

Business Insurance

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LTV takes \$2.26 billion charge for retiree benefit plan liabilities

DALLAS—LTV Corp. last week placed \$2.26 billion in retiree health care and life insurance liabilities on its balance sheet. The action lowered the financially troubled company's net worth to a negative \$5.3 billion.

At the same time, LTV announced it would take a \$2.26 billion charge against its 1988 earnings to reflect the cost of retiree health care and life insurance benefits.

LTV also is adopting a new accounting
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Latest IRS ruling escalates fight over captives

By DOUGLAS McLEOD

WASHINGTON—A recent ruling by the Internal Revenue Service raises the stakes in the battle over whether parent companies can take a tax deduction for premiums paid to their insurance subsidiaries.

Revenue ruling 88-72 denies a parent corporation a deduction for premiums paid to a wholly owned insurance subsidiary regardless of how much unrelated business the insurance unit writes.

While consistent with the IRS' position in previous court cases on this issue, the ruling directly rejects reasoning contained in a footnote to a November 1987 decision by a U.S. Tax Court panel in a case brought by Gulf Oil Corp.

In the Gulf decision, the tax court suggested that if at least 50% of a captive insurer's premiums come from risks unrelated to its parent, parent company premiums might be considered deductible insurance payments (*BI*, Jan. 18).

In addition to its implications for premiums paid to offshore captives, the broadly written IRS revenue ruling also extends to premiums paid by any corporation to a wholly owned insurance subsidiary.

Thus, for example, the ruling could be used to disallow deductions taken by Xerox Corp. for premiums paid to its wholly owned Crum & Forster Inc. units, or deductions taken by ITT Corp. for premiums paid to Hartford Insurance Group affiliates.

Officials of both Xerox and ITT assailed the revenue ruling as "preposterous" and an example of IRS "overkill."

Whether the ruling withstands tax court challenges remains to be seen.

Tax experts are awaiting a tax court decision in a case brought by San Francisco-based Harper Group over deductibility of premiums paid to its Hong Kong captive.

While the case predates Revenue Ruling 88-72, which was issued in September, a Harper brief filed last July points to the footnote in
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Insurers' 9-month tally: Competition taking toll

By JUDY GREENWALD

Competition is taking a bigger bite out of commercial property/casualty insurers' earnings.

In addition, industry observers are worried about the impact of the Tax Reform Act of 1986 and California's Proposition 103 on insurers' bottom lines, though they also point out that both of these factors could hasten a turn in the commercial property/casualty insurance market.

Even without Proposition 103 and the full effect of tax reform, insurers' operating earnings are dropping quickly. Twenty-four major property/casualty insurers surveyed by *Business Insurance* posted a 12.8% plunge in profits during the first nine months of 1988, or more than double the 5.4% decrease reported by insurers for the first half (*BI*, Aug. 29).

The short-term outlook is gloomy.

"The fourth quarter, I think, promises to be a worse quarter; '88 will be worse than '87, '89 will be much worse than '88, and then we'll start to see earnings improvement again in 1990," said Joanne Morrissey, principal with Firemark Consultants Inc. in Morristown, N.J., an insurance research and investment banking firm.

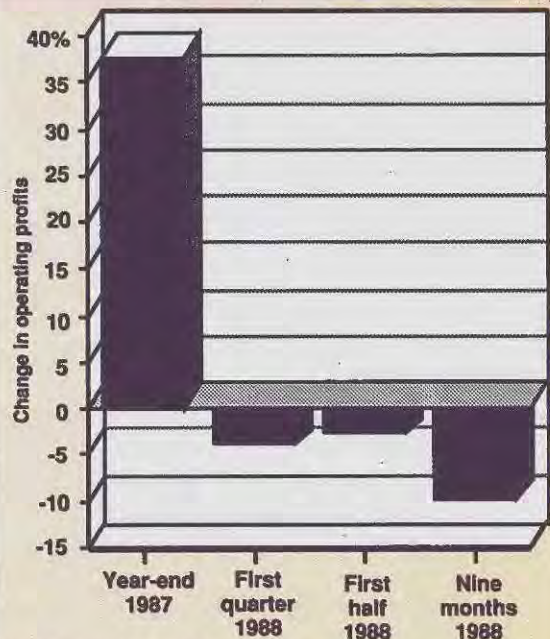
"I think we're in a tough environment," agreed a spokesman for CIGNA Corp.

"There is very little hope that we'll see a leveling off of the rate declines or an increase probably until well in 1989, therefore '89 and '90 don't look like particularly attractive years in the property/casualty business," he said.

The effect of rate competition is clear in commercial property/casualty insurers' results. According to *Business Insurance's* quarterly survey of commercial U.S. property/casualty insurers:

- Net written premium volume increased just 1.8% to \$67 billion in the first nine months of 1988. This is down from the 2.4% increase in volume in the first half

Insurers' profits plummet



Source: BI survey of leading commercial insurers

and sharply lower than the 9.1% increase for the first nine months of 1987.

- Investment income increased 11.3%, to \$8.9 billion, a slight decline from the 11.5% increase in the first half. Investment income increased 12.9% in the first nine months of 1987.

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Pension assets to fund retiree health care

By DEBORAH SHALOWITZ

WASHINGTON—The American Red Cross is terminating its overfunded defined benefit pension plan and using part of the recovered excess funds to lower retirees' premium payment for health insurance.

The Washington, D.C.-based charitable organization also plans to suspend for 10 years pension fund contributions by chapters made on behalf of employees and to set up an endowment fund to further the charity's programs, according to Virginia Mankin, who works in the organization's Alexandria, Va., office as manager of the retirement system and secretary to the board of directors.

Because the Red Cross is a not-for-profit organization, it is exempt from the excise tax on pension reversions taken after Oct. 20, 1988, which was increased to 15% from 10% under the technical corrections legislation signed into law this month by President Reagan (*BI*, Oct. 31).

Red Cross' current pension plan, which has approximately \$740 million in assets, has total accrued liabilities of \$340 million, according to William Rose, director of treasury operations in the Alexandria office.

"It perhaps was not the best use of funds for (the excess money) to sit in the plans," Ms. Mankin said. Thus, the board of directors voted last month for what is called a spinoff termination, she said.

In a spinoff termination, an employer splits its defined benefit pension plan into two new defined benefit plans—one for retirees and one for employees.

The excess assets are placed in the retirees' plan, which the company then terminates. In most cases, the company purchases annuities to pay promised benefits to retirees and can recapture whatever excess assets are left over. The other plan—the one covering cur-

rent employees—is retained.

The Red Cross hopes to complete the spinoff termination within a year.

Of the \$740 million currently in the plan, \$365 million will be spun off into a new defined benefit pension plan for retirees, Mr. Rose said, adding that all these figures will vary depending on interest rates at the time the spinoff is completed.

About \$225 million of the \$365 million will be used to buy annuities for the retirees, he said.

About \$100 million will be recaptured by the organization and used for the endowment fund.

And about \$40 million of the reversion will be used to increase the organization's contributions for premiums for retiree health insurance.

Currently, Red Cross pays an average of 10% to 15% of the cost of premiums for re-

tiree health insurance and the retiree pays the remainder of the premium.

With the \$40 million earmarked for retiree health care, the organization hopes to increase its premium subsidy to an average of 20% to 30% of premiums, Mr. Rose said. Retirees with more than 25 to 30 years of service would receive even greater subsidies, perhaps as high as 40% to 50% of the premium cost, Mr. Rose added.

Red Cross has two retiree health care programs, one for those over age 65 and one for those ages 55 to 65.

Retirees over age 65 are eligible for a retiree health care plan that supplements Medicare.

Red Cross retirees between ages 55 and 65 are eligible for a retiree health care plan that is tied in with the organization's major medical plan.

About one-third of the retirees participate in one of the two retiree health care plans.

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Update

LTV writes off retiree liabilities

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method that will recognize the cost of post-employment benefits as they are accrued rather than as costs are paid.

"Because LTV is in Chapter 11, we believe it is appropriate for the company to record all its liabilities, including the liability for these post-employment benefits, so that they may be appropriately dealt with in the reorganization process," said LTV Chairman and Chief Executive Officer Raymond A. Hay.

The huge hit to LTV's net worth could be indicative of how the equity positions of companies with generous retiree health care programs and large numbers of retirees could be shattered when the Financial Accounting Standards Board issues rules requiring companies to recognize post-employment liabilities on their balance sheets.

LTV, a Dallas-based aerospace and steel manufacturer that in July 1986 filed for protection from its creditors under Chapter 11 of the Federal Bankruptcy Act, provides health care benefits to 70,000 retirees.

Reinsurers' performance static

WASHINGTON—The U.S. reinsurance industry posted a 102.1% combined ratio for the first nine months of this year, a slight deterioration from 102% in the first nine months of last year, according to a survey of 85 reinsurers.

The reinsurers recorded a 73.4% loss ratio and 28.7% expense ratio in the first nine months of this year, the survey by the Reinsurance Assn. of America found.

Net written premium volume for the reinsurers declined 3.2% to \$9 billion from \$9.3 billion in the first nine months of 1987, the survey says.

However, the reinsurers' policyholder surplus increased 10.1% to \$9.7 billion as of Sept. 30 from \$8.8 billion as of Sept. 30, 1987 (BI, Dec. 7, 1987).

Jurors rethink Searle verdict

ST. PAUL, Minn.—Three of the jurors who handed down an \$8.75 million product liability award against G.D. Searle & Co., the maker of the Copper-7 intrauterine device, are asking U.S. District Judge Robert Renner to rescind their verdict (BI, Sept. 19).

The three jurors say their verdict was the result of "continual verbal harassment and intimidation during (jury) negotiations" by the jury foreman. And, they say they are "ashamed and embarrassed to be associated with a verdict that does not represent their true opinions."

The jurors say they believe Searle may have been negligent in advertising its CU-7 IUD, but they were not convinced that the plaintiff in the case was injured by the IUD.

Searle will use the jurors' letter to ask Judge Renner at a hearing Thursday to reverse the jury's verdict and order a new trial.

Searle stopped making the CU-7 in 1986 due to mounting product liability suits. The company now faces about 500 such suits.

Lloyd's plans to cut 200 jobs

LONDON—The Corporation of Lloyd's of London plans to cut its staff by 200—or about 8.5%—early next year to reduce overhead.

A Lloyd's spokesman said he did not know which members of the corporation's 2,350-member staff would be affected. Some of the jobs could be eliminated as part of the planned consolidation of Lloyd's claims offices into one central office (BI, Oct. 17).

The corporation's expenditures have increased at an annual rate of 17% over the last five years, explained Alan Lord, Lloyd's chief executive.

"In the long term this trend is plainly unacceptable," he said. As a result, the corporation's senior management since summer has analyzed ways to reduce those expenditures, he said.

The Lloyd's Council has agreed on a 1989 budget of 105.6 million pounds (\$190.7 million), which is about the same as the current budget, according to Mr. Lord.

"The approved budget means that about 200 posts in the corporation will go, most of them in early 1989, but I have every expectation that we shall be able to manage our way through that problem sensitively and with sympathy and deal with it primarily by maintaining a selective ban on external recruitment, which has been in place for some months, and by some early retirements," Mr. Lord pointed out.

Piper Alpha settlements near

MANCHESTER, England—Lawyers for 136 families of the 167 people who died in the Piper Alpha oil platform disaster in the North Sea in July are expected to agree this week to a 100 million pound (\$180.6 million) compensation offer from the platform's operator, Occidental Petroleum International Oil Inc.

Negotiator David Burnside of the steering committee consisting of lawyers representing the families of 136 of the victims last week agreed to recommend Occidental's offer to the committee lawyers. The committee will meet Thursday in Aberdeen, Scotland, to discuss the offer.

Lawyers for the other families of victims also will be asked this week to accept the settlement, said an Occidental spokesman.

Under the settlement offer, reached after several months of negotiations, Occidental would pay each victim's family an average of 600,000 pounds (\$1.1 million) in compensation, the spokesman said.

Occidental also has agreed to pay the relatives' legal costs in addition to compensation, an announcement by both parties stated.

Occidental also increased the original compensation offer of an undisclosed sum to the victims' parents, the statement said.

In addition, Occidental and the steering committee have worked

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Ruling on claims-made decertified in California

By STACY ADLER

SAN FRANCISCO—A controversial ruling by a California appellate court that essentially transformed a claims-made policy into an occurrence-based policy cannot be used as precedent in the state because it has been decertified by the state's Supreme Court.

However, plaintiffs' attorneys point out that they still can cite the appellate court's decision in their briefs in courts outside of California.

The high court ruling involves an appellate court decision earlier this year that required National Union Fire Insurance Co. of Pittsburgh, Pa., to respond to claims filed by Rolling Hills Estates, Calif.-based Village Escrow Co. against its claims-made errors and omissions policy after the policy expired, unless the insurer's ability to defend against the claim would be impaired (BI, July 25).

The Supreme Court also voted 6-to-1 not to review the lower court ruling.

Village Escrow had a \$1 million per-claim E&O policy with National Union, a unit of New York-based American International Group Inc., from March 1, 1983, to March 1, 1984.

Dissatisfied clients of Village Escrow sued the company on Nov. 8, 1983. However, Village Escrow was not aware of the lawsuit until it was served notice on April 18, 1985.

Village Escrow turned to National Union for defense of the claim, but because the claims-made policy had expired by the time Village Escrow notified National Union of the claim, the insurer denied coverage.

As a result, Village Escrow sued National Union on Sept. 12, 1986.

The trial court agreed with the insurer's argument that there was not enough information to warrant a reply and dismissed the case.

National Union tried to settle its dispute with Village Escrow for \$90,000 after oral arguments were heard before the appellate court to avoid having an adverse precedent on the books. However, the offer was contingent on the appellate court not issuing an opinion in the case.

The appellate court, though, decided the case was too important to the public to refrain from issuing an opinion and ruled on June 22 that National Union had to respond to Village Escrow's claim.

The opinion, written by California Appellate Court Judge Earl J. Johnson, stated: "An insurance company cannot deny coverage under a claims-made policy to an insured who belatedly reports a lawsuit to a company which had been filed during the policy period, but not served. . .until after the policy expired."

