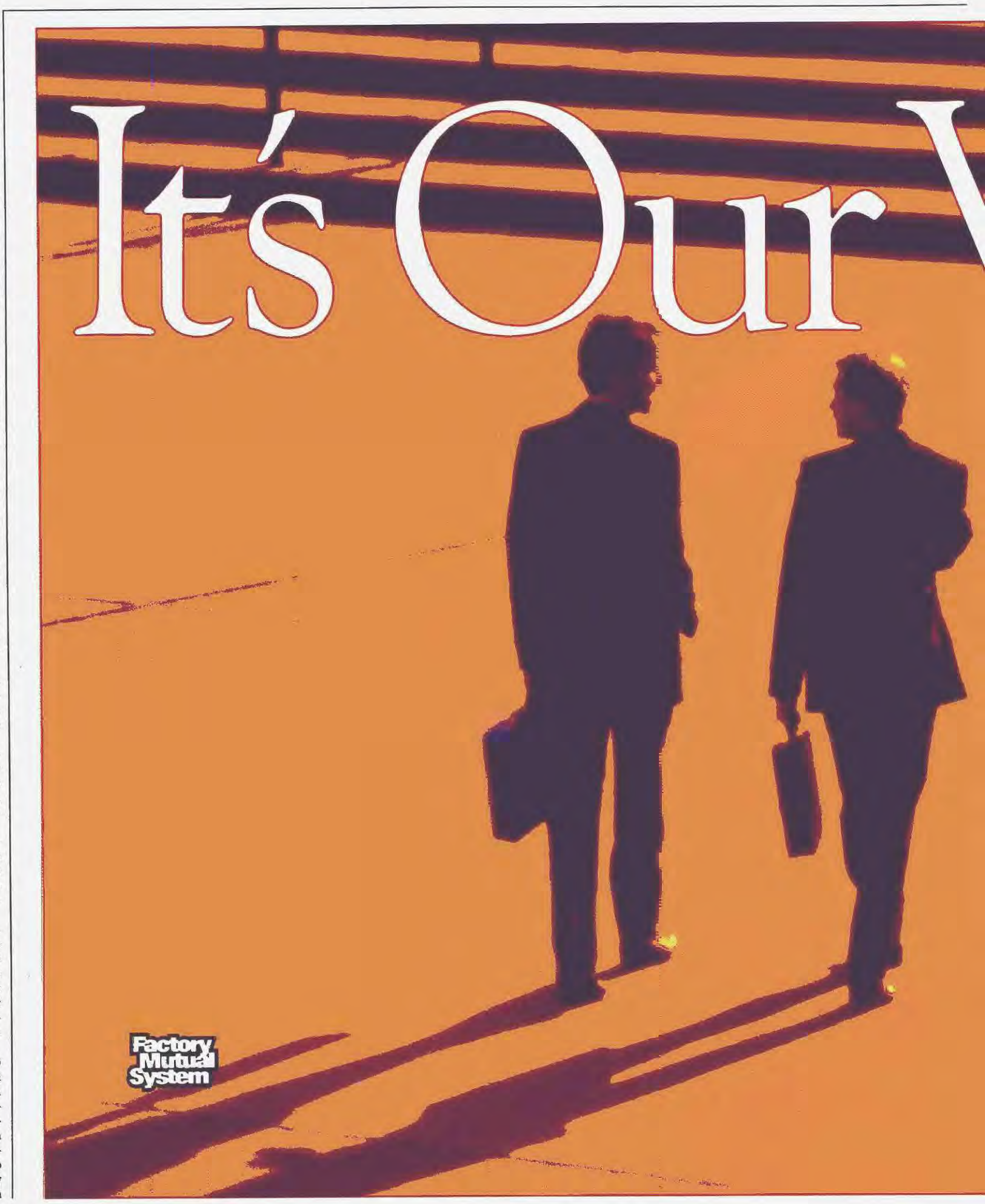

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"While the Australian community may want to see injuries compensated, we can't expect to live in a risk-free society. We can't afford it," Mr. Miller said.

The ALRC's reform package may "impress the little guy in the street because he sees a large corporation paying," Mr. Miller said. However, he suggested that Mr. Goldring was able to "think with his heart," while businesses must think with their heads.

"You can't eliminate risk at the manufacturer's expense. If you want 24-hour compensation, that should be subsidized by the taxpayer, not the manufacturer," Mr. Miller said.

John Dawson, managing director of Hannan Group Pty. Ltd., the largest wholly Australian-owned insurance broker, said he agreed there's a need for product liability reform, but he questioned the ALRC's recommendations, suggesting that the commission is advocating a policy that proof of cause of injury is sufficient to prove liability, without requiring the plaintiff to prove the product was defective.

Mr. Dawson posed several hypothetical cases to explain his objection to the proposal. For instance, he questioned whether a rifle manufacturer could be sued by the family of a murder victim. And he questioned who would be liable if a lightning bolt struck a gas cylinder in a hospital, injuring a visitor.

"We need to ask strange questions to see whether there are strange answers," he explained.

Mr. Dawson said he favored the approach taken in the European Community's product liability directive, which requires that a lack of safety in a product be demonstrated by the plaintiff.

The panelists also criticized the state-of-the-art defense proposed by the ALRC. The defense was not originally included in the ALRC's proposal, but was added after strong lobbying from the business sector.

Mr. Dawson said he thought the defense was not clear. "It seems to me to be difficult for a manufacturer to prove that it was not possible to determine that the goods might cause injury in some circumstance," he explained.

Mr. Hoffman said the defense was "hardly worth the paper it was written on."

One major business group, the Metal Trades Industry Assn. of Australia, which represents more than 7,000 metal and engineering companies, opposes the ALRC's proposals on the grounds that they would impose major handicaps on industry.

The MTIA has established a lobbying group with 12 other industry organizations—including the Insurance Council of Australia and the Business Council of Australia—to oppose the product liability reform proposals.

Rob Howse, MTIA's legal counsel, said the ALRC's proposals could cost Australian industry $2 billion Australian ($1.57 billion) annually.

According to a recent survey of MTIA members, insurance costs would rise by an average of 103% following introduction of the proposals. In addition, insurance would not be available to 7.5% of the MTIA's members, while another 12% would not be able to afford the cost, Mr. Howse said.

The MTIA told the ALRC that current competition forces manufacturers to take all necessary precautions to avoid making unsafe products and that current product liability laws were adequate.

The MTIA also opposes the ALRC's proposals to allow class action lawsuits in Australia.

Mr. Goldring told the NIBA convention that the ALRC favored class actions because they reduced litigation. Combining multiple suits into one court case makes sense when the cases have common circumstances and facts, he said.

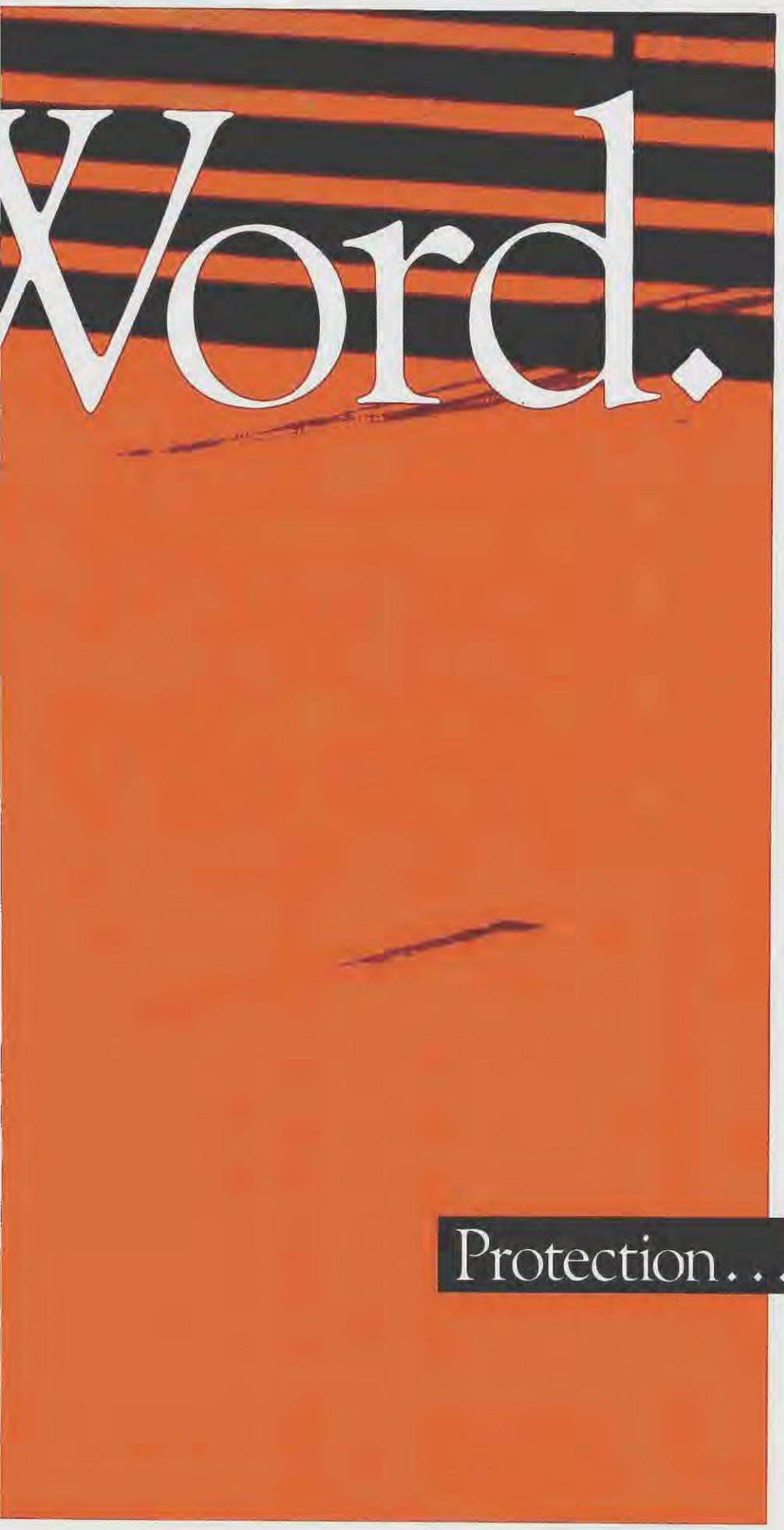
"We are suggesting an individual right to compensation for loss or damage and that will have to be calculated individually," he explained. But proof of causation should be established only once to cover any number of cases, which would reduce legal costs, Mr. Goldring said.

Mr. Hoffman agreed that allowing class actions in Australia may be a good idea, though he added that the ALRC proposal did not contain sufficient protection against frivolous cases.

The ALRC's proposals were forwarded to the attorney general in July and currently are being considered by the government's Industries Assistance Commission to gauge their economic impact. The IAC also has called for public comment on the proposals.

Mr. Goldring said that even if the government does not adopt any portion of the product liability proposal—and generally 70% of ALRC reports become the basis for new laws in some form—the proposal at least has played a significant role in the discussion of product liability reform in Australia.

He added that he was confident that insurers and brokers would take a greater role in advocating product safety as a result of this discussion. ■



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Quake hits Aussie insurer

SYDNEY, Australia—The earthquake that struck the San Francisco Bay Area last month is sending shock waves around the world, including Down Under.

E.J. Cloney, managing director of QBE Insurance Group Ltd., reported that the Oct. 17 San Francisco earthquake could produce millions of dollars in claims for the Sydney, New South Wales-based insurer.