On July 21, the appellate court reconsidered and strengthened its decision, adding that "a claim is 'made' when a lawsuit is filed, not when the injured party communicates to the insured his intent to file a lawsuit or the fact that he has suffered injury through the insured's alleged misbehavior" (BI Aug. 1).

The California Supreme Court order last month decertifying the decision means the ruling is not binding precedent in California.

But, while the Supreme Court's decision helps insur-

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Intere acquisition to boost Minet's reinsurance network

By STACY SHAPIRO

LONDON—Intere Intermediaries Inc., the ninth-largest U.S. reinsurance brokerage, will remain an autonomous entity after it is acquired by Minet Holdings P.L.C.

However, the link with Minet, the world's eighth-largest brokerage company, will give Intere more resources while allowing Minet to expand its worldwide reinsurance brokerage network.

Minet announced last week that it will acquire New York-based Intere, a broad-based treaty broker, in cash for an undisclosed sum.

The sale is "a pretty major event" for Intere, which has been privately held for nearly 70 years, observed Ward B. Gordon, Intere's chairman and chief executive officer.

Intere, which is largely owned by its 208 employees through a profit-sharing plan, has been privately held since it was founded in 1919.

"It is the first time we have engaged in serious dialogue (to sell)," said Mr. Gordon.

The merger with Minet "is going to be an interesting new direction for us with an international firm with which we will be associated," said Mr. Gordon. "It will be a challenging time."

Intere will become one of the kingpins in the worldwide reinsurance division that Minet is building, according to Brian Chapple, deputy chairman and finance director for Minet in London.

"Hopefully, we have now put together a worldwide reinsurance (group) for our clients," said Minet's Mr. Chapple.

The purchase of Intere marks Minet's first expansion into the U.S. market since The St. Paul Cos. Inc. acquired Minet earlier this year for \$495 million, though Minet has since bought other British-based companies (BI, June 20; Dec. 14, 1987).

Among its other moves this year, Minet has established a new U.S.-based unit called Minet Specialty Management in New York to act as the management company for Swett & Crawford Group, a St. Paul unit and the largest U.S. wholesale brokerage operation based on 1987 gross premium volume of \$642.8 million (BI, Aug. 8). The new unit also will oversee Minet surplus lines subsidiary Bowes & Co. in Chicago and Minet International Professional Indemnity Ltd. of Canada.

In addition, Peter Christie, who remains chairman and chief executive of Minet International Professional Indemnity, was named president of Minet Specialty Management in New York.

Intere, however, will remain a separate unit of Minet, reporting to Lloyd's broker J.H. Minet & Co. Ltd. in London, Mr. Chapple said.

He added that Intere, which brokers strictly treaty reinsurance, will fit nicely with the other three reinsurance operations overseen by J.H. Minet Chairman Brian Hayes: RFC Intermediaries Inc., a St. Paul Cos.-

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✓ California voters were duped by proponents of Proposition 103 into believing the measure would solve their personal automobile coverage woes, says this week's editorial. **PAGE 8**

✓ Voters do not realize the threat that California's Proposition 103 poses to the property/casualty insurance industry, a broker warns. **PAGE 14**

✓ The National Assn. of Insurance Commissioners will attempt to develop a model form that risk retention groups can use to file information with state insurance regulators. **PAGE 26**

✓ It would have been virtually impossible for the insurance industry to conspire to restrict coverage as alleged in the antitrust lawsuits, an attorney contends. **PAGE 28**

✓ Lloyd's of London underwriter Robin A.G. Jackson will not be among the three working Lloyd's members to sit on the Council of Lloyd's next year. **PAGE 30**

✓ Workers compensation insurers in Texas expect to continue writing the same amount of coverage, although

the rate increase they were granted is only half the amount they sought. **PAGE 36**

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Texas seeks work comp revisions

By MICHAEL BRADFORD

SAN ANTONIO, Texas—The Texas workers compensation system must be revised because businesses are fleeing the state rather than pay for a system that is expensive and inefficient, according to a state senator.

Workers compensation rates in Texas have more than doubled since 1985, causing small businesses "and certainly some of the larger companies to close and move their plants elsewhere while others are shelving plans for expansion," said Sen. Frank M. Tejeda Jr., D-San Antonio.

The exodus of those businesses comes at a particularly bad time for Texas, because the state is currently trying to overcome the sluggishness of an economy battered by rock-bottom oil prices, Sen. Tejeda pointed out during a speech at a meeting of the San Antonio Chapter of the Society of Chartered Property & Casualty Underwriters earlier this month.

Texas employers will pay around \$700 million more in workers comp premiums, or a total of about \$4.35 billion, in 1989 than they paid this year because the Texas State Board of Insurance earlier this month granted an 18.7% rate hike (BI, Nov. 21).

Texas employers this year paid \$3.65 billion for work comp insurance, up 25% from \$2.9 billion in 1987. In 1987, employers were hit with a 17.7% rate hike.

In percentage terms, the largest increase ever approved in Texas was a 30.7% rate hike in October 1985 (see story, page 36).

The state appears to be working at cross-purposes, according to Sen. Tejeda. "We're spending money to attract businesses into the state, yet at the same time we have this workers compensation system that's certainly not one of the most attractive features for businesses to move into the area."

For example, he referred to Fort Worth-based boot maker Justin Industries Inc.: Two of the company's three Texas plants are idle, but the company is building two new facilities in Missouri.

One reason for Justin's expansion in Missouri rather than in Texas "is the workers compensation system in Texas," Sen. Tejeda said. The company pays \$750 per employee for workers comp insurance in Texas but will pay only \$175 per employee in Missouri for the coverage, he pointed out.

And, employees in Texas are eligible for maximum benefits of \$238 per week, while in Missouri the maximum is \$279, he said.

"Businesses are paying among the highest premiums in the nation in Texas, yet employees are receiving among the lowest benefits in the nation," Sen. Tejeda pointed out.

In a panel discussion following Sen. Tejeda's speech, Bill Huff, senior vp and general counsel for Employers Casualty Co. of Dallas, said that a big problem in the Texas system is the "overpayment of the minor claim and the substantial underpayment of the more seriously injured high wage earner."

Mr. Huff said that low wage earners who are entitled to less than the maximum weekly benefit actually recover 77% of their wages because the formula used to calculate the benefit artificially inflates the worker's wages. The amount of reimbursement to the low wage

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State legislators try to thwart insurer challenge to Prop. 103

By GLENN HUNTLEY

LOS ANGELES—Angered California lawmakers are drafting legislation that would discourage insurers from attempting to avoid complying with the insurance "charge" rollback provisions of Proposition 103.

One bill being drafted would fine insurers that refuse to renew policies in the many lines of property/casualty business governed by the controversial new law.

And, one legislator says he plans to introduce a bill that would require any insurer writing property/casualty business in the state to write personal auto insurance, which insurers say is a highly unprofitable line in California.

Legislators sharply criticized insurers and warned them of their intention to introduce the legislation during a Nov. 18 hearing on insurance company compliance with Proposition 103 held by the state Senate Committee on Insurance, Claims and Corporations.

Although the one-day session was billed as a hearing, legislators did most of the talking, blasting the insurance industry for trying to "run over" the public by taking "disgusting" actions to avoid complying with the new law.

Because of those actions, the insurance lobby has lost its clout with the Legislature, lawmakers informed the approximately 20 insurance company executives who testified at the hearing.

The lawmakers limited many of the executives at the hearing to brief testimony, often to a few yes-and-no answers about their underwriting activity in the state since Proposition 103 was approved by voters. However, others were allowed to defend their positions.

While the availability of property/casualty insurance in California has been relatively stable since the proposition

was approved by voters on Nov. 8, several insurers are refusing to write new business until legal challenges to the new law are resolved (BI, Nov. 21).

Proposition 103, triggered by consumer revolt against high personal automobile insurance premiums, requires insurers to roll back for one year almost all property/casualty insurance "charges" to a level that is 20% lower than in November 1987 as well as mandates "good driver" discounts on auto policies after Nov. 8, 1989.

Workers compensation, marine insurance and reinsurance are exempt from the new law.

The proposition also establishes a prior approval rate system for the first time in the state. After Nov. 8, 1989, all rate increases in lines governed by the proposition must be approved by the California Insurance Department before they can be implemented.

The new law also requires that the insurance commissioner be elected instead of appointed and subjects insurers in the state to all state antitrust laws. As a result, the Insurance Services Office Inc. suspended some services in California (BI, Oct. 31).

In addition, Proposition 103 allows state-regulated banks to enter the insurance business.

The state Supreme Court has stayed the immediate effective date of all provisions of the law pending its rulings on lawsuits filed by the insurance industry charging that the mandated rollback is unconstitutional (BI, Nov. 14).

In one of the suits, filed by several insurers and ISO, the plaintiffs estimate that insurers in the state would lose \$4 billion of property/casualty insurance premiums annually if the Supreme Court upholds the mandated insurance charge rollbacks contained in the proposition.

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Graphic: Roger Schillerstrom

U.S. policyholder not entitled to excise tax refunds: Court

By STACY SHAPIRO

LONDON—A U.S. policyholder is not entitled to any of the \$150 million federal excise tax refund that the Internal Revenue Service paid to 174 British insurers as a result of a 1980 tax treaty, a U.S. appellate court has ruled.

The Nov. 2 decision by the 2nd U.S. Circuit Court of Appeals upholds a December 1987 judgment by the U.S. District Court for the Southern District of New York dismissing Columbia Marine Services Inc.'s lawsuit against the insurers and Reffet Ltd., a non-profit corporation formed in 1982 to retrieve the tax refund.

The suit, originally filed in May 1984 and amended five times, sought more than \$10,000 of the \$150 million tax re-

bate the U.S. government agreed to refund to 174 British insurers after a January 1981 IRS ruling established a procedure for distributing the refund.

Columbia's attorneys had considered the suit a class action in which thousands of policyholders could have claimed a refund from the U.K. insurers if the case had gone to court. However, the class was never certified.

The treaty, ratified in March 1980, provided that premiums paid to British insurers or reinsurers after Jan. 1, 1975, were exempt from U.S. federal excise taxes on insurance premiums, which amounted to 4% on direct, non-life insurance premiums and 1% on reinsurance and life insurance premiums.

Lloyd's of London underwriters were exempt from the tax and therefore did

not qualify for a refund.

Reffet was formed by the British insurers to negotiate with the IRS and to process the tax refunds. Under an agreement between Reffet and the U.S. government, Reffet was to contact the brokers that placed the risks in the U.K. market.

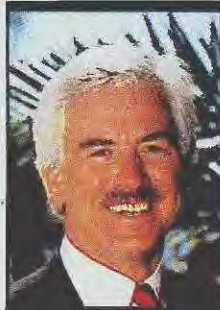
In turn, the brokers were to file proof with the IRS that they deducted the excise taxes from the premiums they passed on to the insurers (BI, June 7, 1982).

To date, the insurers have received \$110 million through Reffet, said Jack Harding, the corporation's general manager in London. The underwriters will receive another \$16 million to \$17 million, and the rest—approximately

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Update insurance regulation: Attorney

By MIKE SCHACHNER



'Regulation provides public confidence in the institution of insurance,' says James P. Corcoran, New York superintendent of insurance. 'Unfortunately, the industry has had a hard time understanding this.'

York. The invited attendees at the meeting were 241 chief executives of member brokerages and chief financial officers of their client firms.

"The primary reason we invited the CFOs was to elevate the discussion beyond speech making," said Mary Lanning, executive director of the IBANY. "We wanted serious dialogue among company officials and public officials who had the authority, at any

point of the discussion, to obligate their company to adopt a change of course."

Mr. Greene proposed a two-tier system of regulation under which restrictions are greater on smaller, personal lines insurers and more relaxed for larger, commercial lines insurers.

"There is room for regulation of a class of insurer that does not cater to citizens who cannot protect themselves, but deals only with a presumed capable insurance-buying

public," said Mr. Greene. These insurers must be regulated in order to meet minimum standards of solvency, he said.

Mr. Greene also said state guaranty funds should not provide coverage to large commercial accounts because these commercial policyholders have the right not to be protected by the state or federal government.

"They also have the right to suffer the consequences of incompetence on their part or failure on the part of their insurer," he added.

Mr. Greene also suggested that the imposition upon insurers of functions that otherwise fall into the government's lap is a heavy burden. He said making insurers responsible for assigned risk auto insurance pools, evaluation of drunk drivers and safety inspections requires ponderous regulation by insurance departments entailing an intrusion into corporate governance by the regulator.

Mr. Green pointed out how successful alternative risk financing facilities, specifically offshore captives, have been in recent

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NEW YORK—Insurance regulation "has not evolved sufficiently to serve the current needs of the insurance community and the United States," contends a leading insurance attorney.

"The 1988 schema of regulation for solvency is in the worst shape in the history of the system," says Donald J. Greene, senior partner with the New York law firm of LeBeouf, Lamb, Leiby & MacRae.

"Regulation provides public confidence in the institution of insurance," counters James P. Corcoran, New York superintendent of insurance. "Unfortunately, the industry has had a hard time understanding this."

Mr. Greene and Mr. Corcoran were among eight panelists who debated state regulation of insurance, the U.S. liability system and the antitrust litigation pending against insurance industry defendants during a forum titled, "We Don't Sit Down Together Often Enough to Hear," sponsored Nov. 17 by the Insurance Brokers' Assn. of the State of New

Revenue ruling

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 the Gulf decision to support its contention that a large volume of unrelated business produces the necessary risk shifting to render parent company premiums deductible.

Although several previous tax court decisions have found that parent companies for various reasons may not deduct such premiums, the Harper case may be the first to produce a direct ruling on whether a large volume of unrelated business renders parent company premiums deductible, tax experts say.

Revenue Ruling 88-72 deals with a parent corporation, identified only as "X," which purchased property, personal injury, pollution and other insurance from its wholly owned domestic insurance unit identified as "S1."

The ruling notes that S1 is a regulated insurer in the states where it does business, and that the policies issued to parent company X repre-

sented only a "small fraction" of S1's total business.

The terms of the policies and premiums charged to the parent company were customary in the industry, and the policies issued by S1 would qualify as insurance for tax purposes were it not for X's ownership of S1, the ruling also says.

For tax purposes, insurance does not exist without a shifting of an economic risk of loss from the policyholder to the insurer, the ruling notes, adding that where an insurance arrangement does not shift risk of loss, courts have consistently found that policyholders' premiums do not qualify as deductible business expenses.

"This result is not altered if the wholly owned insurance company insures unrelated third parties," the ruling states.

Assumption of third-party risks—or "risk distribution"—increases the predictability of average losses and could thus help protect an insurance unit's solvency, the ruling says.

"Acceptance of additional risks, however, does not reallocate the risks that the company previously assumed nor effect a transfer of risks that were not otherwise shifted to the company," the ruling says.

"For these reasons, risk shifting between X (or its subsidiaries) and S1 is not created by the existence of what is called 'risk distribution.' Even though unrelated third parties have successfully shifted their risks to S1 and thus disposed of their economic stakes in whether their losses occur, X continues to have an economic stake in whether its own loss or its subsidiaries' losses occur.

"By operating an insurance business in which it insures unrelated parties, S1 may increase the predictability of the average loss incurred on each risk and may attract additional resources that can be used to pay the loss claims of X or its subsidiaries," the ruling explains.

"The increased predictability of average loss incurred and the availability of these extra resources, how-

ever, does not alter the fact that, unlike the case where there is true insurance, X is made poorer if either X or its subsidiaries experience losses. This is because the loss reduces the net worth of S1, and the net worth of X reflects the reduction in the value of S1. Thus, the risk of those losses has not been shifted to S1," the ruling states.

The revenue ruling explicitly rejects the argument contained in the footnote to the Gulf Oil decision, noting that the IRS "will not follow this dictum in Gulf Oil to the extent that it... suggests that the presence of third-party insureds might under certain circumstances produce the requisite risk shifting."

While S1 is a domestic insurer, the revenue ruling also notes that the IRS' position applies equally to foreign insurance subsidiaries.

The revenue ruling dashes hopes raised by the Gulf decision that parent companies might be able to convince the IRS that they should be permitted to deduct premium pay-

ments to captives in some cases, tax experts observe.

"Many people looked at (the Gulf decision) and said, 'Now at least we have some parameters to use as a jumping off point in beginning a dialogue,'" said Joseph M. Jordan, an insurance tax partner with KPMG Peat Marwick in New York. But "the government just looked at that and said, 'We aren't going to follow it.'"

However, not everyone is disappointed with the IRS position if it discourages captives from assuming large books of unrelated business.

Many parent companies hoping for premium deductions put their captives into the commercial reinsurance business during the soft market of the early 1980s, with poor underwriting results, said D. Hugh Rosenbaum, a principal with the Tillinghast division of Towers, Perrin, Forster & Crosby Inc. in Darien, Conn.

"The Gulf decision for us would have been a minor disaster" to the extent that it encouraged captives to get back into third-party underwriting, he said.

"The risk management community should be heaving a sigh of relief at this point," he said of the ruling. "It's the right medicine at the right time. The captive owners aren't going to like it, but it will be better for them."

Tax officials of large U.S. corporations with commercial insurance subsidiaries are less sanguine about the ruling's effects, however.

"This ruling is just absolutely symptomatic of a bureaucratic approach to a situation that is so clear and obvious on its face that you would almost want to cry about it," said Thomas Maletta, vp with Xerox in Stamford, Conn.

The ruling represents an attempt by the IRS to "bootstrap" its success in disallowing premium deductions by captive parent companies to other corporations with commercial insurance units, he said.

Mr. Maletta expressed amazement that the IRS would not consider Crum & Forster policies issued to Xerox to be "true insurance" for tax purposes. "It is so preposterous," he said. "It just boggles my mind."

"I wish the IRS would show a little more wisdom in directing their attacks against abusive situations," added Daniel F. Lundy, senior vp with ITT in New York, who described the revenue ruling as a "shotgun approach" to the deductibility question that represents IRS "overkill."

Mr. Lundy predicted that the ruling is "destined to go down in smoke" when challenged in tax court.

Tax lawyers, in fact, are awaiting the outcome of the Harper case, which they say could be the first tax court ruling on whether unrelated business can render parent company premiums deductible.

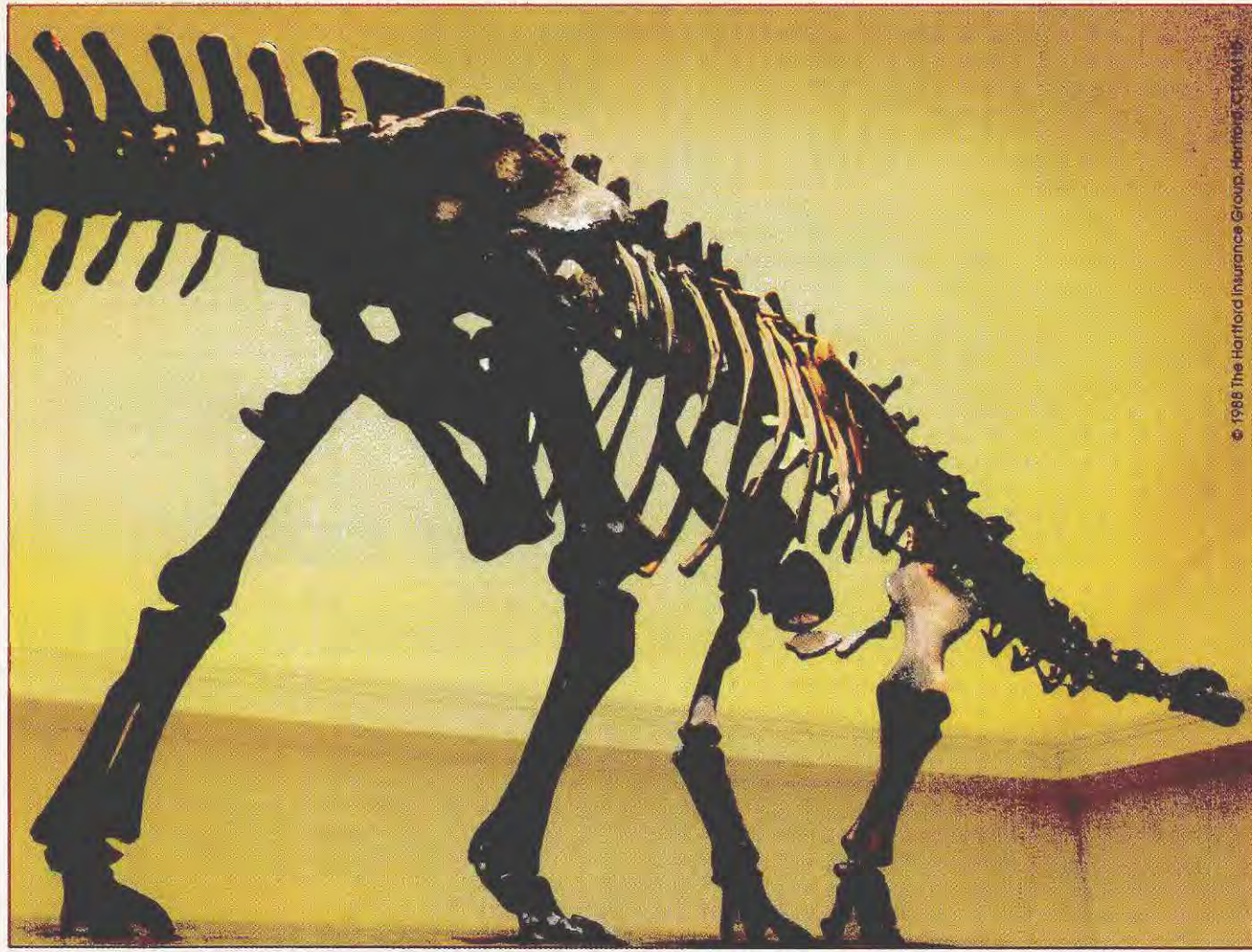
Harper, a freight forwarder whose subsidiaries include Circle Airfreight Corp., formed its Hong Kong captive, Rampart Insurance Co. Ltd., in 1974 to insure its own marine risks, court papers filed in the tax case state.

In addition to its related-company business, Rampart has also insured risks of customers of Harper and its subsidiaries. For the 1981, 1982 and 1983 tax years, unrelated risks represented 29%, 32% and 33% of Rampart's total gross written premium volume, court papers say.

The IRS disallowed Harper premium deductions totaling \$2.7 million for those three tax years, arguing that the Rampart coverage was not true insurance. The IRS also has maintained that the reasoning in the Gulf Oil decision is erroneous and should not be followed.

However, Harper has pointed to the Gulf Oil decision in arguing that unrelated premiums create risk distribution and risk shifting and therefore render the premiums deductible.

Final briefs in the Harper case were filed last month and a decision is not expected for several months, said William L. Riley, a lawyer with Orrick, Herrington & Sutcliffe in San Francisco, representing Harper. ■



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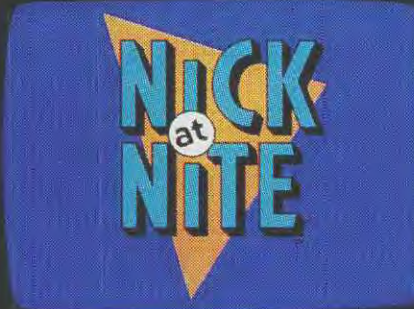


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Health care coalitions increase staff and budgets in '88: Study

Health care coalitions in 1988 generally are better financed and employ more paid professionals than in 1987, according to a recent survey.

The statistical report on health care coalitions, which represent the interests of local businesses on health care issues, was prepared by the American Hospital Assn. on behalf of the Dunlop Group of Six. The Dunlop Group of Six—composed of representatives from the AFL-CIO, the AHA, the American Medical Assn., Blue Cross & Blue Shield Assns., Business Roundtable and the Health Insurance Assn. of America—meets regularly to discuss public and private-sector initiatives affecting the delivery and financing of health care. The health care coalition report re-

Benefit beat

leased this month summarizes the 1988 experience of 121 coalitions that responded to the survey.

Of the 121 coalitions responding, 89 had annual cash budgets during the year that totaled \$12.8 million in 1988. This represented a \$2.2 million increase from the aggregate of budgets reported by 90 coalitions in 1987.

In addition, the median annual budget reported in 1988 was \$60,000, up 33.3% from the \$45,000 median budget reported in 1987. The most frequently reported budget range also increased to between \$50,001

and \$100,000, up from the range of \$10,000 to \$50,000 reported most frequently last year.

This year's survey also reports that 73 coalitions had paid staff, up from 71 of the 90 coalitions reporting cash budgets in 1987.

But the staff growth is more evident in the numbers of professionals employed by those groups. Of the coalitions reporting paid professional staffs in 1988, 51 reported employing 149 full-time professionals, up from the 49 coalitions employing 131 full-time professionals in 1987.

And, 157 part-time professional positions were reported by 32 coalitions in 1988, compared with 71 part-time professional positions reported by 38 coalitions in 1987.

According to the survey authors, "Coalitions have identified the quality of health care, mandated benefits and financing uncompensated care as the most important issues on their agendas."

In the 1987 survey, respondents also listed quality of health care as the issue they were most active in, followed by financing uncompensated care and medical professional liability.

The report notes that education was the main function of health care coalitions in 1988, with 106 coalitions active in education programs for their members. Benefit design was the second-most frequently reported activity, reported by 95 coalitions; survey of members' benefit plans, 73 coalitions; developing model plans, 37; price negotiations, 28; and benefit design negotiations, 25.

In addition, "legislative advocacy" was reported by 79 coalitions, while 72 analyze legislation.

Coalitions responding to the survey are active in 42 states and the District of Columbia.

GM shifts claims handling

General Motors Corp. is consolidating its New York health care claims administration from several contractors to Blue Shield of Western New York beginning Jan. 1, 1989.

The new arrangement will serve about 28,000 employees and retirees throughout the state, according to a statement by the Blue Shield plan and GM.

Employees and retirees covered by the new contract are members of several New York locals of the United Auto Workers union.

Blue Shield, which previously handled only a portion of GM's business in the state, will soon handle about 900,000 claims filed annually by the group, said John T. Mayon, president and chief executive officer of Blue Shield of Western New York, based in Buffalo.

"We're sure our claims processing track record—currently averaging five days—was a major factor in assigning this business to Blue Shield," Mr. Mayon said.

And, the GM contract creates about 100 additional jobs for Blue Shield's Western New York office, he said.

Blue Shield of Western New York has about 1,000 employees and processes about 1 million claims a month.

Benefit beat keeps insurance and employee benefit managers informed on what other companies are doing and of current developments in the employee benefit field. We'd like to know if you've made any changes. Write Glenn Huntley, Associate Editor, Business Insurance, 6404 Wilshire Blvd., Los Angeles, Calif. 90048, 213-651-3710.

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Absence of reason

ORDERING INSURERS to roll back property/casualty insurance charges 20% from November 1987 levels for one year obviously will not solve the personal automobile insurance pricing problem in California.

Neither will prior approval of all future rate increases nor electing the insurance commissioner of California solve the problem.

If insurers are told to write insurance at rates that will produce less premium than they need to pay out in claims and expenses, they will simply quit writing the insurance.

And, whether the insurance commissioner is appointed by the governor or elected by the people will not magically reduce the cost of auto insurance in California.

How could California voters be so stupid, you might ask, to vote for Proposition 103 that provides these remedies for lowering their insurance costs?

They weren't stupid; they were duped by the proponents of Proposition 103 into believing these remedies would work.

The voters of California also were let down by their legislators, who shrugged off their responsibility for making tough decisions on California's automobile liability system.