Its California subsidiary, Menlo Park-based Sequoia Insurance Co., anticipates approximately $2.5 million in claims, Mr. Cloney said at the group's annual meeting Oct. 25. As of the QBE annual meeting—only one week after the quake—Sequoia had received nearly 150 claims, mostly for moderate damage to mobile homes and farms, Mr. Cloney said. Some claims have already been settled, he noted.

In addition, the Australian insurance group expects to receive reinsurance claims from several American ceding companies.

"The most likely source of claims will be from QBE Insurance & Reinsurance (Europe) Ltd., which provides reinsurance protection to some 20 American insurance companies, and from QBE Reinsurance (London) Ltd., which has a lesser exposure," Mr. Cloney said.

"Our best guesstimate for claims against the group is that the net cost will be somewhere between $3 million Australian and $6 million Australian ($2.4 million to $4.7 million)," he said. "To express this in another way, our net earned premiums for 1989-1990 will be approximately $475 million Australian ($371.9 million), so that the cost of claims arising from the San Francisco earthquake could add approximately 1% to 1.25% to the group claims ratio," Mr. Cloney added. QBE's fiscal year ends June 30.

However, he pointed out, "The nature of reinsurance is such that it is almost impossible to forecast what the claims will amount to, and it will be some months before we can confidently estimate the claims figure, which will vary depending upon the type of contract involved." ■

EAP study

Continued from page 3

chemical dependency or psychiatric problems, said Daniel C. Smith, director of employee assistance and human resource risk management services for McDonnell Douglas in Bridgeton, Mo., and Dr. John J. Mahoney, managing director of Health Strategies Group.

Most earlier studies had used smaller populations over shorter periods and were conducted internally, agreed Thomas Delaney, executive director of the Arlington, Va.-based Employee Assistance Professionals Assn.

"The way this study was done is very significant. It was conducted by an outside, reputable firm on a major company that told them to go in there, analyze the data and let the chips fall where they may," Mr. Delaney said.

The findings run counter to recent criticism of EAPs as costly and inefficient (*BI*, May 29).

Companies typically expect EAPs to save money by decreasing absenteeism and turnover and, to a far lesser extent, by reducing health care costs, Dr. Mahoney said.

But in the McDonnell Douglas study, consultants "came out with an entirely different set of priorities," he said. "The lion's share of the savings had to do with medical claims costs and the smallest with absenteeism."

Alexander Consulting began its study of McDonnell Douglas' EAP in 1986, a year after the program was expanded with management's proviso that hard data be collected to demonstrate the EAP's return on investment.

In 1985, services for drug abuse, psychiatric illness and family conditions were added to the alcohol treatment program offered at various company sites since 1970. The EAP, available through the company's indemnity plan, was implemented at all company facilities.

General American Life Insurance Co. of St. Louis writes the health care coverage for McDonnell Douglas workers based in the St. Louis area, and Connecticut General Life Insurance Co. of Bloomfield, Conn., writes the health care coverage for workers based elsewhere in the country. However, the same EAP is available to all employees with indemnity plan coverage.

All 4,000 McDonnell Douglas workers who received chemical dependency or psychiatric treatment through the company's insured health care plan's EAP from 1985 to 1988 were included in the study.

These workers' health care costs were compared with those of employees who received treatment outside of the EAP.

These findings were compared with those of a control group of workers, or those without chemical dependency or psychiatric problems who could be matched with the EAP participants in 10 categories, including age, sex, marital status and family size, geographic location, years of education and job type.

Approximately another 4,000 employees enrolled in HMOs also received treatment through HMO EAPs, but medical claims data was not available from those providers.

About 20,000 McDonnell Douglas workers were studied altogether. McDonnell Douglas employed as many as 155,000 workers during the four-year period.

Since the expansion of the EAP in 1985, utilization has risen to about 5% of the company's workforce from less than 1%.

Average medical claims for workers receiving outside chemical dependency treatment over four years were $7,370 more than those for workers treated through the EAP, and $17,850 greater than those for workers in the control group.

The EAP group's health care costs exceeded the control group's costs by an average of $10,480 over the same period.

Average health care costs for workers who received psychiatric treatment outside the EAP were $2,441 greater than those for EAP participants and $7,439 greater than the control group's costs.

The EAP group's health care costs exceeded the control group's costs by about $5,000 over the same period.

The most significant difference in health care costs between the EAP group and the non-EAP group occurred in the first year of treatment, regardless of whether the worker was treated for chemical dependency or psychiatric problems, according to the study.

In the first year of treatment for chemical dependency, the non-EAP group's health care costs exceeded the EAP group's by $5,284.

The difference dropped to only $275 in the second year of treatment, then increased to $2,145 in the third year, and dropped again to $372 in the fourth year.

Likewise, in the first year of treatment for psychiatric disorders, the non-EAP group's health care costs exceeded the EAP group's costs by $2,115.

The difference dropped to $239 in second year of treatment, then increased to nearly $700 in the third year, and almost $800 in the fourth year.

The "halo effect" of entering treatment accounts for the lack of substantial variation in second-year health care costs, Dr. Mahoney explained.

But the "halo effect rubs off after a while for workers not in the EAP," leading to a greater disparities in the third and fourth years of treatment, he said.

The survey also found that health care costs for dependents of workers treated for chemical dependency or psychiatric disorders were lower than costs for dependents treated outside the EAP.

Health care costs for dependents treated outside the EAP for chemical dependency were $8,483 greater than those for the control group, while costs for dependents treated by the EAP were only $4,000 greater than the control group's, the study showed.

The absenteeism rate for EAP-treated workers with chemical dependency was 44% lower than the absenteeism rate of workers treated outside the EAP. The absenteeism rate for the EAP group treated for psychiatric disorders was 34% lower than the absenteeism rate for the non-EAP group.

And, turnover for EAP-treated workers with chemical dependency problems was 81% less than those for employees that did not use the EAP, while turnover was 60% less among workers receiving psychiatric treatment through the EAP compared with those who were treated outside the EAP.

For 1,032 workers receiving treatment through the EAP in 1988 who could be compared with the control group, the company expects to save $5.1 million: $2 million attributable to reduced individual health care costs; $2.3 million attributable to reduced dependent health care costs; and $800,000 attributable to reduced absenteeism.

'Up until now there have been no clear incentives for people to use the EAP or not. Once management is convinced of the cost savings, then you can go back and address the weakest link in the system, and that is first-line supervisors,' Dr. Mahoney says.

The results of the study have convinced McDonnell Douglas of the effectiveness of its EAP "in creating both quality outcomes and reducing costs, both long-term and short-term," Mr. Smith said.

Dr. Mahoney predicted that the study will lead to greater support for the EAP within the company.

"Up until now there have been no clear incentives for people to use the EAP. Once management is convinced of the cost savings, then you can go back and address the weakest link in the system, and that is first-line supervisors," Dr. Mahoney said.

If those supervisors are better trained, they will refer more workers for treatment in the EAP, Dr. Mahoney explained.

But he said the study should not be interpreted to mean that every company with an EAP will enjoy a substantial return on investment. He explained that McDonnell Douglas' EAP is a hybrid, with traditional and non-traditional components.

For example, a McDonnell Douglas EAP management team directly supervises Personal Performance Consultants Inc. and MWG Hospital Services Inc., both of St. Louis, which assess and refer workers to care givers, provide case management and some utilization review and provide back-to-work monitoring and counseling.

"I'm not sure you could get the same results from an EAP run from an 800 number or an EAP that doesn't follow their cases for two years or an EAP run wholly by an outside vendor," Dr. Mahoney said.

And McDonnell Douglas is modifying its EAP by replacing the EAP provider referral vendors with McDonnell Douglas personnel early next year, Mr. Smith said.

"That's uncommon these days. Most EAPs are being farmed out to vendors," Dr. Mahoney said.

The study, though, pointed out some areas of concern for McDonnell Douglas.

For example, the study showed that health care costs for workers with a drug dependency treated by the indemnity plan EAP were only $2,139 lower than the health care costs of workers who were treated outside of the EAP. This difference "was not comparable to that observed for other forms of chemical dependency," the study said.

Dr. Mahoney explained that "people with alcohol dependency had spectacular recovery" in the EAP, compared with employees with a drug dependency.

"Folklore has it that treating drug abuse is not effective. It's not spectacularly effective, but there is solid evidence that by applying the methodology of the EAP, we could produce a reasonable outcome."

In addition, Mr. Smith also said he was disturbed by the study's findings that there is a significantly higher turnover rate among workers who receive treatment in EAPs available through their HMOs than among workers who received treatment in the indemnity plan EAP.

"The employee treated by an HMO for a chemical dependency or psychiatric condition is three times more likely to lose his/her job than the employee in the traditional plan," the study found.

"About 30% of that variation is due to adverse selection," because single, divorced and low-income groups have a tendency to select HMOs and are also at a higher risk of treatment failure, Dr. Mahoney explained.

"Unfortunately, that leaves us with 70% we cannot explain. I'm not willing to say it's the result of poor treatment by HMOs, because we have no claim records or treatment records. It's up to future inquiries to ferret out" the reason for the disparate results, he said.

"I just leave that as an open issue," Mr. Smith said.

•

Copies of the "McDonnell Douglas Corp. Employee Assistance Program Financial Offset Study 1985-1988" are available free by contacting either Daniel C. Smith, Director-Employee Assistance and Human Resource Risk Management Services, McDonnell Douglas Corp., 3221 McKelvey Road, Suite 101, Bridgeton, Mo. 63044; 314-232-4357; or Dr. John J. Mahoney, Managing Director, Health Strategies Group of Alexander Consulting Group Inc., 16 Wilton Road, Westport, Conn. 06880; 203-226-9902.

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Winter weather

Continued from page 3

dents, he said.

In the South, the temperature plunge "caught enough people short" to change the way certain facilities, such as furniture factories, operate, Mr. Hankins said.

Many Southern manufacturing plants were particularly vulnerable to the 1983 cold snap because it came during the traditional Christmas shutdown period, when many plants are unheated.

Bitter experience taught plant managers they would have to change operating philosophies to protect against the extreme cold, said Bob Brindle, district chief engineer for Norwood, Mass.-based Factory Mutual Engineering Assn.'s Atlanta office.

As a result of losses six years ago, some Deep South pulp and paper mills no longer shut down for Christmas, said Mr. Brindle, who is responsible for facilities in four Southern states and Puerto Rico.

Even when plants still shut down for Christmas, managers now check facilities more thoroughly during the break, Mr. Hankins said.

So-called arctic freezes—bitter cold blasts lasting a week or more—have the potential for great damage to property and equipment, loss control experts warn, adding that risk managers must take precautions to protect their companies.

"The main step is to think and to consider those pieces of equipment" often taken for granted, such as sprinkler systems, because they aren't used every day, said Mr. Hankins.

"The problem is that you tend to think about equipment you use" and forget about equipment that goes unseen, such as piping under the roof of a building, he said. But if pipes burst because of freezing, flooding could cause considerable damage, he said.

Insulating property against the perils of winter "can be done in the normal risk management process," agreed Douglas S. Williams, associate director-corporate insurance for Boehringer Ingelheim Corp., a Ridgefield, Conn.-based pharmaceutical manufacturer.

The risk manager should first identify potential exposures, such as radiators in corporate vehicles, outdoor piping and a facility's heating, ventilation and air conditioning units, he said. Then, he or she must establish a corporate cold-weather loss prevention program.

Mr. Williams recommended adopting a system that provides reminders of when any maintenance, cold-related or not, is needed.

Boehringer Ingelheim, for instance, uses a computerized system that "spits out work orders on a daily basis, weekly basis or whenever we need it," he said. The company's Hewlett-Packard maintenance management system, he said, has an equipment data base, an equipment parts data base, a work order information system and maintains complete maintenance record for each piece of equipment.