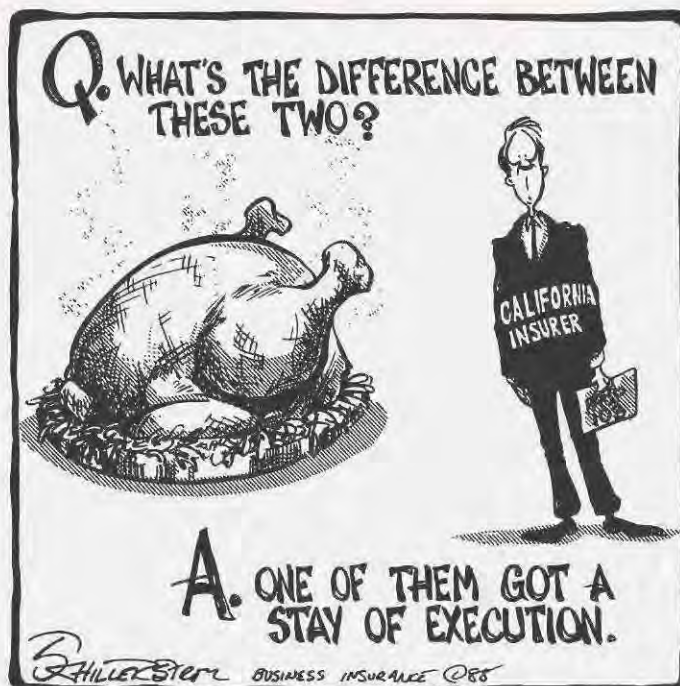
And, the insurance-buying public of California was done a disservice by the insurance industry, which failed for several years—until it was too late—to seriously explain the problem of the rising cost of automobile insurance and to vigorously promote viable solutions. Too many insurers harbored the unrealistic expectation that they could simply underwrite auto insurance on a cost-plus basis and the public would continue to pay without uproar—whatever it cost.

Unfortunately, too many insurers also are taking this approach to underwriting workers compensation insurance.

Now, hope for the insurance market in California rests with the California Supreme Court, which is to rule on whether Proposition 103 is constitutional, and the Legislature, which could yet act responsibly and pass compromise legislation that satisfies consumers and insurers.

Meanwhile, everyone associated with the insurance business had better prepare for battles over insurance regulation in the coming months in states across the country. Like other social and regulatory trends that often begin in California, movements to reform regulation of the property/casualty insurance business will clearly spread to many other state capitals.

Commercial insurance buyers in particular



should get into the debate over insurance regulation and not allow it to be dominated by anti-insurance industry consumer advocates and insurers as it was in California.

Although the reform movement is spurred primarily by consumer revolts against high automobile insurance costs, the result threatens to affect the commercial property/casualty insurance market.

Passage of Proposition 103 in California is clearly a case in point.

Although the mandated one-year 20% reduction in property/casualty insurance "charges" from November 1987 levels is not expected to affect the cost of commercial insurance, since commercial insurance rates have been greatly reduced by the competitive pricing cycle, other aspects of Proposition 103 will affect the commercial market, if the law is upheld by the California Supreme Court.

For example, all rate increases after November 1989 will have to be approved by the California Insurance Department. Commercial insurance buyers generally have not supported such strict rate regulation. One reason is that they realize that if state regulators keep rates artificially low, insurers will simply refuse to write inadequately priced lines of insurance.

Commercial insurance buyers can present themselves to legislators as informed consumers and can bring rationality and credibility to debate over insurance regulation that sadly has been lacking in California.

At issue

When should a part-time worker receive health care coverage?



Alan Ritchie
Vp-compensation and employee benefits
General Mills Inc.
Minneapolis

Employees who work 50% of the regular work week should be eligible for group coverage, but contributions from employees for coverage should be based on the cost-split for full-time workers. If a company pays 50% of the cost for a full-time worker, the company should only pay 25% of the cost for an employee who only works half-time.



Catherine Connolly
Manager of compensation and benefits
Convergent Inc.
San Jose, Calif.

If people work 20 or more hours they should be entitled to benefits. There is a real need for part-time employees when it doesn't make sense to have someone full time. You have a better chance to get a quality part-time employee if you offer them benefits.



Jill Winters
Assistant manager-personnel
City of Allentown
Allentown, Pa.

Our policy is 25 hours a week and payment of a percentage of the premium cost. I think this is fair because a lot of our part-timers are working mothers who often have coverage under their spouses' plans.

Compiled by Christine Woolsey

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Red Cross

Continued from page 1

The charitable organization does not plan to change any retiree health benefits as a result of the spin-off, but it may alter the benefits to coordinate with newly expanded Medicare coverage which covers more acute-care catastrophic illnesses, according to Mr. Rose (BI, June 13; June 6; May 30).

The remaining \$375 million of the \$740 million in assets will be put into a new pension plan for current employees, he said.

About \$100 million of the \$375 million will be spent to buy annuities for the accrued benefits of active workers, Mr. Rose said.

Another \$275 million will remain in the plan and be used for two purposes.

First, Red Cross chapters—which contribute to the plan for their employees—will not have to make contributions to the plan for approximately 10 years. There will be

kind of a "contribution holiday" for chapters, Mr. Rose said.

Second, future retirees' benefits will be increased in the years ahead on an ad hoc basis, explained Ms. Mankin. Currently the pension plan guarantees an annual benefit increase of 1%, but the organization could increase that benefit in future years, perhaps in times of high inflation, using part of the \$275 million fund, she continued.

The Red Cross has 16,835 active participants in the plan, 5,600 retirees and 3,750 terminated employees with vested benefits. There are 525 Red Cross chapters nationwide that participate in the pension plan.

Red Cross pays out about \$35 million annually in pension benefits.

The current pension plan, which was created in 1936, is overfunded because it has realized "excellent investment results" over the years, Mr. Rose said. Also, the "actuarial assumptions were slightly conservative," he added.

Currently, participants are completely vested in the pension plan after five years of service but do not earn partial vesting for fewer years of service, Ms. Mankin said. The vesting schedule is also the same for the retiree health care plan. This vesting schedule will continue under the spin-off plan.

Employees retiring at age 60 receive full benefits. Also, Red Cross employees can retire at age 55 with 10 years of service and receive a reduced benefit.

Under the early retirement program, retirees receive 75% of their accrued benefit at age 55 and another 5% of the benefit per year, so that at age 60 they are receiving the full benefit.

Red Cross will not have to pay the 15% excise tax on asset reversions because not-for-profit organizations specifically are exempted from the tax under the law.

Henry Saveth, a managing consultant in the New York office of A. Foster Higgins & Co. Inc., noted that the exemption from the excise tax for not-for-profit institutions makes asset reversions "more attractive" for these organizations than for corporations.

Although Mr. Saveth said he has not seen a trend in pension terminations by not-for-profit organizations, it could develop in the future as these organizations are subject to the same financial pressures as corporations.

The Red Cross pension reversion is one of the largest reversion transactions of its kind by a charitable organization.

Other pension terminations involving not-for-profit organizations include a 1985 termination by the New York-based National Audubon Society Inc., in which it recaptured \$6.6 million.

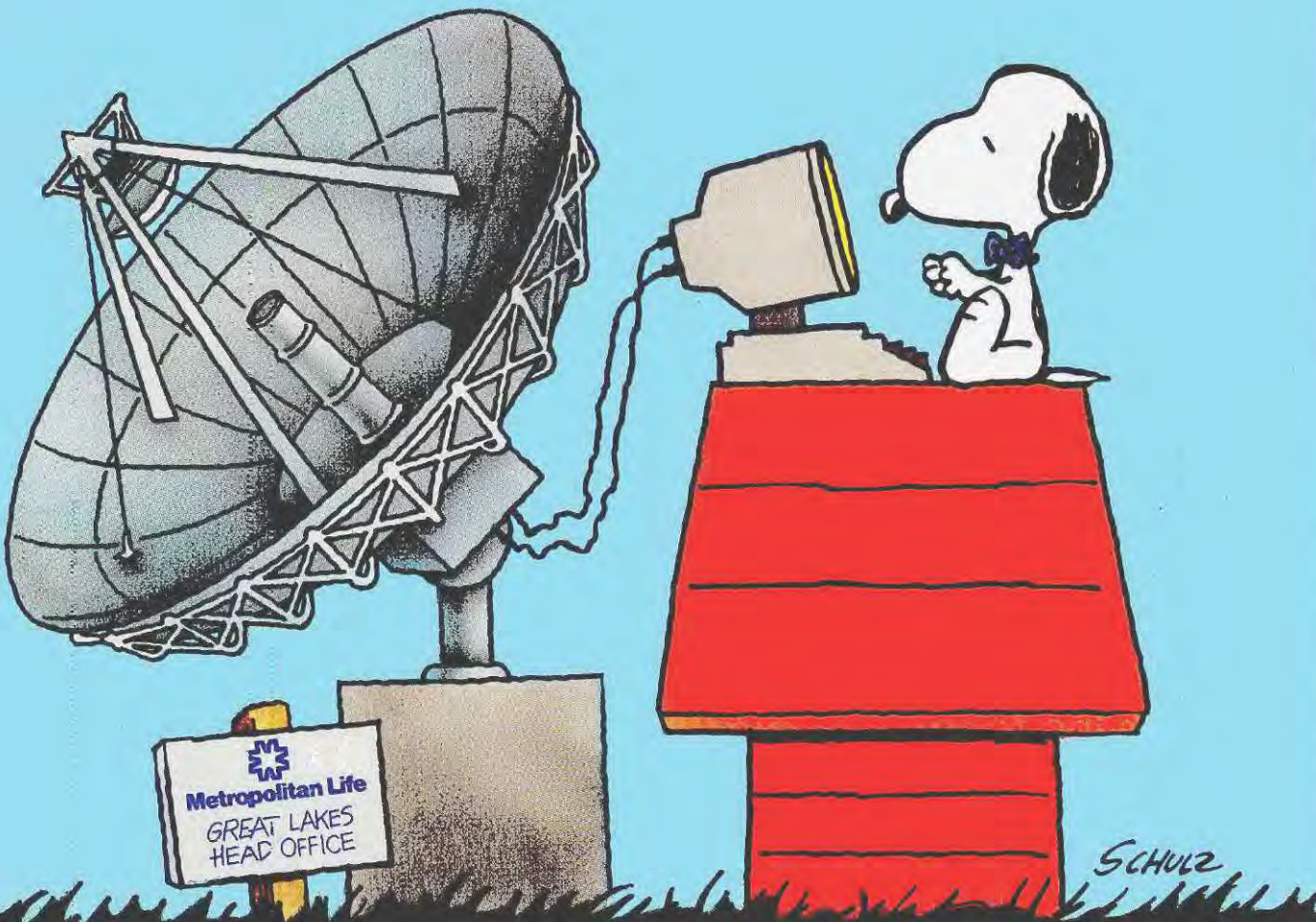
Since 1981, there have been 1,827 pension plan terminations in which institutions recaptured \$19.7 billion in excess assets, according to the Pension Benefits Guaranty Corp.

The largest pension termination to date was Exxon Corp.'s recovery of about \$1.6 billion in assets when it terminated its pension plan in 1986 (BI, June 16, 1986).

Last month, the Internal Revenue Service declared a temporary moratorium until May 1, 1989, on issuing determination letters for terminating defined benefit pension plans with assets in excess of liabilities (BI, Oct. 31).

According to a Treasury Department statement, "while the Treasury Department believes the current policies regarding plan terminations are sound and does not anticipate any changes in this area, the delay in the issuance of letters until May 1, 1989, will provide an opportunity for additional review of the guidelines applicable to determination letters for terminating plans."

HOW MET LIFE KEPT CLAIMS PAYMENTS UP
EVEN WHEN PHONE LINES WENT DOWN.



The date was Sunday, May 8, 1988. A serious fire completely knocked out the Illinois Bell switching station in Hinsdale, outside of Chicago. All telecommunications service for the area went dead. Including the vital links required for Met Life's Group Sales and Claims Office in nearby Aurora, where 70,000 claims are processed per week.

Somehow, Met Life had to find alternate means of fulfilling their obligations to customers. Within hours, computer records on thousands of medical and dental claims were transferred to other Met Life claims centers. Virtually the entire Aurora claims staff began packing their bags to follow the

data to Met Life offices as nearby as Milwaukee. And as far away as Denver.

By 8:30 p.m. on Monday night, segments of the claims staff were seated in front of CRT's in other cities throughout the U.S., paying Aurora's claims. In the meantime, Met Life arranged with the phone company to have a huge microwave dish installed on the roof of the Aurora office. As a result, within one week of the disaster, full service was resumed for all customers.

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Prop. 103 threat unrecognized: Broker

By DONNA DIBLASE

SAN FRANCISCO—Voters do not realize the threat that California's Proposition 103 poses to the property/casualty insurance industry, a broker warns.

Nevertheless, the consumer advocates who proposed and supported the recently passed insurance reform initiative in California don't seem to believe financial security is a problem, observed D. Michael Enfield, a managing director in the San Francisco office of Marsh & McLennan Inc.

He suggested that the public's low opinion of insurers was behind the industry's inability to convince California voters of the threat Proposition 103 poses to the insurance industry.

"Insurer financial security is the major concern of the end of this century" and, if steps are not taken to ensure financial strength, "the pyramid of insurance as we know it will fall," Mr. Enfield warned participants at the 40th Annual Insurance Industry Day sponsored by the Northern California Chapter of the Society of Chartered Property & Casualty Underwriters earlier

this month. However, "Ralph Nader convinced the voters here that this isn't a problem; that it's a myth created by the insurance industry," Mr. Enfield said, referring to Mr. Nader's support of Proposition 103, which was narrowly approved by California voters on Nov. 8 (see story, page 3).

Among other things, Proposition 103 calls for most property/casualty "insurance charges" to be rolled back to 20% below November 1987 rates. However, the measure, which was to have taken effect immediately after the election, has been blocked by a state Supreme Court injunction sought by several insurers. The insurers have asked the court to review the constitutionality of the initiative (BI, Nov. 21; Nov. 14).

Although the initiative would provide insurers with relief from the rollbacks if they can prove to the Insurance Department that the rollbacks would threaten their solvency, the measure does not specify the time period in which regulators must grant or deny relief from Proposition 103.

Insurers argue that the unspecified length of time involved in such an appeal and the fact that they would have to continue charging the lower prices in the meantime would provide them with no immediate relief from lost premiums that would result from "confiscatory" prices.

"Soon, I think everyone will find that Mr. Nader is not qualified to speak on the issue of insurer financial solvency," Mr. Enfield predicted, referring to the financial difficulties insurers may have to face if Proposition 103 is put into force.

To illustrate the seriousness of the problem, as well as the swiftness in which an insurer can reach insolvency, Mr. Enfield referred to the Mission Insurance Co. entry in the 1984 edition of Best's Insurance Reports. Los Angeles-based Mission was ordered liquidated by a California court in 1987 (BI, Feb. 9, 1987).