Although the cost can run into the "tens of thousands of dollars," maintenance management systems are worth the money because the diary function "virtually eliminates" the possibility of overlooking routine, yet critical maintenance, he said.

Maintaining steady indoor temperatures—which can vary according to the substance being stored—is crucial to a pharmaceutical company and requires around-the-clock monitoring, he said.

"Since it is pharmaceuticals, we have to maintain a certain parameter for temperature fluctuations," he said.

Boehringer Ingelheim's location on the Eastern Seaboard is advantageous because the ocean tends to moderate cold weather, Mr. Williams said.

To reduce the impact of extreme cold on company property, risk managers must be thorough, stressed Mr. Brindle of Factory Mutual.

For example, a sprinkler system filled with a 50%-50% solution of water and a non-freezing agent on an outside loading dock should be checked annually, he said, because changing liquid density could make the system vulnerable to freezing.

"They're out there all year round, and you don't really think about it," he said.

Loss control experts also advise risk managers to devise site-specific cold weather plans because a single strategy will not necessarily meet the needs of a company with multiple locations, even if the locations are similar.

For example, Florida Progress Corp.'s strategy against arctic freeze is "plant-directed, plant-specific," said Denis A. Julien, risk manager for the St. Petersburg, Fla.-based utility holding company. "In Miami, you don't have to do what you have to do in south Georgia."

Mr. Julien, a former claims adjuster, said that the most common mistake he has seen is placing sprinkler systems above heated areas in commercial buildings. After a hard freeze, the thawing sprinkler pipes can rupture and flood facilities, he explained.

Foam insulation around piping helps minimize the problem, Mr. Julien said.

While retrofitting a facility to guard against freeze can be expensive, proper insulation "sure does mitigate the damage," he said.

Frozen gauges and other instruments also can produce significant losses, according to Richard Leone,

Continued on next page

Winter precautions outlined on checklist

HARTFORD, Conn.—In an effort to minimize cold weather damage to commercial property, Industrial Risk Insurers has prepared a precautionary checklist for risk managers.

The list, which accompanies the insurer's "Overview, A Total Management Program for Loss Prevention and Control," includes general and specific suggestions for heating systems, water tanks, hydrants and underground piping.

Among the precautions IRI recommends prior to and during cold weather are:

- Make plans to remove snow from flat roofs or other structures that might collapse.
- Ensure that all doors, windows, skylights, ventilators and other openings are weather-tight so they will not admit cold air that could cause sprinkler systems to freeze.

Specific instructions for heating systems include:

- Examine entire system to ensure it is operating properly and correct deficiencies. Burners, boilers and flues also should be clean. Obstructions should be removed from all pipes, radiators and unit heaters. Heating equipment controls should also be tested.
- Where possible, maintain adequate fuel supplies at all times. Safe alternate energy sources should be investigated.
- Temperatures of at least about 40 degrees must be maintained at all times in buildings equipped with wet pipe sprinkler systems; in all dry pipe, pre-action and deluge valve closets; and in all pump houses.
- Clearances should be maintained between heating system components and combustible floors, walls, partitions, platforms and stock.

According to the IRI checklist for protective systems:

- Plans should be made to promptly clear snow from access ways, control valves, hydrants, hose cabinets, smoke and heat vents, explosion relief vents, and other essential equipment.
- Wet pipe sprinkler systems in areas that are inadequately heated should be converted to dry pipe and pre-action systems.
- Dry pipe sprinkler systems and preaction or deluge systems' dry pilot lines should be inspected carefully to make sure piping is properly pitched for drainage. Any condensation that collects in low points or excessive priming water should be removed.
- Sprinkler heads in the immediate vicinity of steam pipes, unit heaters or other heat-producing appliances should be of the correct temperature rating.
- Solutions in all antifreeze sprinkler systems should be tested and antifreeze added as necessary.
- Any "shut-in-water" valves controlling small, unheated areas should be closed, tagged with cold weather shut-off tags and properly drained. Consideration should be given to converting such systems to either a dry pipe or preaction system.
- All wet standpipe systems with piping located in areas subject to freezing should be shut off, drained and tagged.
- Connections to water motor gongs and fire department connections should be properly drained.

Among the checklist instructions for fire protection water tanks are:

- Gravity tanks must not leak, since an accumulation of ice on trestles can cause the tank structure to collapse. The expansion joint and riser boxing should be in good condition.
- The water temperature in the gravity tank should checked frequently during cold weather and maintained at 42 degrees or above.
- The tank heating system should be flushed and put in good working order.
- The tank roof-hatch cover should fit tightly and be fastened.

Tips for hydrants and underground piping include:

- Hydrants and fire hose headers should be drained. Outlet hose valves must be left half open to prevent damage from freezing.
- Hoses should be properly drained and dried.
- Packing on post indicator valves should be drained or otherwise protected against freezing.
- Sections of exposed piping should be drained or otherwise protected against freezing.
- Valve and meter pits should be dry and frostproof.

Portable and wheeled fire extinguishers in cold areas should be suitable for such locations or installed in heated cabinets, according to IRI.

In addition, automotive fire apparatus should be properly serviced for cold weather.

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Broker forecast

Continued from page 1

before," Mr. Malis said.

"Certainly the events in the insurance marketplace that occurred in September and October will have a very pronounced effect (on rates) going forward," predicted J. Michael Bischoff, vp-corporate development group for Marsh & McLennan Cos. Inc. in New York.

But, brokers and analysts agree that a change in insurers' commercial underwriting philosophies would have little, if any, impact on brokers' fourth-quarter 1989 results.

Fourth-quarter results will show only a "slight improvement" compared with the third quarter, Mr. Rosencrants predicted.

"I don't see any significant impact at this point. It's going to take a while" for proposed rate increases to go into effect, said Frank R. Wieczynski, corporate secretary of Alexander & Alexander Services Inc. in New York.

"Right at the moment, we see a little tightening, but not a great deal," said Michael J. Cloherty, vp-finance for Arthur J. Gallagher & Co. in Rolling Meadows, Ill.

And, even when commercial property/casualty insurance rates do start to rise, "it generally takes between six and nine months for brokers to feel a major rate change in their results," he pointed out.

"I would not be surprised at all to see revenues remain weak for the remainder of the fourth quarter," said Shearson's Mr. Smith.

Although several insurers have said they will increase rates, "we're not anticipating changes in the fourth quarter," agreed Robert P. Cuthbert, first vp and chief financial officer of Corroon & Black Corp. in New York.

"We're assuming that (rates are) going to stay flat to slightly down" in the fourth quarter, said William F. Poe, chairman of Poe & Associates Inc. in Tampa, Fla. "We don't expect to see much of a rate impact until 1990," he added.

Brokers gave three primary reasons why they do not expect improvements in their fourth-quarter results.

First, while they acknowledge that some insurers are discussing their plans to raise rates, brokers say it takes time for home office decision makers to pass that message down to branch offices.

Because of that lag time, "January renewals will be the first real sign of what will happen in the marketplace," predicted M&M's Mr. Bischoff.

Second, brokers observed that

Continued on next page

The professional marketplace

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Others Allied to the Field 2,771
TOTAL 50,751

* Source Business/Occupational breakdown of qualified circulation, May 29, 1989 issue, as submitted to BPA for June 1989 BPA Publisher's Statement.

Continued from previous page
much of the coverage that will renew during the fourth quarter has already been placed or negotiated.

And, third, since fourth quarters are historically low-volume business quarters for brokers, any rate increases implemented before year-end would only minimally impact their results, analysts and brokers agreed.

Shearson's Mr. Smith also pointed out that many insurers will wait until they know the costs of their own catastrophe reinsurance programs before they renew primary coverages.

And, the London reinsurance market, which supplies much of the world's high-layer catastrophe reinsurance capacity, is holding back on finalizing renewals until it assesses the losses stemming from the recent spate of catastrophes, according to Mr. Smith.

Because of this scenario, it is likely that many primary property/casualty insurance renewals will not be completed until January, which means that any broker revenue gains will not show up until 1990, Mr. Smith noted.

"I expect the first quarter to be gangbusters, relative to earlier expectations," Mr. Smith said. And because "brokers have budgeted and designed their expense controls for 1990 for a continued soft market, that will result in much better earnings for them than we had anticipated."

But, while other analysts and brokers agree that brokers may start to benefit from a tightening of the market early in 1990, they predict that those gains may initially be minimal.

"It is premature to expect rates to change overnight on the primary side. The end of commercial rate cutting and maybe slight rate increases is a much more likely happenstance," said Herbert E. Goodfriend, securities analyst with Prudential-Bache Securities Inc. in New York.

"I'm cautiously optimistic that rate levels will be at least flat in 1990. I don't expect a dramatic turnaround," said Robert H. Hilb, president of Hilb, Rogal & Hamilton Co. in Richmond, Va.

"On January renewals, we may see a flattening or some (minor) rate increases," agreed Corroon & Black's Mr. Cuthbert.

However, all of the brokers felt the continuing impact of commercial property/casualty rate reductions in the first nine months.

Marsh & McLennan's gross revenues grew 6.2% in the first nine months of 1989 to $1.84 billion from $1.73 billion in the first nine months of 1988.

During the same period, M&M's net income dropped 2.7% to $239.1 million from $245.7 million.

In the third quarter of 1989, M&M's gross revenues grew 7.8% to $606.6 million from $562.7 million in the third quarter of 1988, while net income fell 1.5% to $73.5 million from $74.6 million.

Breaking its third-quarter results down into major business segments, M&M reported:

- A 3.4% increase in insurance services revenues to $346.1 million from $334.8 million in 1988.

While the "rate of decline on commercial rates was slightly less than it had been earlier in the year, it was still showing very much that we were in a soft market through the third quarter," Mr. Bischoff said. And, while the division saw strong new business development in the quarter, rate reductions kept revenue gains modest, he said.

M&M's domestic reinsurance brokerage revenues increased 1% in the quarter, the first quarter-to-quarter revenue increase for those operations in two years, Mr. Bischoff said.

- An 18.7% increase in consulting revenues to $192 million from $161.8 million in 1988.

"Our consulting operations are still showing strong growth. That has been a very good story for us for quite some time," he observed.

- A 3.6% increase in investment management revenues to $68.5 million from $66.1 million in 1988.

M&M's third-quarter results "came in right on the money," Prudential Bache's Mr. Goodfriend said, referring to his estimates.

And, Alex. Brown's Mr. Malis noted that M&M has seen less of an impact in each of the last three quarters from rate reductions, which indicates that rate competition was moderating even before Hurricane Hugo and the San Francisco earthquake.

But, Shearson's Mr. Smith said M&M "showed a little more on its expense line than we had been anticipating, because they have accelerated their replacement hires."

Mr. Bischoff said M&M began to increase staffing in its retail operations in the third quarter by accelerating its replacement of employees who had resigned.

Alexander & Alexander reported a 1.1% revenue increase in the first nine months of 1989 to $920.1 million from $909.8 million in the first nine months of 1988.

During the same period, net income fell 12.6% to $46.4 million from $53.1 million.

In the third quarter of 1989, A&A's gross revenues grew only 0.4% to $298 million from $296.9 million in 1988's third quarter. Net income fell 44.8% to $9.1 million from $16.5 million.

The primary reason for the decline in third-quarter profits was an $11 million increase in reserves for non-recurring expenses, including the settlement of professional liability claims stemming from the 1986 San Juan Dupont Plaza hotel fire.

A&A, which placed property and liability coverages for the hotel, agreed in principal late last month to pay $12 million to the Plaintiffs Steering Committee to settle the pending litigation (*BI*, Nov. 6).

The remainder of the reserve was established to write off costs associated with upgrading the broker's automation systems, Mr. Wieczynski explained.

"A&A looks like it cleaned the house and took care of a few lingering problems that hit it for about 10 cents per share in the quarter," Mr. Smith noted.

"Taking out these adjustments, we only had about a 2.5% increase in expenses in the quarter. This shows a sign that our company is poised in terms of expense control going into the hard market," Mr. Wieczynski said.

A&A's "expenses were held beautifully, not counting their non-recurring expenses," agreed Alex. Brown's Mr. Malis. A&A's quarter came in "a little better than I had anticipated."

And, Prudential-Bache's Mr. Goodfriend predicted that both M&M and A&A "will benefit much more in 1990 than the other publicly traded brokers because their reinsurance intermediary operations represent a much larger portion of their total revenues." Reinsurance rates likely will rise more quickly than primary insurance rates as a result of the catastrophes, he said.

Corroon & Black's gross revenues grew 8.9% in the first nine months of 1989 to $346.5 million from $318.3 million in the first nine months of 1988.

For the same period, net income fell 73.1% to $29 million from $107.9 million. However, Corroon & Black's 1988 results were inflated by a non-recurring net aftertax gain of $73.9 million from the sale of its 29.9% equity interest in London broker Minet Holdings P.L.C. to The St. Paul Cos. Inc. (*BI*, Feb. 1, 1988; Dec. 14, 1987).

In the third quarter, Corroon & Black's gross revenues rose 4.6% to $116.8 million from $111.7 million in the third quarter of 1988. However, its net income fell 14.9% to $10.7 million from $12.6 million.

Mr. Cuthbert said that many purchase acquisitions made in 1989 inflated Corroon & Black's 1989 revenues and expenses. Otherwise, "we really have an expense discipline that's been evident in our numbers," he said.

However, Corroon & Black continues to suffer from its small life, accident and health insurer subsidiary, Consumer Benefit Life Insurance Co. of Nashville, Tenn. An increase in frequency and severity of claims forced Corroon & Black to add to the insurer's reserves and re-underwrite the business in the first half of 1989.

"A lot of those revenues have disappeared because of the increase in pricing, and we expect further deterioration in the fourth quarter," Mr. Cuthbert said.

"Corroon & Black was able to correct the losses in its life insurance underwriting unit, but in the process they learned about the economy of supply and demand," Shearson's Mr. Smith said. "They lost $3 million in revenues" because of client attrition.

And, Mr. Cuthbert said that Corroon & Black's G.L. Hodson & Son Inc. reinsurance brokerage subsidiary "continued to struggle along in the quarter in an operating environment that was very difficult."

"Our trend in new business production, combined with staff reductions accomplished in the third quarter, the effects of acquisitions made in 1989 and the increase in reinsurance business we will be getting from Reliance Insurance Co. (*BI*, June 26), will produce either savings or an increase in revenues exceeding $20 million in 1990," Mr. Addeo predicted, referring in part to Reliance's decision to award a major portion of its reinsurance brokerage business to Hall subsidiary Madison Intermediaries Inc.

Reliance owns almost half of Hall's common stock.

Alex. Brown's Mr. Malis said that Hall's third-quarter results "are showing the effects of their paying up to get new producers, but their revenue growth is positive and they should also benefit from a turn in the marine market."

However, Mr. Malis added that he is much more optimistic about Hall's continuing operations than he is about the earnings potential of its common stock.

"Hall's losses continue to be huge and, despite its revenue growth in the quarter, its loss was larger than a year ago and larger than I expected," Interstate's Mr. Rosencrants said.

While Chicago-based Aon Corp. does not separately report the net income of its Rollins Burdick Hunter Group Inc. subsidiary, it does separate the unit's revenues, minus investment income, and pretax earnings.

For the first nine months of 1989, RBH Group's revenues increased 15.6% to $231.4 million from $200.2 million in the first nine months of 1988. Its pretax income fell 27.7% to $21.4 million in the first nine months of this year from $29.6 million in the comparable period of 1988.

In the third quarter, RBH Group's revenues rose 26.5% to $84.4 million from $66.7 million, while its pretax income fell 47.3% to $4.5 million from $8.5 million.

RBH Group attributes its declining profitability in 1989 to two factors: acquisitions made in late 1988 and the first nine months of 1989 that have added to its expenses, and the negative impact of the soft market on property/casualty commissions and fees.

While Mr. Rosencrants noted that the results of Aon's brokerage operations were "a little lighter than we expected," he added that they were not surprising, given RBH's July acquisition of Bayly, Martin & Fay International Inc.

Arthur J. Gallagher reported a 7.3% increase in gross revenues in the first nine months of 1989 to $126.5 million from $117.9 million in the first nine months of 1988. During the same period, its net income fell 0.9% to $13.5 million from $13.6 million.

In the third quarter, Gallagher's gross revenues rose 7.2% to $47.5 million from $44.3 million in the third quarter of 1988, while its net income fell 1.2% to $7.7 million from $7.8 million.

Mr. Cloherty said the broker was pleased with its third-quarter results, considering that Gallagher paid over 100% more in taxes in the third quarter than it paid in the third quarter of 1988, because it settled a prior year's tax audit in the third quarter of 1988.

"Our employee benefits division, Gallagher Benefits Services, continues to perform well ahead of its business plan while undertaking the added costs of upgrading its claims and administrative systems," Mr. Cloherty said.

He also pointed out that while Gallagher's cost containment programs are still in effect, it is "hiring new sales and support resources when they present themselves."

The broker's third quarter was "better than I was looking for," said Alex. Brown's Mr. Malis. "Gallagher is doing just fine."

Hilb, Rogal & Hamilton reported a 13.3% increase in gross revenues in the first nine months of 1989 to $49.4 million from $43.6 million in the first nine months of 1988.

Net income during the same period rose 21.8% to more than $4.8 million from just under $4 million.

In the third quarter, HRH's gross revenues grew 6.2% to $15.5 million from $14.6 million in the third quarter of 1988, while its net income rose 7.3% to $1.3 million from $1.2 million.

This makes HRH the only publicly held broker to report a net income gain in both the first nine months and third quarter of 1989.

Mr. Hilb attributed HRH's profit growth to the brokerage's aggressive acquisition strategy. That "saved our bacon again," he said. "Our existing offices would not have been able to sustain these increases."

Mr. Hilb characterized the third-quarter operating environment as "tough as nails."

HRH has completed 12 acquisitions thus far in 1989 and will soon complete another.

During 1988, the broker completed 18 acquisitions, he said.

Because some of HRH's acquisitions have been made on a purchase basis—in which revenues are recorded from the date of purchase—and some have been made on a pooling basis—in which revenues are restated for prior years—"it's hard to compare quarters," Alex. Brown's Mr. Malis observed.

However, HRH "continues to grow, and we think that, looking back, they will have made these acquisitions at a very opportune time," Mr. Malis noted. "It's been the best stock that we follow" during the soft market, he added.

In addition, HRH last week announced a five-for-four stock split on its common shares and increased its quarterly dividend rate to 7 cents per share after the split from $.05 per share.

Poe & Associates reported a 10.3% gross revenue gain in the first nine months of 1989 to $30.4 million from $27.5 million in the first nine months of 1988.

During the same period, its net income fell 4.1% to $3.6 million from $3.7 million.

In the third quarter of 1989, Poe's gross revenues rose 28.6% to $11.2 million from $8.7 million in the third quarter of 1988, and its net income soared 65.6% to $1.6 million from $938,000 in the third quarter of 1988.

Like Mr. Hilb, Mr. Poe attributed revenue and income growth in the quarter to the impact of four acquisitions made in the second and third quarters. Excluding acquisitions, "we basically had a flat quarter," he said.

Mr. Poe said that while Poe & Associates had a very strong quarter in the first quarter of 1988, which has made year-to-year comparisons this year difficult, the broker has "almost caught up" in 1989 because of the additional revenues generated from those acquisitions. ■

Nine-month 1989 broker results

Results are reported in thousands of dollars

Broker	Gross revenues	% change	Net income	% change
Marsh & McLennan	$1,835,600	6.2%	$239,100	-2.7%
Alexander & Alexander	920,100	1.1	46,400	-12.6
Corroon & Black	346,490	8.9	29,025	-73.1[1]
Frank B. Hall	278,622	3.1	-82,973	N/M
Rollins Burdick Hunter	231,383[2]	15.6	21,422[3]	-27.7
Arthur J. Gallagher	126,463	7.3	13,516	-0.9
Hilb Rogal & Hamilton	49,417	13.3	4,833	21.8
Poe & Associates	30,361	10.3	3,574	-4.1

[1]1988 first-half income includes a $73.9 million net after-tax gain from the sale of its equity interest in Minet Holdings P.L.C. [2]Excludes investment income [3]Pretax N/M-Not meaningful

Source: Company reports

BI/HOLLY SEGUINE

Service audits work comp medical bills

Product & services

A service that audits workers compensation medical bills is available in 11 states through MedStar, a new division of Tampa, Fla.-based Insurance Software Packages Inc.

Heathrow, Fla.-based MedStar uses Insurance Software Packages' newly enhanced medical fee auditing software and a staff of medical experts to:

- Adjudicate bills against the appropriate state's fee schedule or reimbursement guidelines.
- Check claims history for duplicate billing.
- Prepare a hard copy explanation of medical benefits and a savings report.

MedStar also provides ancillary services such as consulting on difficult cases and self-administration procedures and setup, as well as hospital, chiropractic and drug and supply bill review.

Billed on a per-line or per-procedure basis, charges for the service are based on the intricacy and length of the bill, a MedStar spokesman said.

The service currently is available in Florida, Texas, California, New York, Michigan, Georgia, Oklahoma, Maryland, Oregon, Massachusetts and Kentucky.

Tampa, Fla.-based Insurance Software Packages' newly enhanced workers compensation claims management system also is available to self-insured employers, insurers, third-party claims administrators and others involved in processing work comp claims.

The new Version 3.0 software, available in 5¼-inch and 3½-inch diskettes, incorporates Insurance Software Packages' medical fee schedule validation system, which provides:

- Full reimbursement rules and values.
- Duplicate charge and history checking.
- Modifier code payment reductions that indicate ancillary services administered.
- Global reimbursement validation.
- Associated cost containment mechanisms.

The software also automatically verifies employee eligibility, validates payment against the approved state fee schedule payment plan and tracks reserves.

It also can generate an array of reports, including explanations of medical benefits, checks, management and safety reports, statutory reports and the most frequently required state and federal forms such as initial notice of injury and wage statements.

Available in single and multiuser versions, the software is designed for operation on IBM XT/AT, PS/2 or compatibles. The software is covered by a two-year warranty and costs $15,495-$25,000.

For more information on MedStar's medical bill audit and review service for workers comp, call Pat Allen, Vp, MedStar, 250 International Parkway, Heathrow, Fla. 32703; 407-333-8912.

Information on Insurance Software Packages' workers comp claims management software is available from Peter Reynolds, Senior Marketing Executive, ISP Inc., 5118 N. 56th St., Tampa, Fla. 33610; 800-237-8133.

Small-employer ASO

A life and health administrative services-only contract for small employers is now available from The New England General Life Insurance Co. of Boston.

The New England ASO contract lets companies with as few as 25 employees use the same group benefit plan funding method usually reserved for large employers.

Under ASO contracts, employers can improve their cash flow by paying claims only when they occur, plus a fixed monthly fee to cover administrative costs.

The New England also provides its ASO contract employers with aggregate stop-loss protection, which is triggered when claims exceed a predetermined ceiling.

The cost of the small-employer ASO contract is based on employee demographics.

For more information, contact Jim Toms, Assistant Vp-Employee Benefits, The New England General Life Insurance Co., 501 Boylston St., Boston, Mass. 02117; 617-578-3715.

EIL coverage

Owners and operators of underground storage tanks can purchase third-party bodily injury and property damage pollution liability coverage from National Union Fire Insurance Co. of Pittsburgh, Pa.