Mr. Enfield first compared Mission's 1983 policyholders' surplus of \$233.34 million with its 1984 policyholders' surplus of \$43 million. Emphasizing this significant drop in surplus in a one-year span, he also noted that Mission's 1985 Best's rating, which took into account 1984 financial figures,

'Insurer financial security is the major concern for the end of this century' and, if steps are not taken to ensure financial strength, 'the pyramid of insurance as we know it will fall,' warns broker D. Michael Enfield.

dropped to an "O"—meaning it was eligible for a rating but did not meet minimum standards to receive a rating. In 1984, Mission received an "A" Best's rating based on its 1983 financial results, he

said. By 1987, Mission was not even listed in Best's Insurance Reports because of its liquidation, Mr. Enfield said. With this illustration in mind, he

charged that "for a self-appointed consumer advocate to suggest there is no problem with insurer security is, in my opinion, reckless."

And, "it is absolutely appropriate for insurance companies to contest the constitutionality of Proposition 103," he said.

"This proposition reads like a protest. There is no compromise included here. The inconsistencies in the proposition as it is written and the uncertainties about its effect on commercial insurers are alarming," Mr. Enfield said.

However, regardless of whether there are inconsistencies in Propo-

sition 103, the insurance industry could not convince the state's electorate to vote against the ballot proposal because of the industry's own public image problem, he said.

"How did this all happen?" he asked. "I've often said insurance companies are their own worst enemy. They've lost the public relations campaign."

For example, "the fact that insurers allowed day-care centers in this state to go without liability insurance is a disgrace," he said, referring to one factor contributing

Continued on next page

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Continued from previous page to insurers' poor public image.

The battle between Proposition 103 and the industry's own no-fault auto insurance initiative, Proposition 104, "was won and lost not on what we did, but on what the people who supported 103 said," Mr. Enfield observed.

But, there are ways in which the insurance industry could start working to improve its image, he said.

"Maybe what insurance companies need is to have someone outside the industry speaking for them. Maybe they need to have risk managers and intermediaries, who have no vested interest in insurance companies, stand up for them against people like Ralph Nader," he suggested. ■

Cycles may be easier to control: Insurer

By DONNA DiBLASE

SAN FRANCISCO—The property/casualty insurance industry may be better equipped than in the past to reduce the severity of market cycles and achieve stability, according to an insurance company president.

However, before insurers can stabilize the marketplace, "we have to look at the factors that have contributed to the cycles in the insurance market," said Jeffrey W. Greenberg, president of National Union Fire Insurance Co. of Pittsburgh, Pa., a unit of New

Factors that contributed to cycles in the insurance market include the capacity of the industry to underwrite insurance, state guaranty funds and the lack of underwriting professionalism, according to Mr. Greenberg.

York-based American International Group Inc.

These factors include the capacity of the industry to underwrite insurance, state guaranty funds and the lack of underwriting pro-

fessionalism, Mr. Greenberg continued.

Mr. Greenberg made his comments at the 40th Annual Insurance Industry Day Seminars, sponsored by the Northern California

Chapter of the Society of Chartered Property & Casualty Underwriters. The meeting was held Nov. 15 in San Francisco.

"The supply of capacity is one of the bigger variables" that drive insurance cycles, Mr. Greenberg said.

Capacity is influenced by a number of factors, such as "insurance company reactions to anticipated problems."

"And, the underwriting mentality of the industry focuses more on the premiums today than on the losses of tomorrow," Mr. Greenberg explained.

In working toward achieving stability in the market, insurers also need to look closely at the function of state guaranty funds, Mr. Greenberg suggested.

"Why? Because they provide a bailout for companies that act with less responsibility. And, if the broker or insurance buyer feels protected by the guaranty fund, they buy insurance based on price instead of based on the stability of the insurer" offering the coverage, he charged.

"Another aspect that drives our cycles is a historical lack of underwriting professionalism.

"In the United States, this is more so, because many of the bigger risks (have been written) offshore," so U.S. underwriters did not have the experience of writing those risks, Mr. Greenberg pointed out.

Another major factor contributing to the severity of recent market cycles is "the opening up more and more of global reinsurance markets," Mr. Greenberg added, pointing out that "insurance companies are acting irresponsibly" when writing business and setting loss reserves because they feel they are securely backed by reinsurance.

However, the industry currently faces the problem of having to recover huge amounts of reinsurance, Mr. Greenberg explained.

Another problem underlying the industry's cycles, according to Mr. Greenberg, is a "lack of understanding of the mechanics of insurance company accounting and underwriting by consumers."

He said this misunderstanding is reflected in the approval by California voters of Proposition 103, which, among other things, calls for the prices of most lines of property/casualty insurance to be rolled back to 20% less than November 1987 prices (see story, page 3).

Despite all of these factors that hurt market stability, "it's been suggested that we are headed for shorter cycles," Mr. Greenberg said.

"One reason for this is that we now have better information" to monitor insurers' financial conditions, he said.

"The rating agencies like Best's and others are much more sophisticated now in their analyses and ratings. And, there's much more aggressiveness on the part of these professional observers of the industry," he suggested, referring in part to Oldwick, N.J.-based A.M. Best Co.

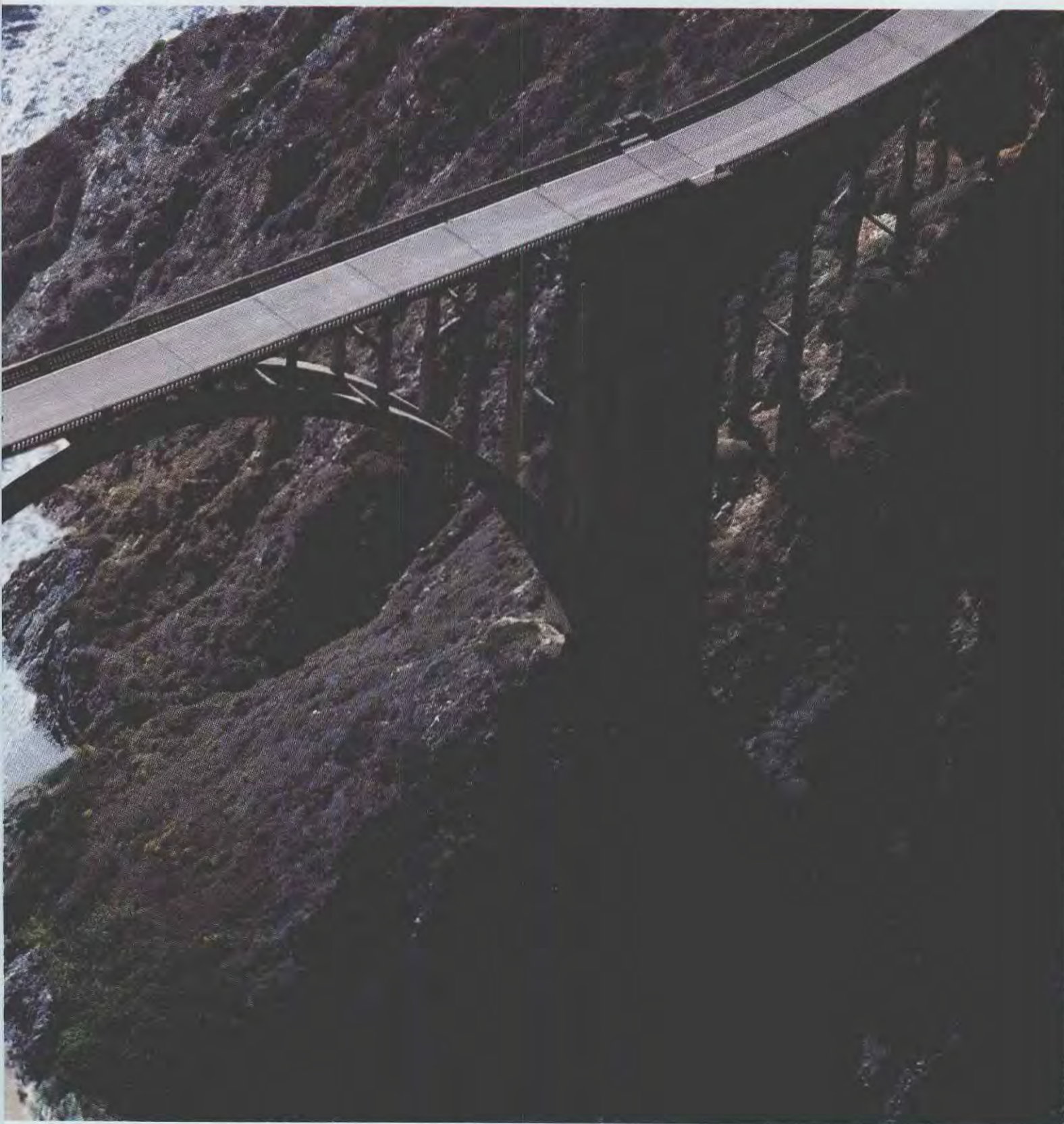
In addition, Mr. Greenberg pointed out that insurers now are increasing their net retentions, which reduces their reliance on reinsurance.

"So, arguably, companies will act more responsibly," Mr. Greenberg said.

Also, the insurance company tax provisions of the Tax Reform Act of 1986 "will drive costs up for insurers and this will dampen the cycles," Mr. Greenberg predicted.

"Where the insurance industry is going depends on how the issues raised here are addressed," he said. ■

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Work comp reform proposition next: Expert

By DONNA DIBLASE

SAN FRANCISCO—Workers compensation reform may be the next insurance-related issue to appear as a proposition on the California ballot unless employers, insurers and legislators work out a solution, workers compensation experts say.

Along with legislative reform of the work comp system, employers also must address workers compensation issues arising from the changing demographics in their workforces, the experts said.

Despite an increase in stress-related claims, employers can reduce workers compensation claims costs and litigation stemming from these claims by adopting a non-adversarial claims handling philosophy, according to one expert.

"We're going to have to face workers compensation reform in the Legislature, or we'll have another slew of initiatives like in the last election," said Rick Dietrich, a partner with the San Francisco law firm of Airola, Williams, Dietrich & Otis, referring to the five insurance reform initiatives on the California ballot on Nov. 8 (BI, Oct. 24).

Raymond Bacon, chief deputy insurance commissioner in the California Department of Insurance, agreed with the warning Mr. Dietrich delivered to the 40th Annual Insurance Industry Day Seminar sponsored by the Northern California Chapter of the Society of Chartered Property & Casualty Underwriters earlier this month.

The California Legislature failed this summer to approve a workers compensation reform bill that would have increased benefit levels to employees injured on the job without increasing employers' costs (BI, Aug. 22; April 11).

Work comp reform is a hot issue in California, where employers paid \$5.3 billion in direct written workers compensation premiums in 1986, an 83% increase from \$2.9 billion in 1982, says a report released earlier this year by the Commission on California Government Organization and Economy.

The inability of state lawmakers and interested parties to reach a compromise on work comp mirrors the battle over state automobile insurance reform. Earlier this year, insurers, trial attorneys and the Legislature could not agree on auto insurance reform and the situation erupted into a ballot initiative war (BI, Nov. 21; Nov. 14; Jan. 18).

Along with addressing reform of work comp laws, employers must prepare for work comp problems associated with a changing workforce, according to Gary Glasser, human resources manager for Industrial Indemnity Co., a San Francisco-based insurer.

"There are three major trends in the workforce today: the aging of the workforce; the growth in the number of females in the workforce; and the growth of a multicultural workforce, particularly in California," he observed.

"The implication of the aging of the workforce is that there is an increase in infirmities related to aging," he said.

And, the greater percentage of women in the workforce will cause employers to focus attention on workplace hazards—such as video display terminals—that could affect pregnant women, he said.

"But the greatest change is the growing multicultural workforce. If we don't educate employees and supervisors about cultural differences, the stress level in the workplace can be very high," he added. And, training in English as a sec-

ond language may be necessary, especially to help certain employees understand safety procedures, he added.

Along with demographic changes, employers must understand the causes and effects of stress in the workplace, said Cheryl K. Lambert, vp and claims manager for California Casualty Insurance Co. of San Mateo.

"According to the California Workers Compensation Institute report on mental stress claims, one-half of all stress claims are filed by women who are clerical workers. And, virtually all mental stress claims are litigated," she explained.

The causes of the increase in stress claims in recent years include a faster pace of work and life

in general; unfulfilled expectations of workers; a greater awareness of the disabling power of stress; and the fact that there no longer is a stigma attached to filing claims for mental stress, she said.

Employers can control the amount they spend on these claims, as well as reduce the amount of litigation, by "adopting a non-adversarial claims handling stand-

point," Ms. Lambert said.

"Less than 2% of total disability claims are fraudulent. So, why do we spend so much time and energy on all of these cases?" she asked.

Employers should "focus on the cases that don't create problems and get these people back to work. That's what workers comp is all about: getting people back to work," she suggested. ■



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Law limits space launch firms' liability

By DEBORAH SHALOWITZ

Washington

WASHINGTON—Commercial space launch companies' liabilities will be limited to \$500 million under a new law signed earlier this month by President Reagan.

However, the law requires commercial space launch vehicle companies to buy \$500 million in liability coverage limits for damages

to private third parties and \$100 million in limits for damage to government property. The government will be liable for the next \$1.5 billion in total damages.

The legislation expires in five years.

Commercial space launch companies had lobbied Congress for the law, arguing that without a promise of federal indemnification, underwriters would not be willing to insure private space launches or would charge unaffordable liability insurance rates (*BI*, June 6).

ity insurance rates (*BI*, June 6).

Drug testing rules

While federally mandated drug testing will cost the transportation industry more than \$2 billion over 10 years, the benefits will save the industry about \$8.7 billion, the Transportation Department estimates.

Benefits include fewer accidents; reduced absenteeism, medical costs and thefts; and lower workers' compensation costs.

The new rules, issued earlier this month by Transportation Secretary Jim Burnley, will affect more than 4 million employees in safety- and security-related jobs in all major modes of transportation.