National Union, a unit of New York-based American International Group Inc., will underwrite the policy, which also covers off-site cleanup costs, for the storage of motor fuel and waste motor oil.

In addition, coverage for owners and operators of underground storage tanks that contain diesel fuel and heating oils is available "in some cases," said John Amore, president of AIG's technical insurance group.

The coverage is available on a claims-made basis with limits of $1 million per loss/$2 million aggregate. Higher limits also are available, according to Mr. Amore.

Premiums, which start at $25,000, are written on a site-specific basis, taking into consideration factors such as the number of tanks at a single location, tank and pipe construction, monitoring systems, inventory methods and proximity to drinking water, Mr. Amore explained.

Policies are subject to a $50,000 minimum deductible, and exclusions are "consistent" with other environmental impairment liability policies, he said.

The policy is available in most states through licensed agents and brokers, Mr. Amore said.

For more information about the pollution liability policy, contact Gladys Thomas, American International Group Inc., 70 Pine St., New York, N.Y. 10270; 212-770-7000.

Books/videos

"Corporate Directors and Officers Liability, Insurance and Risk Management," published by Executive Enterprises Inc., guides risk managers, lawyers, directors and officers and insurers through the process of developing effective D&O risk management policies to protect the corporate entity, avoid litigation and maximize defenses in court. Included are sections on defining the role of directors and officers, selecting an insurer, tailoring a policy to an individual company's needs and defense techniques in litigation. The 250-page book is available for $75 from Executive Enterprises Publications Co. Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 212-645-7800. ■

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Work comp

Continued from page 2
party initiated the review proceedings," Justice Stevens wrote.

"First, the underlying claim for compensation that is at issue from the beginning to end is unquestionably a claim against the insurance company.

"Second, the fact that as a matter of state law the burden of proof remains on the employee is of more importance in determining the true character of the judicial proceeding than the identity of the party who filed the initial pleading.

"Third, and perhaps of greatest importance, the question of whether the matter in controversy is sufficient to sustain federal jurisdiction is determined by the magnitude of the employee's claim, rather than by the amount of the award that the insurance company challenges," Justice Stevens wrote.

Michael Jung, the attorney for Northbrook and a partner with Strasburger & Price in Dallas, said the decision is important for insurers nationwide because it gives them the right to file challenges to workers compensation awards in state or federal court.

"In different parts of the country, the relative climate of state courts vs. federal courts differ," he noted.

An insurer's decision governing the court in which to file a challenge "will vary between urban and rural communities and by the pro-business vs. anti-business climate that prevails in the given area," Mr. Jung explained.

For instance, if Northbrook had been forced to file suit in state court, Mr. Jung noted the appeal of the workers compensation award would have been heard by a judge elected by the injured worker's peers and by a jury composed of the injured worker's peers, which could have swayed the court in favor of the injured worker.

Mr. Jung further noted that the Supreme Court decision could have positive implications for employers.

He noted that one reason for the current workers compensation crisis in Texas "is that Texas state courts have awarded total and permanent disability in many cases where it has not been warranted. If there are fewer and smaller recoveries" because awards are reduced by federal courts, "then that can only have a positive impact on the premiums insureds are paying," Mr. Jung contends.

Eric J. Oxfeld, counsel with the American Insurance Assn. in Washington, agreed that the ruling sets an important precedent.

"The number of cases actually removed to federal court is not as important as the deterrent effect having this right available to insurers has on keeping the state court system from getting too far out of line," Mr. Oxfeld explained.

The AIA filed an amicus curiae brief in this case because it "felt there were some important issues at stake," Mr. Oxfeld explained.

"Insurance companies have to be one of the major groups for which diversity jurisdiction is an important right. When the injured party and the court are in the same state and the insurer is out of state, then the likelihood of bias against the out-of-state deep pocket is clear," Mr. Oxfeld said.

Adverse state court decisions "would be reflected in higher insurance costs for policyholders. In a small way, this decision will help break the escalation of workers comp insurance rates for Texas employers," he predicted.

However, the attorney for the injured worker noted that the decision could harm injured workers.

Because the federal court system does not have a rule like some state courts that gives workers compensation cases priority over other cases, the injured worker could face lengthy delays in federal court as a result of this ruling, explained Timothy M. Fults, an attorney with Fults & Francis in Dallas.

In light of those potential delays, the worker "will have to give some added consideration to whether he wants to settle the case for a lower amount" to get it over with, Mr. Fults noted.

In addition, the Supreme Court decision will likely "create a race to the courthouse" between the worker and insurer, he said.

Besides Justice Marshall, Chief Justice William Rehnquist and Justices William Brennan, Byron White, Harry Blackmun, Sandra Day O'Connor, Antonin Scalia and Anthony Kennedy ruled in favor of Northbrook. ●

Northbrook National Insurance Co. vs. Brewer et al.; U.S. Supreme Court, No. 88-995.

N.J. risk manager wins Lenz award from CPCU

By JUDY GREENWALD

NEW YORK—George M. Mills, who left retirement to serve as risk manager for the New Jersey Highway Authority, has received the Matthew Lenz Jr. Risk Management Award from the New York chapter of the Society of Chartered Property & Casualty Underwriters.

The award was presented last week during the chapter's 44th annual conferment of the Chartered Property & Casualty Underwriter designation in New York. Fifty-seven men and women received the professional designation during a ceremony.

"This certainly has been a high point of my insurance career," said Mr. Mills, who was cited for his contributions to education and public service in insurance and risk management.

He joked at the ceremony that one of his more memorable experiences was grading a CPCU exam that asked for a definition of grace period. One answer: "The time the insurance companies give you to pray to come up with a premium."

More seriously, Mr. Mills later discussed his concern with public ignorance of risk management and insurance.

"I don't think the concept of risk management is known to the public at large," he added. Although the profession helps provide security to the public at large, "we're sort of an unknown occupation."

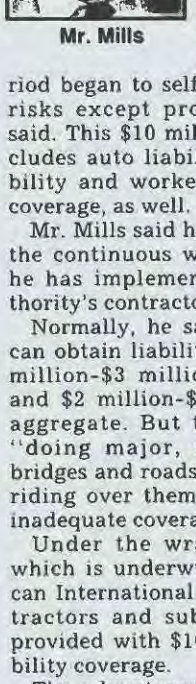
To help increase awareness, he said risk managers should make speeches at every possible opportunity. Noting that he follows his own advice, Mr. Mills quipped: "I'll talk anywhere, as long as they pay for dinner."

Mr. Mills said he was honored to receive the award. "I didn't think they knew we existed way out here on the farm. It is a very, very nice award. I certainly appreciate the people that thought of me, and the people that picked me."

Mr. Mills retired in 1976 as president of George M. Mills Inc., an underwriting and general agency in Highland Park, N.J., after 30 years.

But he soon became bored with retirement and joined the Woodbridge-based New Jersey Highway Authority, which operates the Garden State Parkway, as risk manager, he said.

Mr. Mills supervises the authority's self-insurance programs and a continuous wrap-up insurance program he implemented for the authority's contractors.


Mr. Mills

Mr. Mills considers the authority's move to a largely self-insured program one of his major accomplishments.

Beginning in 1977 with health benefits, the authority over a three-year period began to self-insure all of its risks except property risks, he said. This $10 million program includes auto liability, general liability and workers compensation coverage, as well.

Mr. Mills said he also is proud of the continuous wrap-up program he has implemented for the authority's contractors.

Normally, he said, a contractor can obtain liability coverage of $1 million-$3 million per incident, and $2 million-$5 million in the aggregate. But the authority is "doing major, major work on bridges and roads while people are riding over them. There just was inadequate coverage," he noted.

Under the wrap-up program, which is underwritten by American International Group Inc., contractors and subcontractors are provided with $100 million of liability coverage.

The advantages of this, he said, are that the contractors have an adequate insurance program "with a good, sound company that's able to respond in the event of a serious loss," he said.

New York-based Frank B. Hall & Co. Inc., which nominated Mr. Mills for the Lenz award, helped the authority set up both its self-insurance and construction wrap-up programs, said Mr. Mills.

Among his many professional affiliations, Mr. Mills has served as chairman of the International Bridge Tunnel & Turnpike Assn.'s risk management committee.

He also served on the New Jersey Governor's Committee for Health Maintenance Organizations, and was as a consultant to the Governor's Committee for Business Efficiency in the Public Schools and for Sound Municipal Government.

Mr. Mills has served on the Risk & Insurance Management Society Inc.'s Future Planning Committee. He also is a member of the Public Risk Management Assn.

He has also been president and a board member of the National Interfraternity Conference, where he established an insurance program for member fraternities and personnel.

Mr. Mills holds a bachelor's degree from Rutgers University in New Brunswick, N.J., and a master's degree and a professional certificate in administration from Columbia University in New York.

A committee including members of the New York chapters of the Society of CPCU and RIMS, as well as several brokerages, selected Mr. Mills for the Lenz award.

Matthew Lenz Jr., for whom the award is named, was a prominent writer on risk management, and was dean of academic affairs and professor at The College of Insurance in New York.

The award is given annually to someone whose conduct, character and personal achievements have made a major contribution to the risk management profession in the New York, New Jersey and Connecticut area. ■

Update

Ashland settles 20 oil spill suits

PITTSBURGH—Ashland Oil Co. has reached a $30 million settlement agreement with an unspecified number of plaintiffs who have filed 20 class-action lawsuits over the January 1988 oil spill in the Monongahela River, according to an Ashland spokesman.

The settlement, which was tentatively approved last week by the U.S. District Court in Pittsburgh, will include $14 million in claims Ashland has already paid or agreed to pay.

In addition to the $30 million, Ashland has agreed to pay $6.2 million to cover settlement and attorneys' fees and to compensate people whose water service was interrupted by the spill.

If the District Court approves the settlement at a February hearing, a committee of company and plaintiff representatives will review all claims, and Ashland will pay them according to procedures established in the agreement, the Ashland spokesman said.

If those claim settlements do not bring the amount of total settlements to $30 million, Ashland will use any difference to settle new claims that would qualify for this settlement.

Ashland has $400 million in liability insurance from Oil Insurance Ltd. and OIL Casualty Insurance Co. Ltd. (*BI*, Jan. 11, 1988).

Punitive damage cases rejected

WASHINGTON—The U.S. Supreme Court may have refused to review two constitutional challenges to punitive damage awards last week because the states in which the suits originated have established caps for such damages, says a tort reform advocate.

The Supreme Court instead is looking for a case that presents the issues surrounding punitive damages clearly and will "pick a case that has the biggest shot at getting a clear consensus" from the justices, said Jeff Smith, general counsel for the American Tort Reform Assn.

The court ruled in June that punitive damage awards did not violate the Eighth Amendment's excessive fines clause, but four justices noted that such damages may run afoul of the constitutional right to due process under the 14th Amendment (*BI*, July 3).

Both cases the court declined to review last week—*Clardy vs. Sanders* and *Combined Insurance Co. of America vs. Ainsworth*—challenged the due process clause of the 14th Amendment.

Mr. Smith believes the court rejected the cases because Alabama, where the *Clardy* case originated, and Nevada, where the *Combined Insurance* case originated, were moving toward reform when the petitions for Supreme Court review of those cases were filed.

"If the political process is working in a state, and the court sees that it is dealing with the issue of punitive damages, the court is less inclined to jump in with a constitutional solution," Mr. Smith said.

Briefly noted

State plaintiffs in the **insurance antitrust litigation** filed a notice of appeal with the 9th U.S. Circuit Court of Appeals in San Francisco Nov. 7, said Thomas A. Greene, California deputy attorney general (*BI*, Sept. 25). Briefs in the case are expected to be filed late next month. . . .**New York state sheriffs** can no longer be held personally liable for their deputies' mistakes under Proposal One, a constitutional amendment New York voters approved last Tuesday that overturns a 19th century law (*BI*, Nov. 6).