The rules require affected employers to have an employee assistance program that provides information and training for workers and supervisory personnel on the effects and consequences of drug use on health and safety. Every employer also must appoint a medical review officer to evaluate drug test results and participate in setting up any rehabilitation program offered to an employee.

However, the rule does not require employers to offer a rehabilitation program for workers.

The rules become effective in December 1989 for companies with 50 or more employees and a year later for companies with fewer than 50 employees.

The rules generally call for five kinds of testing: before employment; periodically during employees' regular medical exams; random; with reasonable cause; and after an accident.

The tests are designed to detect the presence of marijuana, cocaine, opiates, amphetamines and PCP.

Under the drug-testing rules, employees who test positive must be removed from safety or security-related functions. These employees can be reinstated after rehabilitation with the approval of a medical officer. They also would be subject to follow-up testing. In some cases, such as for airline pilots, government approval also may be necessary for reinstatement.

Reporting requirements vary depending on the industry. For example, employers in the railroad, aviation and mass transit industries must submit drug testing reports regularly to their regulatory agencies. Employers in the marine and highway industries must submit reports to their regulating agencies only after accidents. And, employers in the pipeline industry must maintain records but do not have to submit them to their regulatory agencies.

Penalties for non-compliance vary significantly depending on the regulatory agency. For example, penalties imposed by the Federal Aviation Administration can be as much as \$10,000 per violation, while penalties imposed by the Federal Highway Administration range from \$500 to \$2,500 for recordkeeping violations and up to \$10,000 for non-recordkeeping violations.

The definition of a violation will be up to the discretion of the regulatory agency and depends on individual circumstances, according to a Transportation Department official.

The rule applies to approximately 538,000 aviation industry employees; 3 million interstate truck and bus drivers; 195,500 mass transit workers; 90,000 railroad workers; 120,000 mariners on commercial vessels; and 116,500 pipeline industry workers.

The Transportation Department estimates that testing will cost about \$25 per employee for the initial screening, about \$35 per employee for a confirmatory test and about \$35 per employee for administration. Other costs to employers, which the Transportation Department did not calculate, will include the cost of the EAP, planning, lost work time and reporting.

Transportation union officials denounced the new rules.

Continued on next page

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Corroon & Black names benefits vp

Rita Hebel, 37, has been named vp-compensation and benefits at Corroon & Black Corp. in New York. In this newly created position, she oversees all pension, health and welfare benefits as well as executive compensation. She reports to C. Jackson Blair, senior vp-administration and human resources. Prior to joining Corroon & Black, Ms. Hebel was director of corporate compensation at Joseph E. Seagram & Sons Inc. in New York. She also has held positions in compensation and benefits at Metropolitan Life Insurance Co.,

IU International Corp. and Schering-Plough Corp. Ms. Hebel holds a bachelor's degree from Iona College in New Rochelle, N.Y., and a master of business administration degree from Fairleigh Dickinson University in Rutherford, N.J. In addition, Ms. Hebel is a member of the American Compensation Assn. and the American Management Assn.

Comings & goings: buyers

Janice Chamberlain, 41, has been promoted to vp at Washington Mutual Savings Bank in Seattle. In this promotion she continues to oversee the risk management department, including insured and self-insured programs and loss control. She reports to Emil J. Riccardi, senior vp and general auditor. Ms. Chamberlain joined the bank in 1986 as assistant vp/risk manager. She holds the Chartered Property & Casualty Underwriter designation and is first vp of the Washington chapter of the Risk & Insurance Management Society.



Ms. Chamberlain

Suzanne C. Mercure has been named manager-benefits planning for Honeywell Bull Inc. in Wellesley Hills, Mass. In this newly created position she is responsible for retirement, health and welfare benefit programs for 1990 and beyond. She reports to Ronald Sullivan, director of compensation and benefits. Prior to joining Honeywell Bull, a computer manufacturer, Ms. Mercure served with Touche Ross in Boston. Prior to that she was benefits manager for Wang Laboratories Inc. in Lowell, Mass. She received a bachelor of arts degree in psychology from Central Connecticut State University in New Britain. Ms. Mercure serves on the elder care advisory committee for the Washington Business Group on Health and is on the board of directors of the Greater Boston Visiting Nurses Assn.

Eileen M. Gabriel, 37, appointed vp-benefits and compensation at USLIFE Corp.'s new corporate facility in Neptune, N.J. In this promotion she continues to oversee employee benefit and compensation programs for the life insurance holding company. She reports to Christopher S. Ruisi, executive vp-administration. Ms. Gabriel, who joined USLIFE in 1979 as benefits administrator, most recently served as second vp-benefits and compensation. She currently is working toward her bachelor of science degree in business administration.

We'd like to report on staff changes in your company's risk management, safety and employee benefits departments. Just drop a note to Paul Winston, Copy Editor, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611-2590, or call 312-649-5442. Please send a photograph, too.

Washington

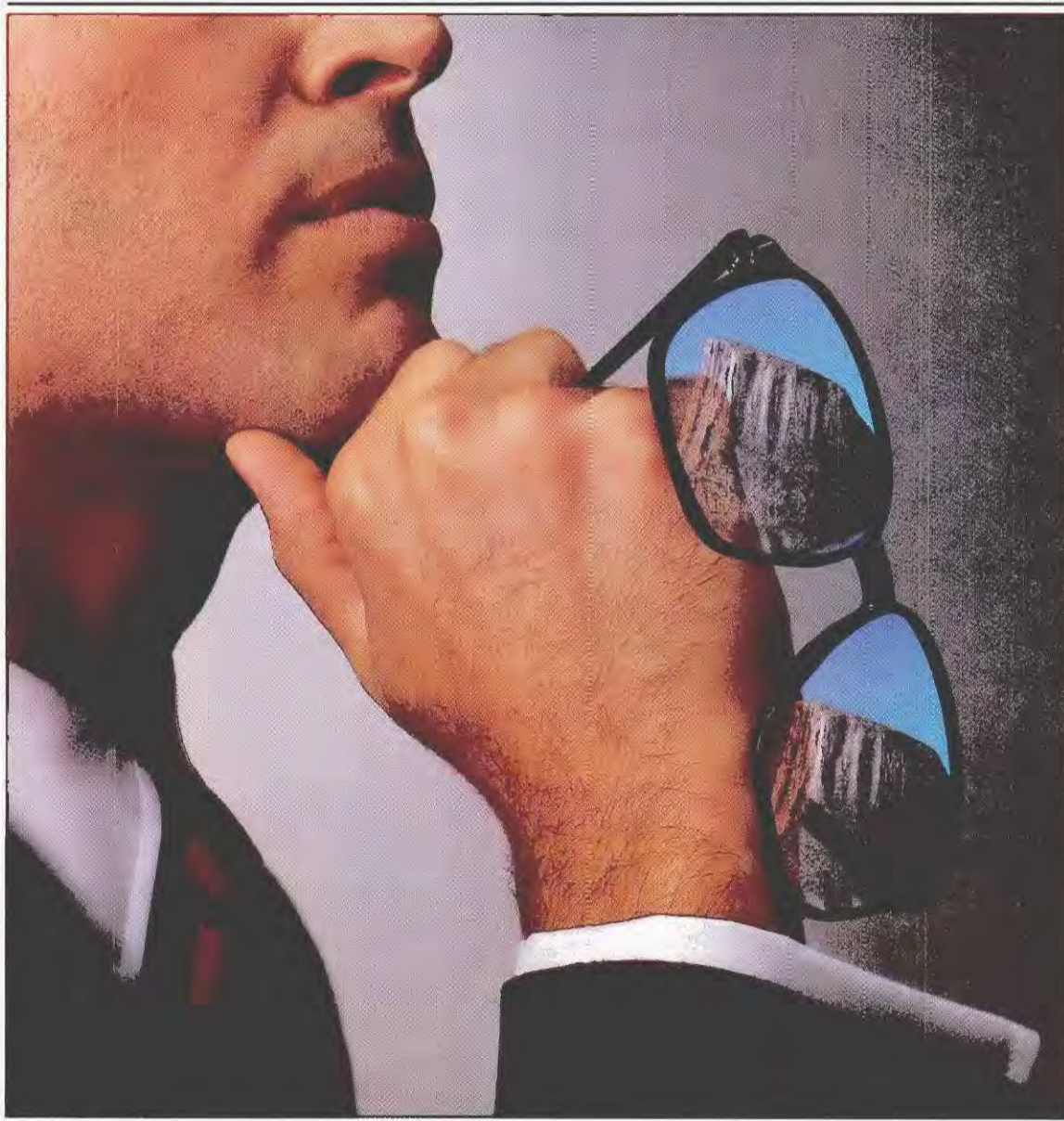
Continued from previous page Job injuries up 5%

Occupational injuries and illnesses jumped 5% in 1987 to 8.3 per 100 workers, the highest level since 1981, according to the federal government.

In 1986, the occupational injury and illness rate was 7.9 per 100 workers, the same as in 1985, according to the Labor Department's Bureau of Labor Statistics (BLS, Dec. 7, 1987).

However, one of the reasons for the increase may have been more complete recordkeeping by employers in 1987 following an educational outreach program by the BLS in the last two years, said Commissioner of Labor Statistics Janet L. Norwood.

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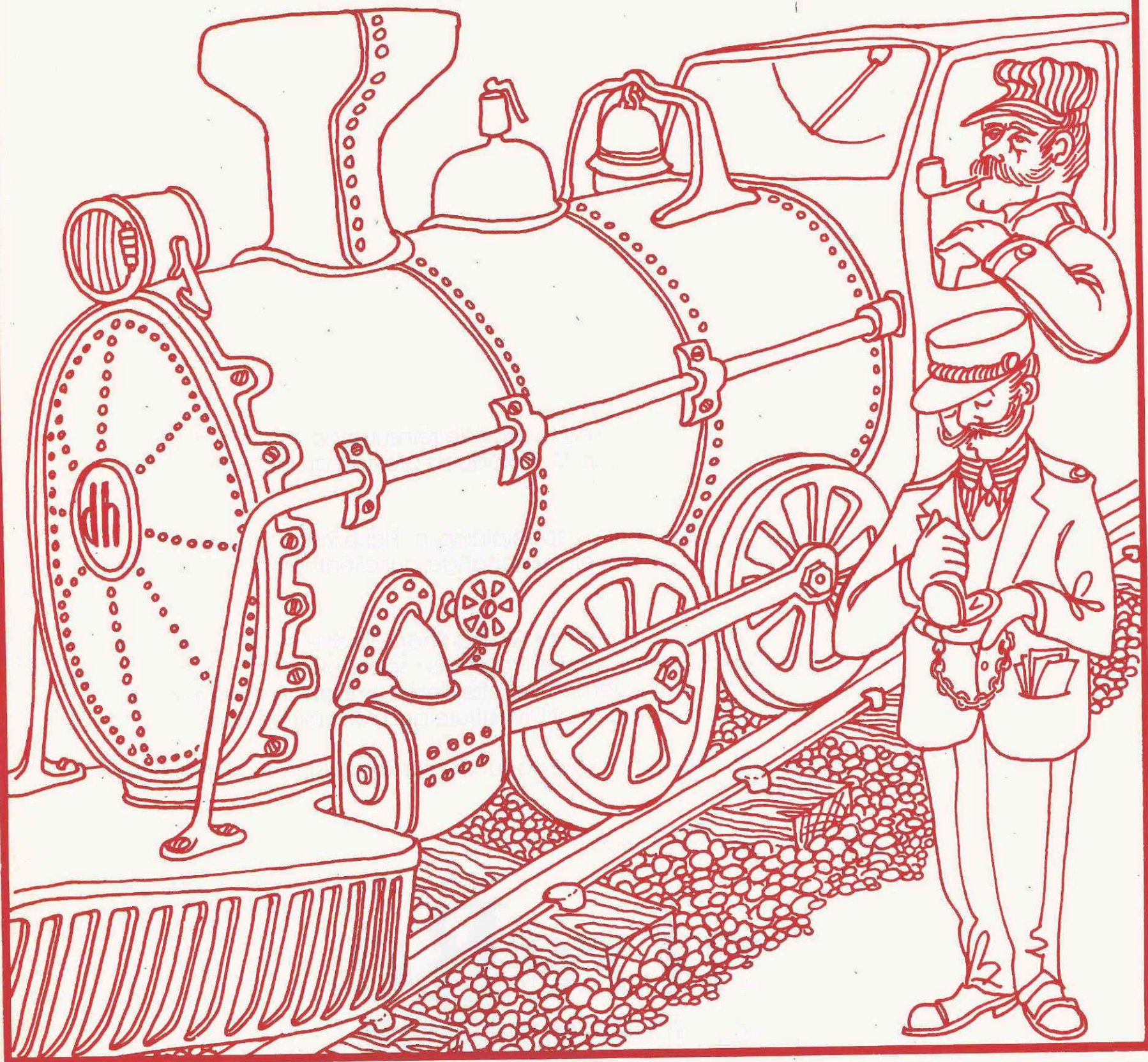
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ASK A BENEFIT MANAGER

Managed care better at containing costs

Q

What are the reasons companies are now considering managed health care plans as a way to stabilize and better control their health care costs?

A

Payers of health care bills will be facing their second consecutive year of significant health care cost increases. They also face the effects of the Financial Accounting Standards Board's requirements for retiree medical benefits. A FASB

disclosure draft is due next month with an effective date for a charge to earnings in 1993 and inclusion of the retiree liability on the balance sheet in 1997.

Some estimates indicate that the annual income for some of the largest manufacturing companies could decrease by 20% or more—depending on final FASB requirements—when they begin to recognize these liabilities for accounting purposes. Payers will be seeking more cost-effective health care programs and delivery systems because of these cost pressures.

Many payers have concluded that the cost-containment efforts taken since the early 1980s worked for a short period of time but did not work in 1987 or 1988, and it does not look like they will work in the future.

Payers also recognize that there is a tremendous amount of cost shifting to indemnity plans by the medical community to make up for lower income from other parts of its practice.

There is a growing awareness by payers that indemnity plans will not be effective in stabilizing

health care costs for the future and the search is on to find a system that will be more cost effective. That search has led to managed care for many payers since managed health care cost trends are better than indemnity plan trends.