Oil spill liability

Continued from page 2
gross ton or $10 million, whichever is greater.

The bill passed by the Senate would allow states to supersede this limit.

A House-Senate conference committee must now reconcile the differences between the two bills.

The House Merchant Marine and Fisheries Committee, which in June passed legislation that would pre-empt all state laws regarding oil spill liability, is opposed to the new language added to the House bill by the Miller-Studds amendment because it would open many shipowners to unlimited liability, said a spokesman for the House committee.

'There is lots of talk of people who will have to get out of the business because they won't be able to get insurance,' says a spokesman for the House Merchant Marine Committee.

"There is lots of talk of people who will have to get out of the business because they won't be able to get insurance, or they are not willing to risk their assets against unlimited liability," he explained.

Robert Lagatolla, president of the New York-based Water Quality Insurance Syndicate, a syndicate of 25 insurers that writes liability coverage for vessels that operate in domestic waters, said that vessel owners traditionally have been subject to limited liability because they cannot control the happenings on a vessel hundreds of miles away from home port.

Limits on liability are revoked, however, if management had prior knowledge of any misconduct or negligence that causes an accident, he said.

The House rejected an additional amendment offered by Rep. Miller that would have re-defined the criteria for revoking all limitations on oil spill liability limitations to "simple" negligence from willful or gross negligence.

The spokesman for Rep. Miller contends that a business should be held responsible for the actions of the workers while they are on the job. "If you hire people for a job, then you have to be responsible for them," he said.

However, the House did approve another amendment—sponsored by Reps. Dean A. Gallo and Robert Torricelli, D-N.J., and Rep. Steve Gunderson, R-Wis.—that would require:

- Double hulls for all newly constructed U.S. or foreign vessels carrying oil or hazardous material in domestic waters.
- Retroactive re-fittings of double bottoms only for all vessels traveling in domestic water within a seven-year period, with all ships, foreign or domestic, having a double bottom after that time.
- Double hulls for all vessels within 15 years. ■

Insurance rates

Continued from page 1

"We have been monitoring the insurance markets for the opportune time to raise prices. We believe that time is now," Mr. Moseley said in a quarterly report to shareholders of Baltimore-based USF&G.

"The decision reflects significant losses from involuntary markets and the anticipated tightening of the reinsurance markets," he said. "Hurricane Hugo and the California earthquake do not themselves provide a reason to raise prices, but the approaching end of the soft property/casualty market has certainly been accelerated by these two events."

Meanwhile, William E. Thiele, senior executive vp of Continental Corp. in New York, has notified branch managers to "redouble efforts" to raise rates, a Continental spokesman confirmed.

Mr. Thiele did not target particular lines of business or regions of the country, or specify the amount of the required increases, according to the spokesman, who said these decisions are being left to local managers.

In a Nov. 2 letter to managers of Philadelphia-based CIGNA Corp.'s Property & Casualty Group, Caleb L. Fowler, president of the group, also advised rate hikes.

"The market is in the process of rationally responding to an economic reality," Mr. Fowler's letter says. "Starting immediately we should get meaningful price increases on the risks we write."

Seattle-based SAFECO Property & Casualty Insurance Co. has concluded that "it is essential to take some modest increases, excluding workers comp, of about 10% across the board," said Don Chapman, senior vp of commercial lines.

Mr. Chapman said rate increases are scheduled for all territories and that the greatest increases will come in general liability and small commercial lines. SAFECO has already targeted California for 10% to 12% increases, he said.

Wausau Underwriters Insurance Co. of Wausau, Wis., is preparing to make "modest increases of less than 10%" in 1990 on many property risks, according to Assistant Vp Robert Green, who added that increases for risks with loss experience may be "a little higher" than 10%.

Without specifically announcing plans to hike rates, the chairmen of American International Group Inc. and Travelers Corp. also predict a quick end to the soft market in the wake of recent catastrophe losses.

"Even before Hurricane Hugo and the recent California earthquake, commercial insurance rates in a number of classes were beginning to strengthen," said AIG Chairman Maurice R. Greenberg in announcing the New York-based insurance group's third-quarter results. "The latest catastrophes have simply hastened the timetable for and, to some extent, the amount of required increases in virtually all commercial classes of insurance."

'Hurricane Hugo and the California earthquake do not themselves provide a reason to raise prices, but the approaching end of the soft. . .market has certainly been accelerated by these two events,' says USF&G Corp. Chairman Jack Moseley.

AIG is "raising prices and we are prepared to lose business," Joseph R. Wiedemann, president of AIG affiliate American Home Assurance Co., said last week at the annual meeting of the National Assn. of Independent Insurers in Seattle.

Hugo and the earthquake "will speed up price corrections to restore satisfactory margins, but the precise timing is difficult to predict in this very competitive business," noted Edward H. Budd, chairman of Hartford, Conn.-based Travelers.

Several other insurers say they are not planning any across-the-board rate increases but will be reviewing individual risks and raising rates where appropriate.

"I'm sure there will be some premium increases based solely on the fact that they are appropriate for that account," said Milton Anstey, assistant vp with Industrial Risk Insurers in Hartford, Conn., a consortium of insurers that writes property insurance.

Oil and chemical risks, for example, will probably see rate increases because of their loss experience, though Mr. Anstey added that even within such classes some risks may not be hit with higher premiums.

"We do it on an account-by-account basis," he said.

"Some prices for some branches might need some fine-tuning on a case-by-case basis, but any upward adjustment would be minimal for good accounts who stayed with us through the soft market," said Morgan Davis, president of the commercial lines division of Fireman's Fund Insurance Cos. in Novato, Calif.

Mr. Davis added that "we need no new or specific directives geared to our individual branch offices. The branches have had effective guidelines all along."

Mike McIntyre, senior vp-marketing with Johnston, R.I.-based Allendale Mutual Insurance Co., anticipates 1990 rate hikes for smaller commercial property accounts. Large accounts, he added, may not see much price fluctuation and risks will be treated individually.

"Our corporate philosophy is one of modest adjustments," said Dick Roth, marketing manager with Arkwright Insurance Co. in Waltham, Mass. "So, some risks may see rates go modestly up next year."

Brokers generally report seeing little evidence of pricing changes so far, though they expect rate hikes by next year.

"There aren't many signs yet. It's just too early," observed Lawrence Drake, managing director with Marsh & McLennan Worldwide in New York.

"We're hearing a lot of carriers talking, saying they are going to increase rates. We haven't seen anything," said Robert P. Cuthbert, first vp and chief financial officer for Corroon & Black Corp. in New York.

"On our January renewals," he added, "we may see a flattening or some increases."

"We hear it, but we haven't really experienced it," said Robert H. Hilb, president of Hilb, Rogal & Hamilton Co. in Richmond, Va.

Insurance company "branches are saying that rates are not going down further and that there will be 10% to 15% increases on renewal," he said.

"But what we're seeing is still an extremely competitive marketplace. The bulk of our renewals are showing decreases in rates. The likelihood is that we won't see any action until 1990, if then," Mr. Hilb said.

"I don't think that insurance companies are clear yet about their losses," he observed.

Many insurers are still in the process of deciding how they will approach the market in upcoming renewal negotiations, noted Horace Holcomb, senior vp with Alexander & Alexander Inc. in New York.

"They are all finalizing their strategy for 1990 and are starting to figure out how they are going to implement it in the field," Mr. Holcomb observed.

These strategies will differ significantly from insurer to insurer, he added.

"It's all over the map, from trying to hold their prices on their renewal business to maybe getting out of certain lines that have been unprofitable to selectively raising rates in certain categories," Mr. Holcomb said.

While some insurers may try to impose across-the-board rate hikes, others may see an opportunity to "improve their competitive position" by luring business away from these insurers, he said.

"It's a very fractured marketplace," he noted.

Nevertheless, Mr. Holcomb said he expects prices to level off and in some cases—such as energy and chemical risks and to a lesser extent general liability business—to rise.

"People are not talking about the soft market anymore," he said. "They are talking about a more stabilized situation."

M&M's Mr. Drake agreed, noting that underwriters may renew some accounts at expiring rates while asking others for increases of 10%-20%.

Many underwriters, though, are warning buyers not to expect further rate reductions, he said.

While the market may tighten more rapidly in the wake of the recent catastrophes, brokers and insurers agree on one thing: This turnaround will not be a reprise of the convulsive market change of 1985, when rates shot through the roof, capacity dried up and insurers tried to impose sweeping reductions of coverage.

The change this time around is likely to happen gradually, with modest rate increases in most cases and with few attempts to drastically limit coverage, brokers say.

Instead, insurers "will each try to correct where they perceive some of their problems are," Mr. Holcomb observed.

•

Associate Editor Michael Schachner in New York and Agent/Broker Editor Linda J. Collins in Chicago contributed to this report.

Catastrophe losses mount

More insurers are estimating their losses from Hurricane Hugo and the California earthquake. All figures are in million of dollars.

	Hurricane Hugo		Earthquake	
	Gross losses	Net losses	Gross losses	Net losses
Aetna	NA	36[1]	NA	25-30[1]
Allendale	NA	28[2]	NA	6-10[2]
Allstate	250	80[1]	NA	NA
AIG	NA	45[2]	NA	NA
Arkwright	NA	25[2]	5	5[2]
CIGNA	NA	90[1]	NA	NA
Commercial Union (U.K.)[3]	NA	32[2]	NA	Less than 8[2]
Continental	400	77[1]	NA	NA
Fireman's Fund	70	36[1]	200	50[1]
General Accident (U.K.)[3]	133	77[2]	16	16[2]
Guardian Royal (U.K.)[3]	8	NA	3	NA
Hartford	NA	35[1]	NA	20-30[2]
IRI	NA	83[2]	NA	0.5[2]
Kemper National P&C	48	NA	20	NA
Munich Re[3]	81-86	NA	30[4]	NA
Nationwide	154	24[1]	0-1	0-1[2]
Royal (U.K.)[3]	NA	55[2]	NA	NA
SAFECO	5	5[2]	4.5	4.5[2]
St. Paul	NA	35[1]	NA	NA
State Farm	500	500[2]	300	300[2]
Transamerica	NA	6[1]	NA	Less than 6[1]
Travelers	NA	40[1]	NA	Less than 10[2]
USF&G	75	26[2]	2	2[2]

[1]Aftertax [2]Pretax [3]Converted to dollars [4]U.S. office only NA-Not available

Source: Company reports

Quake loss estimates varied, likely to change

Estimates of insured losses from last month's California earthquake vary source to source because of different methods of gathering loss information.

Current insured loss estimates range from $960 million, according to the Property Claim Services division of Rahway, N.J.-based American Insurance Services Group, to as much as $2 billion, according to A.M. Best Co. of Oldwick, N.J., and Standard & Poor's Corp. of New York.

These estimates are unscientific early projections and will likely be adjusted as additional claims are filed, officials say.

In addition, estimates are based on surveys of insurers writing earthquake coverage in California, and some companies provide more complete information than others.

Best, which estimates insured quake losses at $1.5 billion to $2 billion, sent questionnaires to 40 large insurers writing quake coverage in California, but some did not respond, said Paul Wish, a Best vp.

"We're not looking for anything we would stake our lives on until Dec. 31," Mr. Wish said, referring to insurers' year-end results. "We're just as eager as everybody else to get accurate figures. . .but adjusters haven't even been able to get at some areas."

AISG's Property Claim Services also projects losses based on the number of total earthquake policies written and the size of policyholder deductibles, said Vp Ed Hermanson. The division also uses loss information from the 1987 earthquake near Whittier, Calif., he said.

"Obviously, the problem is the extent of the damage is unknown until all buildings are inspected. We anticipate making a change in our estimate as more information comes in," Mr. Hermanson said.

—By Michael Schachner

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Piper Alpha

Continued from page 3

Piper Alpha-related reinsurance claims could continue to spiral in the London excess-of-loss reinsurance market for more than five years, with many Lloyd's of London members possibly being hit with cash calls as soon as next year, sources say.

Court battles could ensue over liability for the disaster, following publication of the inquiry's conclusions next year

However, Occidental stressed that its lawsuits, filed in September, will not necessarily lead to court action.

They "are simply a legal mechanism to protect time limits. They have been issued but they have not been served and may never be served," said the spokesman.

Under English law, plaintiffs have six years after an alleged breach of contract or violation of law to file litigation. Plaintiffs have 12 months after lodging a writ in a court to serve the lawsuit on the defendants.

The lawsuits filed by Occidental, most of which refer to contracts written in the late 1970s, seek unspecified "loss and/or damages and/or expenses, contribution and/or indemnity resulting from the destruction of the Piper Alpha oil and gas production platform on July 6, 1988."

Among others, Occidental has filed writs against:

- McDermott-Hudson Engineering Ltd. of Wembley, Middlesex, England. McDermott was involved in the construction of the rig's jacket, which is a tubular steel support structure affixed to the seabed, said the Occidental spokesman.

McDermott refused to comment on the lawsuit or its insurance.

However, sources say McDermott has a package insurance policy placed in the London market by Bain Clarkson Ltd. and led in Lloyd's by marine underwriter Richard Youell.

- Bechtel Ltd. of London. Bechtel designed the platform, according to Bob Parker, commercial manager of Bechtel.

Bechtel refused to comment on its insurance. But sources in London agreed that Bechtel also has a package insurance policy placed in the London marine market by Willis Faber P.L.C. and led by Lloyd's underwriter Seamus Cowley.

- Bawden International Ltd. of Aberdeen, Scotland. Bawden, a drilling contractor on the rig, has an insurance package policy placed in the marine market by Lloyd Thompson Ltd. and led by Lloyd's marine underwriter Chris Rome, sources say.

Bawden refused to comment.

- Ingersoll-Rand Co. Ltd. of London. Ingersoll-Rand, which manufactured the gas compressors on the rig, refused to comment.
- C.J.B. Offshore Ltd., now part of John Brown Engineers & Constructors Ltd. C.J.B. was involved in manufacturing generating equipment for the rig, said the Occidental spokesman.

John Brown refused to comment.

- Lloyd's Register of Shipping. Lloyd's Register, which was the certification authority for the Piper Alpha, would not comment.

Occidental, meanwhile, has avoided years of court battles over personal injury claims filed by survivors of the incident and relatives of those killed by agreeing to out-of-court settlements totaling more than $180 million.

Relatives of all but two of the workers killed in the explosion have accepted compensation offers from Occidental, according to the company spokesman.

Survivors' injuries still are being evaluated, but 59 of 62 survivors have accepted an Occidental formula to settle claims based on the extent of their injuries, the spokesman said.

So far, only one lawsuit has been filed on behalf of a victim of the disaster, according to the Occidental spokesman. The widow of a U.S. citizen who died in the accident is suing Occidental and other defendants in a Texas court, the spokesman said.

While Occidental settles liability claims, Lloyd's underwriters, who are bearing the brunt of the Piper Alpha loss through excess-of-loss reinsurance arrangements, now are producing more accurate estimates of their individual losses.

And, several syndicates are warning members that losses from Piper Alpha will shoot through their reinsurance protection, causing large losses for the 1988 underwriting year.

Some syndicates, already faced with a cash-flow crisis, will be calling for cash from their members in 1990, a year before the 1988 syndicate accounts are due to close under Lloyd's three-year accounting system, some underwriting agency executives say.

"We expect a significant number of syndicates to go through their reinsurance programs, and several of these will make cash calls next year," said a members' agency executive responsible for monitoring Lloyd's syndicates.

For example, marine syndicate 540, underwritten by Patrick Fagan and managed by Feltrim Underwriting Agencies Ltd., predicts a loss of 24.4 million pounds ($44.2 million at year-end 1988 exchange rates) for the syndicate's 1988 year.

The loss represents 66% of the syndicate's total capacity of 37 million pounds ($69.6 million at year-end 1987 exchange rates) for the 1988 year, said a Feltrim spokesman. As a result, the agency may have to make a cash call on syndicate members as early as next May, he said.

"The problem has been exacerbated by newer and more efficient claims settlement procedures at Lloyd's," he added.

Two years' worth of claims can now be settled in the excess-of-loss reinsurance market in less than six months which, while benefiting policyholders and ceding companies, exacts a cash flow strain on some syndicates, underwriting agency executives agree.

Meanwhile, "there are signs that the LMX (market) is going to shrink quite considerably," altering the whole structure of the Lloyd's marine insurance market, said one underwriter.

One agency executive pointed out that only about five marine syndicates currently do not write any excess-of-loss reinsurance business.

However, many Lloyd's members are cutting their exposure on excess-of-loss syndicates.

For example, syndicate 540's capacity for 1990 will fall to 25 million pounds ($39.5 million at current exchange rates) from 41 million pounds ($74.2 million at year-end 1988 exchange rates) this year, an agency executive said.

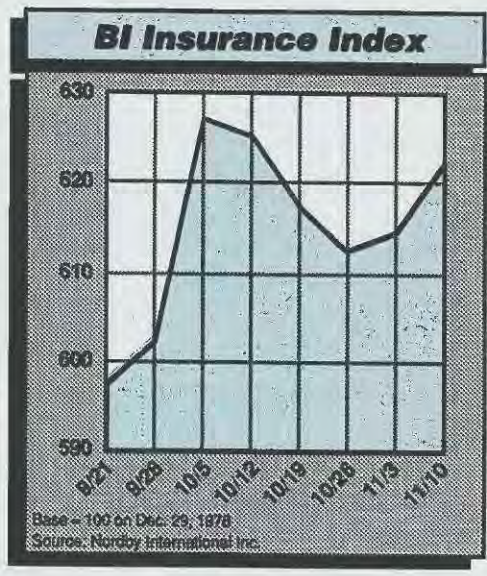
But, other syndicates hit by excess-of-loss reinsurance losses from the Piper Alpha disaster are reporting increased capacity from members looking forward to huge rate increases this renewal season.

Syndicate 744, underwritten by Trevor Johnson and managed by Wendover Underwriting Agency Ltd., will increase its capacity to more than 60 million pounds ($94.8 million at current exchange rates) in 1990 from 52.5 million pounds ($95 million at year-end 1988 exchange rates) this year.

Members' capacity is increasing despite the fact that the syndicate is estimating a 15% to 30% loss on 1988 premium capacity of 42.5 million pounds ($79.9 million at year-end 1987 exchange rates), which represents a loss of 6.4 million pounds to 12.8 million pounds ($11.6 million to $23.2 million).

"We have sought additional capacity because we could see rates were going to increase," said Wendover Managing Director Angus Sladen.

In addition, syndicates will need greater capacity because underwriters will be forced to retain more risk in a tightening excess-of-loss reinsurance market, sources said. ■



Insurance industry stocks climbed last week, as the *Business Insurance Index* rose 7.8 points to 622.4 on Nov. 10 from 614.6 on Nov. 3. Advancing issues were led by HMO America Inc., up 14.8%; Re Capital Corp., up 9.1%; and SAFECO Corp., up 8.2%. Declining issues followed AmBase Corp., down 6.4%; United Medical Corp., down 5.7%; and Frank B. Hall & Co. Inc., down 4.2%. The most active stock during the period was Sears, Roebuck & Co. (Allstate), with 2.5 million shares traded. The *Business Insurance Index* gained 1.43 for the period; the Standard & Poor's 500 was up 0.4%; the New York York Stock Exchange, up 0.4; and the Dow Jones 30 Industrials dropped 0.2%.

British Issues

Nov. 9 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence	pence
Comml Union	469	23.5	29.3	6.3	469	451
Genl Accident	1053	12.8	68.0	6.5	1053	1020
Gdn Royal Exch	222	15.3	15.7	7.1	222	218
Royal	482	23.0	34.0	7.1	483	461
Sun Alliance	302	9.5	17.0	5.6	302	286
Brokers						
Bradstock	219	15.0	10.0	4.6	219	211
CE Heath	503	14.4	34.5	6.9	503	488
Hogg Robinson	160	11.2	9.7	6.0	160	150
Lloyd Thompson	270	18.0	9.3	3.5	270	260
PWS Holdings	50	13.5	2.7	6.7	51	50
Sedgwick Grp	288	20.3	16.7	5.8	289	273
Steel Brrl Jones	251	15.7	15.3	6.1	254	250
Willis Faber	260	18.3	15.3	5.9	262	253

Source: Philip Olsen/Alan Clifton, Insurance Industry Specialists Kitcat & Aitken Stockbrokers, London