On average, we are seeing cost increases in managed care programs running at about half of the increase we see in the fee-for-service indemnity plans. The fact is that managed health care cost increases are, at present, running higher than you would want over the long term. But, when comparing them to the fee-for-service indemnity programs, they deserve an opportunity to prove whether they can provide quality health care at more affordable costs to the payers.

Managed care, by its definition, has the providers more intimately involved in determining the need for appropriate and cost-effective health care. The reason indemnity cost-containment efforts have not worked for a longer period and will probably not work in the future is because providers were not included in the cost-containment efforts; we shifted the additional cost to employees and continued to throw money at the problem.

It is important that an acceptable balancing of interest be found between payers, providers and users of health care if we are going to stabilize health care costs. This is where managed health care becomes prominent: It may be our last hope to better control and stabilize health care costs without significant government intervention.

The reason managed health care programs represent a possible solution to our current out-of-control health care cost escalation is that they change the present patient/provider relationship and move the patient to providers that are committed to be more cost effective. The fee-for-service indemnity plans provide the wrong incentive for providers since they encourage more treatment and services and, in some situations, these services are unnecessary.

A real challenge is to develop a program that will encourage employees to use the managed care

networks of providers and that contains disincentives if they want to use non-network providers. The most important part of this change in the health care delivery system is that the payer obtains the financial benefit of its participation in managed care, which is reflected in its own financial experience. An employer can negotiate with an insurer or health care company a risk contract, an experience-rated contract or an administrative services only arrangement that could be on a national or regional basis.

It seems to me that managed care, as we know it today, offers some real potential to control health care costs, but it will take hard work by many parties for the program to work effectively.

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.

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

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.

System safety techniques control losses

By The Insurance Institute of America

A.R.M. exercises

The following question and answer are drawn from the curriculum for the Associate in Risk Management designation awarded by the Insurance Institute of America. They represent the type of question asked—and the possible answers—in one of the three examinations for the A.R.M. designation.

This month's exercise, drawn from a recent national examination in ARM 55—risk control—deals with how the family of procedures known collectively as system safety techniques should be used to identify and to control possibilities of loss.

Q: Several forms of system safety analysis may be particularly helpful in analyzing exposures to accidental loss and in suggesting ways in which these losses may be prevented or their severity minimized. For each of the following types of system safety analysis, describe the reasoning underlying that type of analysis and give one example of how that type of analysis might be used in preventing or reducing the severity of property or net income losses from the explosion

of a major steam boiler that provides heat to an organization's multi-story building.

- Scenario analysis.
- Cost-benefit analysis.
- Performance evaluation review technique.
- Fault tree analysis.
- Technique of human error rate production.

A: • Scenario analysis involves "brainstorming" many conceivable severe, even worst-case, accidents and tracing their possible causes and consequences as a basis for identifying feasible measures.

As applied to the potential explosion of a steam boiler, scenario analysis would begin by gathering together groups of both engineering and managerial personnel to discuss how the boiler might explode, what specific circumstances would make the organization's resulting losses most severe and how to prevent the boiler from exploding and control the severity of the consequent losses.

- Cost-benefit analysis assigns actual or estimated dollar values to

the costs and benefits expected from various proposed changes in a system and then selects the change or changes that promise the greatest excess of benefits over costs, either as a ratio of benefits to costs or as the absolute excess of benefits over costs.

For an existing steam boiler, the alternatives to be analyzed probably would focus on changes in or replacement of the present system. After all tangible costs and benefits to those who might be affected by a change in the boiler have been evaluated in projected actual or estimated dollars, the one with the best cost-benefit relationship should be chosen.

- The performance evaluation review technique focuses on a sequence of events needed for completing a particular project, emphasizing especially the lead times and concurrent events and preconditions that must exist before a given project can be completed. As a system safety technique, PERT identifies and suggests the steps to prevent "bottlenecks" that may delay or frustrate the completion of a

specific project.

With respect to boiler safety, a PERT network or chart could be developed, before any loss occurs, for planning and practicing the most prompt possible replacement of a damaged boiler or, alternatively, for scheduling the renovation of an undamaged boiler with minimum downtime.

- Fault tree analysis views an accident as the culmination of a series of lesser faults within a system. A fault tree traces back through the system to identify every failure or series of failures within that system that could produce a specified accident. FTA then strives to prevent the accident by precluding one or more system faults necessary to produce the accident.

For a potential boiler explosion, FTA would first determine all the

Continued on next page

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

Reducing vulnerability of RMIS

IT IS NICE TO TALK about "ideal systems." Realistically, though, the risk management professional does not operate in a vacuum. There are intricacies and complications that are certain to have an impact on the best designed risk management information system.

However, this month I will conclude my series on the major RMIS problems that confront risk managers in mergers, acquisitions or divestitures (MAD) by discussing how best to structure an RMIS to minimize the adverse effects of these actions.

The importance and urgency of planning may sometimes be overlooked. Nevertheless, planning is the key process in designing a MAD-resistant system.

The risk manager's first step is to identify his exposure to MAD, which requires a knowledge of the corporate environment. What is its track record on mergers and acquisitions? If the firm is publicly traded, what susceptibility do they have for a possible takeover? Are there any advanced warning signs of any imminent change? Have there been any recent senior management changes? New product or service introduction? Movements into different product/service markets? Geographic expansion?

Once these questions are examined, the risk manager should expand his network of contacts, both internal and external, to develop an "early warning system." The faster he knows of an impending change, the better he will be able to respond.

The next step in planning is to develop "ideal" system specifications. I assume that the risk manager is fully aware of his current system and its shortcomings. It should not be too difficult for him to outline desired system attributes.

However, he must further this process by identifying useful system and vendor attributes that better insulate him against the changes brought about by MAD.

What are these characteristics?

The first is system comprehensiveness. To essentially "cover the bases" the RMIS should have a diversity of functions—from data base management to decision support analysis, from standard to ad hoc reporting with graphics and so on.

Furthermore, it must be accurate and reliable, operable in a variety of hardware environments and easy to use by personnel who are not computer literate. It should also be unaffected by data base size or number of personnel with access to the system.

Finally, the RMIS must be flexible enough to contemplate performing a wide variety of applications software

that operate related insurance and risk management activities.

System comprehensiveness can be further defined as:

- Flexible. Selecting a system (and vendor) with a high degree of system flexibility is one of the best defenses against MAD.

- Expandable. While a reduction in total amount of data to be stored and analyzed does not present much of a problem, wholesale data increases may. So, too, can a dramatic increase in the number of people with access to the RMIS. In short, can the RMIS sustain a dramatic increase in the number of users of its information (input/output access), not to mention a sheer increase in the volume of data?

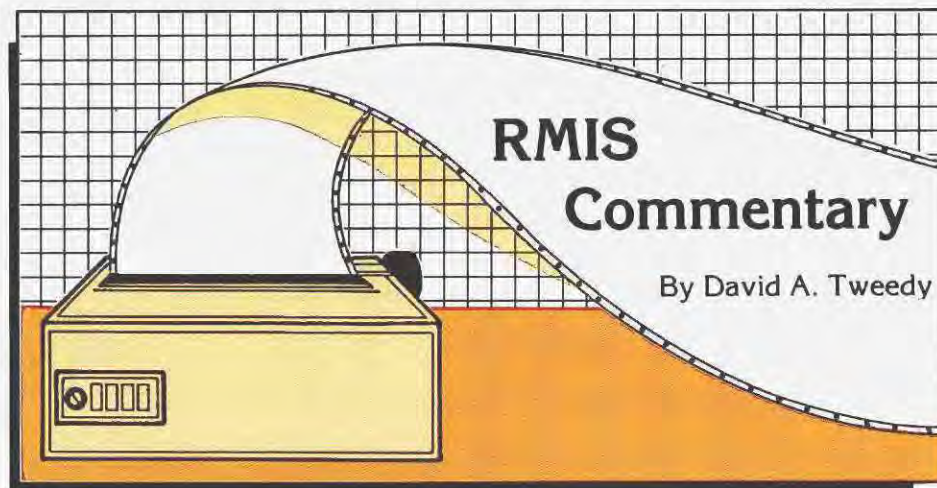
While the increasing power and speed of microcomputers do much to diminish the chance that the present

and maintained internally by corporate management information system departments.)

Suppose that a firm has been monitoring only its claims program through the RMIS. Then, upon acquisition, the firm increases its claims volume and decides that internal claims administration—rather than by insurer or TPA—is the preferred route. Not all RMIS can perform claims administration.

Similarly, an internally built RMIS that has been exclusively devoted to data base management and reporting of claims costs to different divisions now must perform more sophisticated loss development/loss forecasting and financial modeling. Again, not all RMIS can do this.

The flexible RMIS must not only provide the "basics" of claims analysis



hardware environment will become too small, an increase in the number of active users of the system does have a hardware impact. In short, the RMIS must be able to meet unexpected and dramatic changes in the number of users/recipients and data base size.

- Analytical. The RMIS must have an ability to perform risk finance analysis, such as cost of risk allocation, alternative funding analysis, etc. Also desirable, though not critical, is if the system can perform basic loss development and some loss forecasting, assuming a statistically credible data base.

- User friendly. This often-used term, describing the ability of non-computer people to efficiently use the system, becomes even more important in a MAD situation. New functions, new data bases, new reports and new people using the system all require a system that is easy to learn and use.

Beyond the RMIS' comprehensiveness, the ideal system has a supporting vendor with demonstrated stability and expertise. (For the most part, we anticipate that most RMIS will be provided by external vendors but there is a steadily increasing portion of systems designed

and quantitative analysis. It should also be capable of producing a variety of standard and ad hoc reports to several levels of organizational structure—senior management receiving summarized analysis while lower levels receive more detailed output.

Items of interest such as insurance management policy registers, property and auto schedules, certificates of insurance, tracking, litigation management analysis, etc., are only some of the highly sought RMIS capabilities today. The MAD-resistant RMIS should be easily able to provide these capabilities with a minimum of customization.

Obviously, the key question is whether the internal management information system department or external vendor can handle the degree of change that a MAD would bring. Does the vendor/internal MIS have sufficient personnel to commit to a significant expansion? What material change, to an existing service contract, would occur? What kind of stress will the MAD place on the conversion capabilities of the vendor or internal MIS department? If the acquisition or merged company has a system that is not compatible with the existing

RMIS, what kind of time and cost is involved in the data conversion process? Can the vendor provide the training necessary for the system upgrade?

The third step in the planning process is a system evaluation. Once the ideal system has been charted, it is time to examine the current RMIS and determine where its weak points are. Then the risk manager must develop contingency plans based on the scenarios described in the previous two columns (*BI*, Oct. 17; Sept. 19). By running several mock simulations, the risk manager can approximate the ultimate impact of the system changes in terms of additional software, hardware, training and support and other incidentals. Costs are then more easily quantified.

If your system or vendor falls short in this step, it is a good time to identify other vendors with systems able to provide a wider range of capabilities.

The final planning stage involves the development of a detailed schedule of events in the event of a MAD. Backup/alternative vendors should be identified, specifications for proposed changes should be documented, and cost and time implementation schedules should be quantified. Where possible, system changes should be made if they do not involve a major budget variance.

If you learn that your company will soon be involved in a merger, acquisition or divestiture, you can use it as an opportunity to impress upon senior management as to how valuable your input would be in the future. Consider demonstrating that a well-designed RMIS could provide solid, quantitative analysis on the firm's cost of risk and could gauge the impact of the MAD.

Mergers, acquisitions and divestitures will likely continue to play a major role in corporate America. Much of the frustration and anxiety surrounding their impact on your RMIS can be avoided through careful planning and constant evaluation of your company's needs both now and in the future.

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



System safety techniques

Continued from previous page

logical possible combinations of events that could lead to a boiler explosion. This analysis would then seek one or more cost-effective measures for preventing each of these events from being fulfilled.

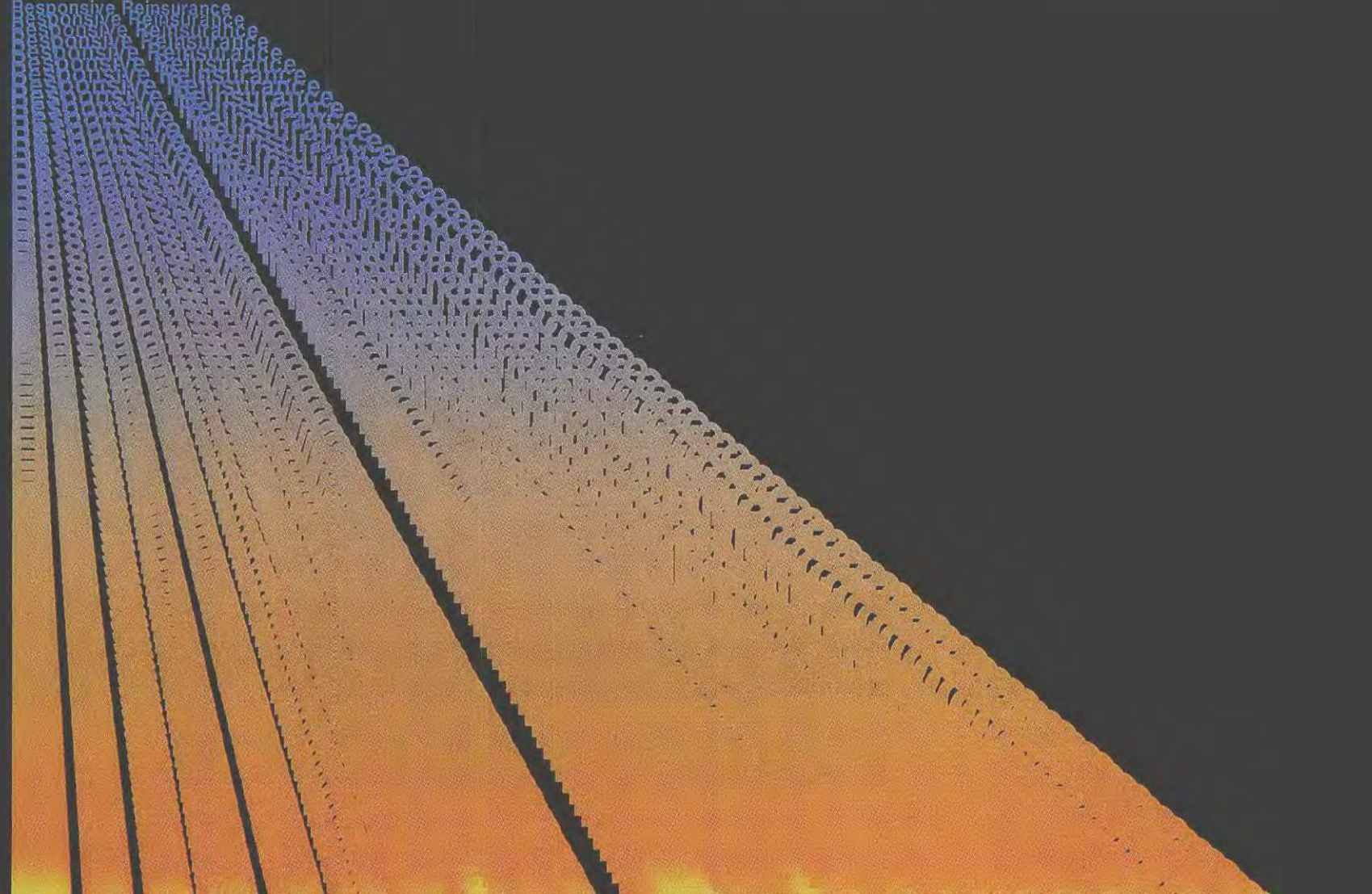
- The technique of human error rate prediction focuses on the interactions between people and

machines identifying highly specific ways in which human errors may lead to the failure of a mechanical system and thus cause an accident.