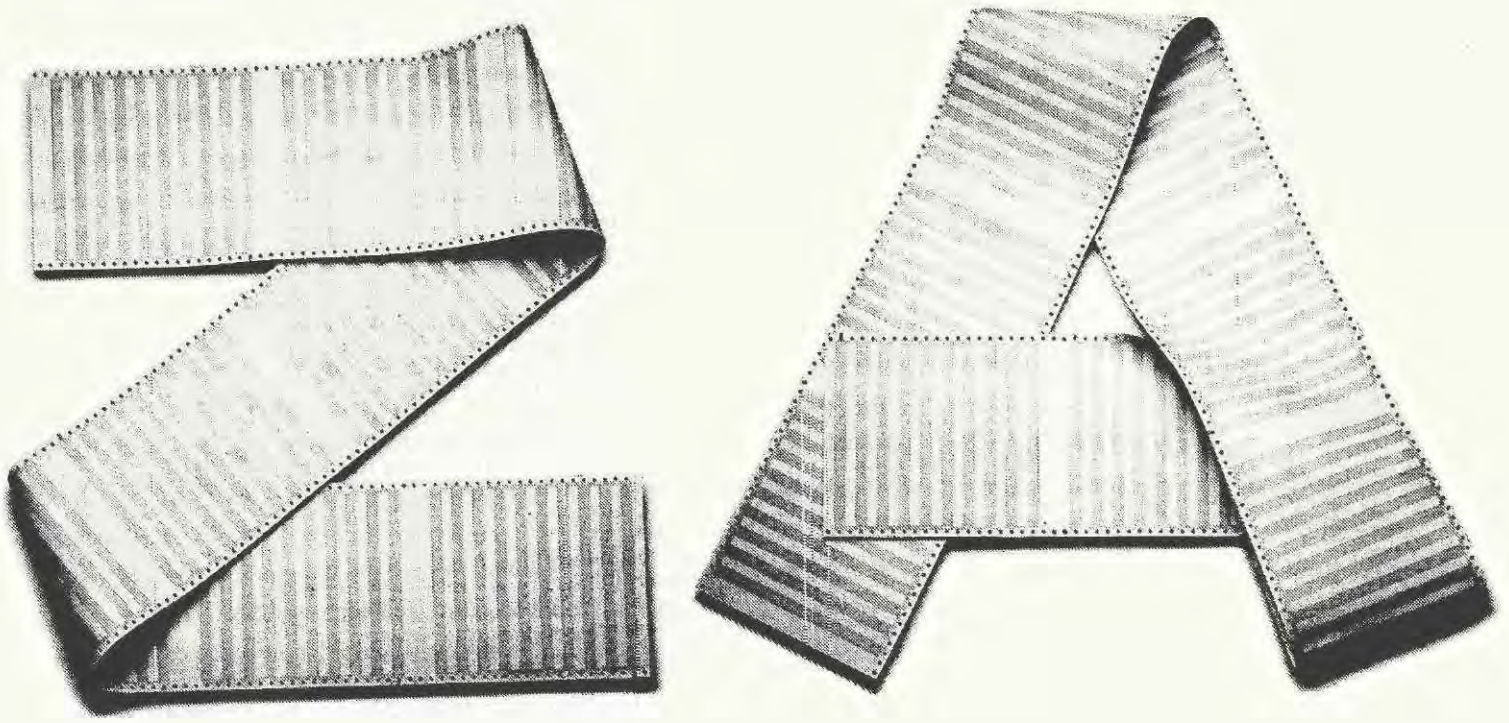
BI Industry Stock Report

NOV. 10, 1989 — **11/3/89 THROUGH 11/10/89**

		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	NYS	33.13	-0.76	42.47	34.00	22.63	656	1.00	3.02	20	2.90	11.42
Corroon & Black	NYS	40.25	3.21	26.77	40.25	29.13	472	1.24	3.08	18	7.62	5.28
Gallagher Arthur J. & Co.	NYS	24.50	3.16	44.12	26.50	15.88	44	0.52	2.12	17	5.33	4.60
Frank B. Hall	NYS	2.88	-4.17	-4.17	4.63	2.50	84	0.00	0.00	-1	N/A	N/A
Hilb, Rogal & Hamilton	OTC	24.25	6.59	74.94	24.75	12.38	42	0.20	0.82	21	4.60	5.27
Marsh & McLennan	NYS	86.00	-2.27	54.95	89.75	55.00	1027	2.48	2.88	21	6.48	13.27
Poe & Associates	OTC	9.50	2.70	8.57	9.50	8.00	3	0.40	4.21	9	1.43	6.64
BROKERS	AVERAGE		1.2	35.4					2.3	15		
CONGLOMERATES & HOLDING COMPANIES												
Berkley W.R. Corp.	OTC	44.88	4.05	51.48	44.88	29.00	659	0.40	0.89	10	21.28	2.11
Berkshire Hathaway Inc.	NYS	8250.00	-1.20	77.42	8900.00	4600.00	1	0.00	0.00	27	2468.63	3.34
ITT (Hartford Group)	NYS	58.25	-0.43	16.21	64.50	47.75	1234	1.60	2.75	9	56.33	1.03
Sears (Allstate)	NYS	37.88	-0.67	-6.19	48.13	37.75	2459	2.00	5.28	12	36.09	1.05
CONGLOMERATES	AVERAGE		0.4	34.7					2.2	15		
INSURERS/REINSURERS												
Aetna Life & Casualty	NYS	59.88	-2.24	27.73	62.50	46.00	1317	2.76	4.61	10	58.11	1.03
Ambase Corp.	NYS	12.88	-6.36	15.73	16.38	10.50	328	0.20	1.55	5	18.66	0.69
American General	NYS	35.13	-1.75	17.08	38.50	29.50	619	1.48	4.21	11	28.04	1.25
American Heritage	NYS	27.50	-2.65	7.84	28.50	25.00	4	1.20	4.36	10	22.47	1.22
American Indemnity/Fin'l	OTC	8.25	-2.94	-21.43	13.00	8.25	2	0.56	6.79	-6	17.38	0.47
American International	NYS	106.88	-0.35	60.41	109.00	61.75	1538	0.48	0.45	13	33.55	3.19
Aon Corp.	NYS	37.38	3.82	35.29	38.00	26.00	326	1.40	3.75	11	16.67	2.24
Argonaut Group	OTC	68.50	3.40	57.47	69.50	42.75	38	1.00	1.46	8	36.83	1.86
AVEMCO Corp	NYS	22.50	4.65	-12.20	27.50	20.38	63	0.40	1.78	13	9.20	2.45
Baldwin & Lyons Inc.	OTC	20.25	1.25	39.66	21.13	14.38	1	0.28	1.38	6	17.57	1.15
Belvedere Corp.	ASE	5.25	7.58	16.67	6.50	4.25	20	0.04	0.76	16	8.43	0.62
Chandler Insurance	OTC	11.38	1.11	51.67	12.25	6.25	39	0.00	0.00	6	9.53	1.19
Chubb Corp.	NYS	92.00	4.25	59.31	92.00	53.75	951	2.32	2.52	10	53.50	1.72
CIGNA Corp.	NYS	64.63	0.58	39.73	65.75	45.75	417	2.96	4.58	13	53.08	1.22
CNA Financial Corp.	NYS	96.00	-1.03	63.40	97.75	56.00	97	0.00	0.00	9	54.52	1.76
Continental Corp.	NYS	33.25	0.76	3.91	38.63	31.50	785	2.60	7.82	21	42.10	0.79
Durham Corp.	OTC	34.00	2.26	6.25	34.75	30.00	4	0.92	2.71	26	26.32	1.29
Fireman's Fund	NYS	35.50	-2.07	21.89	40.75	28.38	872	0.60	1.69	13	32.74	1.08
Fremont General Corp.	OTC	17.50	4.48	40.00	18.25	11.25	235	0.80	4.57	60	17.61	0.99
Frontier Insurance Group	NYS	19.00	4.11	70.63	21.75	9.63	11	0.00	0.00	9	7.53	2.52
General RE Corp.	NYS	95.00	2.56	72.73	95.00	53.13	1302	1.36	1.43	15	29.04	3.27
Hanover Insurance Co.	OTC	31.38	0.40	18.40	33.00	25.50	169	0.44	1.40	7	31.47	1.00
Harleysville Group	OTC	26.38	6.57	48.59	26.38	16.13	36	0.60	2.27	9	18.94	1.39
Hartford Steam Boiler	OTC	52.25	-0.95	41.22	59.25	31.00	147	1.60	3.06	14	13.04	4.01
Kansas City Life Ins.	OTC	35.00	0.00	2.19	39.50	32.25	10	1.04	2.97	18	39.22	0.89
Kemper Corp.	NYS	47.50	-1.04	102.13	51.88	22.75	313	0.84	1.77	10	28.91	1.64
Lawrence Insurance Group	ASE	7.13	-0.07	-10.94	10.25	6.63	1	0.28	3.93	15	3.19	2.23
Liberty Corp.	NYS	35.25	-1.40	-3.09	39.38	32.50	6	0.80	2.27	15	21.17	1.67
Lincoln National	NYS	60.13	-0.62	39.02	61.13	42.75	229	2.60	4.32	11	39.21	1.53
NAC Re Corp.	OTC	40.88	3.48	97.80	40.88	19.50	333	0.20	0.49	18	22.81	1.79
Navigators Group	OTC	27.25	5.83	32.93	27.75	19.25	33	0.00	0.00	11	15.22	1.79
Nobel Insurance LTD.	OTC	2.38	5.56	-48.65	5.50	1.50	4	0.00	-	-1	7.76	0.31
NWNL Companies	OTC	38.00	0.98	23.58	40.63	26.88	918	1.20	3.16	10	37.50	1.01
Ohio Casualty Corp.	OTC	51.25	0.49	43.36	52.50	33.25	134	2.08	4.06	8	33.30	1.54
Old Republic Int'l	OTC	28.75	-1.30	26.45	30.38	22.63	41	0.72	2.50	15	26.60	1.08
Orion Capital Corp.	NYS	23.75	1.58	46.44	28.50	13.88	43	0.84	3.54	7	12.93	1.84
Phoenix RE Corp.	OTC	14.00	4.63	43.59	14.00	8.75	411	0.00	0.00	11	12.99	1.08
Protective Life Corp.	OTC	14.75	0.00	11.32	16.25	12.88	20	0.68	4.61	28	14.54	1.01
Provident Life	OTC	26.25	-0.49	35.48	29.38	17.75	900	0.80	3.05	9	12.60	2.08
Re Capital Corp.	ASE	14.88	9.13	60.81	14.88	8.63	56	0.00	0.00	13	10.71	1.39
RLI Insurance Corp.	NYS	8.25	8.13	8.20	9.38	6.88	44	0.40	4.85	8	11.93	0.69
St. Paul Companies	OTC	61.25	1.66	42.44	61.88	40.50	1366	2.20	3.59	8	32.00	1.91
SAFECO Corp.	OTC	38.00	8.17	62.57	38.00	23.13	2166	1.20	3.16	9	24.88	1.53
SCOR U.S. Corp.	NYS	12.50	0.00	44.93	13.00	6.88	50	0.40	3.20	9	10.35	1.21
Seibels Bruce Group	OTC	10.38	-2.40	-7.78	13.63	10.25	67	0.80	7.71	10	13.42	0.77
Selective Ins. Group	OTC	18.00	-2.70	-21.74	19.50	14.50	87	0.96	5.33	6	22.33	0.81
Statesman Group Inc.	OTC	2.44	-2.48	-15.20	4.00	2.00	20	0.20	8.20	14	3.48	0.70
Tokio Marine & Fire	OTC	76.00	-1.30	-17.17	98.00	66.00	1	0.92	1.21	32	N/A	N/A
Torchmark Corp.	NYS	47.25	-0.53	54.92	50.75	29.38	384	1.40	2.96	13	12.24	3.86
Transamerica	NYS	46.00	-2.91	37.83	48.00	30.38	463	1.92	4.17	11	30.70	1.50
Trenwick Group Inc.	OTC	24.50	2.08	71.93	24.75	13.25	313	0.36	1.47	12	16.91	1.45
United Fire & Casualty	OTC	33.50	0.75	9.84	34.50	28.75	1	1.20	3.58	7	22.56	1.48
USF&G Corp.	NYS	30.00	-1.64	3.45	34.00	28.25	827	2.80	9.33	47	22.57	1.33
UNUM Corp.	NYS	44.13	-1.40	64.95	46.13	25.75	289	0.60	1.36	12	30.64	1.44
USLIFE Corp.	NYS	41.38	-0.90	20.36	48.13	32.88	230	1.48	3.58	9	54.27	0.76
Washington National	NYS	26.25	-3.24	-1.41	29.13	24.00	69	1.08	4.11	-	32.33	0.81
Zenith National Ins.	NYS	18.25	-1.35	3.55	21.50	15.00	14	0.84	4.60	8	13.61	1.34
INSURERS/REINSURERS	AVERAGE		0.9	28.9					3.0	12.7		
HEALTH MAINTENANCE ORGANIZATIONS												
FHP International	OTC	46.50	6.90	295.74	51.13	10.88	458	0.00	0.00	22	3.54	13.14
HMO America Inc.	OTC	7.75	14.81	726.23	10.63	0.81	586	0.00	0.00	-11	1.12	6.92
Pacificare Health Sys.	OTC	24.13	-1.53	93.00	30.38	5.75	772	0.00	0.00	29	6.35	3.80
Safeguard Health Enter.	OTC	9.25	-1.39	72.09	12.50	4.75	82	0.00	0.00	14	2.99	3.09
Sierra Health Services	ASE	7.50	5.19	361.54	8.25	1.38	122	0.00	0.00	-8	1.59	4.72
United Healthcare Corp.	OTC	11.63	5.68	173.53	12.63	3.88	931	0.00	0.00	23	0.31	37.50
United Medical Corp.	ASE	6.25	-5.73	16.28	7.25	4.25	8	0.00	0.00	2	4.11	1.52
U.S. Healthcare	OTC	14.25	-1.72	153.33	15.50	5.25	1051	0.20	1.40	34	2.87	4.97
HMOs	AVERAGE		2.8	236.5					0.2	13		
ALL COMPANIES	AVERAGE		0.9	27.1					2.6	11.7		

System design: Nordby International Inc.

Who Covers Business Insurance From A to Z?



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