THERP then applies predetermined probabilities of each of these human errors to predict the likelihood that some human error will cause such an accident.

As applied to a boiler, THERP would identify the

ways in which maintenance or other personnel working with the boiler (such as checking pressure gauges, adjusting valves or cleaning pipes) might make specific types of errors. This technique then would find the likelihood of these various human errors and calculate the overall probability that some human error will cause a boiler explosion.



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NAIC to develop reporting form for RRGs

By MEG FLETCHER

CHICAGO—The National Assn. of Insurance Commissioners will attempt to develop a model form that risk retention groups can use to file information with state regulators, the NAIC announced last week.

The NAIC's Risk Retention Working Group will develop the form, David Thornberry, a member of the Texas State Board of Insurance who chairs the working group, told those attending a recent conference in Chicago sponsored by the Risk & Insurance Management Society Inc.

The plan to develop a model form follows recent complaints by risk retention group organizers about the lack of uniformity among states' filing requirements (BI, Oct. 31).

Meanwhile, proposed revisions to the Risk Retention Act now being circulated by Commerce Department staff members clarify the type of documentation that risk retention groups would be required to file and with whom (BI, Nov. 21).

Under the proposals, risk retention groups would only have to prepare one set of documents, which they would file with their domiciliary state as well as with all states in which they do business. However, the proposals also say any state may require a risk retention group doing business there to conform to NAIC standards when filing an annual statement.

Multiple state filing requirements is one of the major problems with the 1986 Risk Retention Act amendments, because it is time-consuming and requires a lot of staff resources, said John Salisbury, executive director of the Cheshire, Conn.-based Housing Authority Risk Retention Group Inc., which operates in about two dozen states.

Before it begins offering insurance, a risk retention group is required under the amended Risk Retention Act to submit to the insurance commissioner of the state in which it is chartered a plan of operation or a feasibility study. The plan or study must include detailed information about such items as coverages and deductibles as well as subsequent revisions.

In addition, the prospective risk retention group also must file a copy of such a plan or study and subsequent revisions with insurance departments in other states in which it intends to do business.

The law also requires the group to send regulators in all states where it is doing business copies of its annual financial statement, which must be certified by a public accountant and contain an opinion letter on the adequacy of loss reserves from an actuary or qualified specialist.

State regulators differ in their interpretation of the act, and some even request additional information from risk retention groups than that authorized by the 1986 amendments, according to a U.S. Commerce Department report on the implementation of the act (BI, Oct. 5, 1987).

For example, one state requires a listing of members participating in the group to verify their qualification to participate, the report said.

The NAIC had not previously addressed the problem of states' disparate information requests because regulators thought the problem of multistate filing requirements focused on risk purchasing groups, Mr. Thornberry explained.

Solving that problem became unnecessary after an Iowa federal court upheld the ability of Iowa state regulators to require insurers to be admitted or authorized in the state before selling insurance to members of a purchasing group that are located in the state, he said (BI, Oct. 31; Aug. 3, 1987).

A few RIMS conference attendees said they were pleased at Mr. Thornberry's announcement. However, it is

important to point out that states can ignore NAIC model recommendations.

In addition to regulatory issues, the Nov. 15 RIMS meeting also addressed other risk retention group and captive issues.

During a closed meeting, about 50 attendees discussed whether there was sufficient interest to form a RIMS common interest group exclusively devoted to risk retention group and trade association captive insurance company issues.

The attendees, who included many

service providers like captive managers and consultants, also considered what form the group should take, said Jon Harkavy, RIMS' director of governmental affairs.

Among the organizational options under consideration are:

- An industry section of RIMS.
- Expansion of the Captive Insurance Companies Assn. Inc., a Delaware-based non-profit trade association that RIMS administers.
- A separate association.

After the meeting, Mr. Harkavy announced that RIMS will host an

industry session to further discuss the formation of a risk retention group section during its annual conference April 9-14 in Atlanta.

RIMS attendees include risk managers as well as representatives of risk retention groups and single-parent and group captives.

RIMS is exploring the idea of organizing a vehicle in response to the increasing need for a network to keep risk retention groups and captive insurance companies informed about issues affecting them, and because "we want to serve our members," Mr.

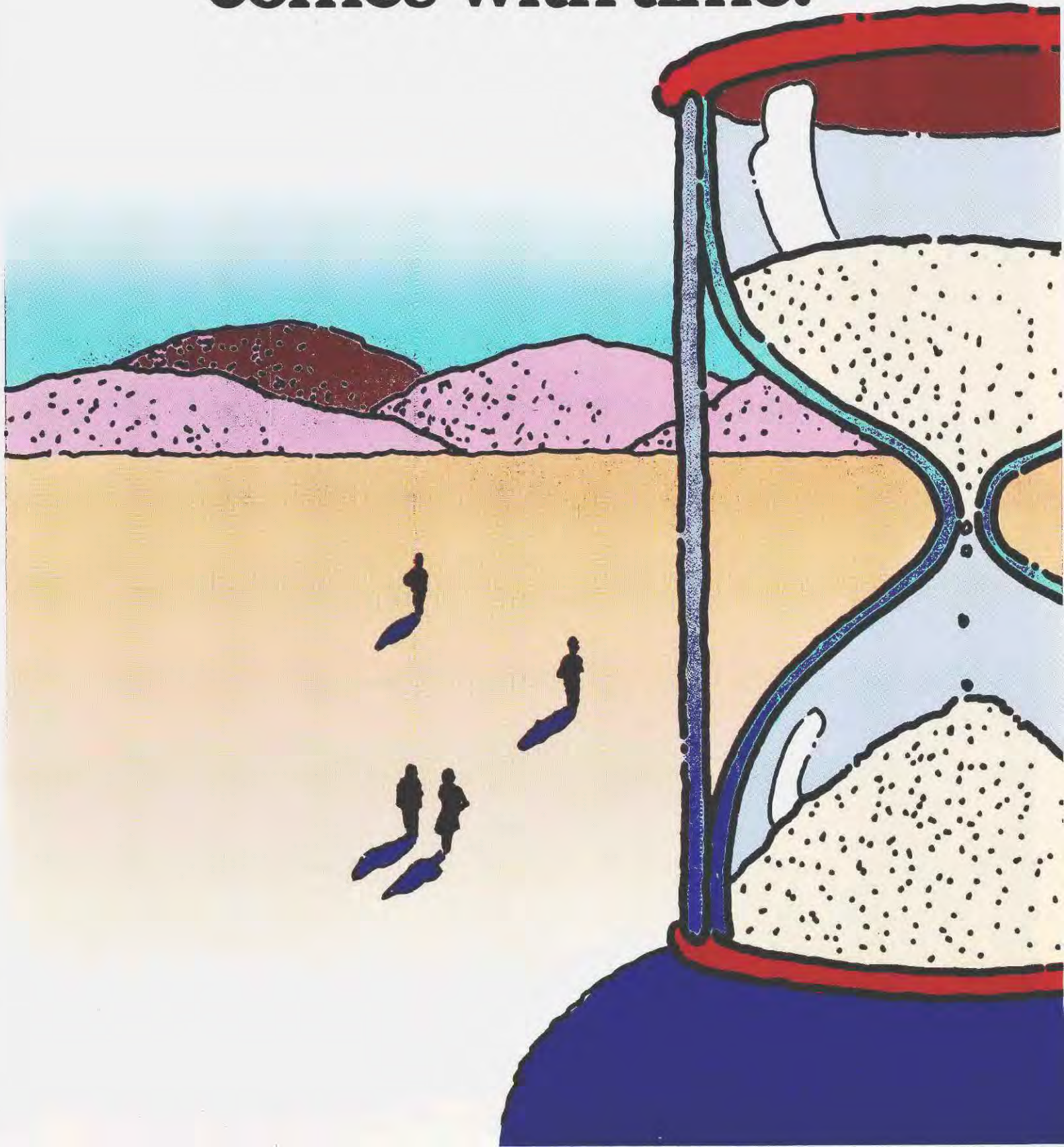
Harkavy explained.

During subsequent sessions at the Chicago RIMS conference, speakers made several recommendations about how to develop viable risk retention groups, including:

- Companies should choose the risk retention group format only after they have considered the advantages and disadvantages of all modes of self-insurance—including offshore and onshore captives—and find that a risk retention group would best meet their needs.

Continued on next page

Experience that only comes with time.



Continued from previous page

- Before a risk retention group becomes operational, members must consider several structural issues, said James Cameron, a partner with the law firm of Baker & McKenzie in New York.
- A board of directors should consist of five to nine members representative of the group, he said. And, board members should be allowed to serve indefinitely, or else consultants run the group because members are not educated enough to do so, he added.
- Also important is choosing between organizing as a stock company, which has more of a short-term investment orientation, or a mutual, which has longer-term

- service objectives, he said.
- Voting rights need to be balanced with capitalization and/or premium requirements, or small members will be fearful of being dominated by big ones, and vice-versa, Mr. Cameron said.
- Members also must set rules for profit sharing, forcing a member to leave the group and coping with the voluntary withdrawal of a member, he said.
- Risk retention groups should investigate reinsurers' financial solvency as well as the services they supply, said Roger Greiner, president of Genesis Underwriting Management Co., a General Re Corp. unit in Stamford, Conn.
- However, they also should be

- aware that reinsurers will be scrutinizing them to ensure that they have long-term viability, including appropriate claims-handling arrangements, he said.
- Risk retention groups should provide members with very detailed offering information, said Jeffrey Altman, a partner with McKenna, Conner & Cuneo in Washington, D.C.
- Members should be made aware of structural provisions, such as a provision that may allow one member to be charged higher capitalization and premium costs than another, he said. Otherwise, he suggested, the group may face a lawsuit filed under the anti-fraud provisions of some securities law.

- A risk retention group should develop a good working relationship with regulators.
- However, there is no "magic formula" for developing such a relationship because state insurance departments have diverse rules about dealing with risk retention groups, said Illinois Insurance Director John Washburn, who is president of the NAIC.
- For instance, resolving disputes over issues like some states' requirement that risk retention groups use licensed agents is not easy, he said, because regulators draft such requirements to protect the public.
- The Risk Retention Act amendments removed regulators' au-

- thority in some areas, Mr. Washburn explained. And, the more authority regulators lost, the greater the difficulty they have in discerning good risk retention groups from unscrupulous operators, Mr. Washburn said.
- When reviewing a newly established risk retention group or group captive, Illinois and many other states tend to focus on a few key factors, he said.
- The department wants to know "that you understand what you are doing, that you have assessed the risk correctly" and that a group will be able to fulfill its contracts, Mr. Washburn explained.
- To ascertain that, the department scrutinizes whether the group was formed by its members or by an outsider, both of which can be acceptable. It then examines the group's administrative plan to ensure that it has sufficient resources.
- The Illinois department also examines the group's marketing plan to ensure that it is based on sound actuarial projections and quality reinsurance. The department also wants to know where the group's risks are located and how quickly the group plans to expand.
- State regulators will particularly question a group that is formed in one state but plans to write elsewhere, Mr. Washburn said.
- In addition, the Illinois Insurance Department requires that risk retention groups file quarterly reports for the first few years.
- If the group's business does not develop according to plan, Mr. Washburn urged administrators to convey that to regulators themselves rather than waiting for regulators to approach them. "You will have it a lot easier," he said.
- The Vermont Department of Banking and Insurance requires a risk retention group to file both an acceptable feasibility study and a plan of operation before it will issue a certificate of authority, said Chief Insurance Examiner Edward Meehan.
- Mr. Meehan says he focuses on who is organizing the group and becomes "nervous" if the organizers are solely service providers, such as captive managers or consultants.
- The Vermont department takes a conservative approach to determining appropriate levels of capitalization and has its estimates checked by an outside review firm.
- If a group is approved, it must stick to its plans or submit for approval any proposed changes. Otherwise, "I get very nasty," and may consider drawing down on a group's letter of credit, said Mr. Meehan, who Mr. Harkavy said was "affectionately" known as "Ayatollah Eddie."
- However, state insurance departments differ in their approaches to several related issues, including acceptability of letters of credit, mandatory participation in joint underwriting associations and premium taxes, speakers said.
- A risk retention group should market itself aggressively, said Jaxon White, president of Hamilton Resources Corp., the operational unit of MEDMARC Insurance Co. Risk Retention Group Inc. in Vermont.
- It should develop synopsis fact sheets and policy forms to aid in its marketing effort, he said. It also should concentrate its resources on persuading key companies to join and developing links with brokers, he said.
- Using well-known service providers will help establish the group's credibility, he said. And, services themselves should be broad-based, he added.
- The risk retention group also can gain name recognition by publishing a record of its accomplishments, sending releases to the trade press and providing speakers for industry events, Mr. White suggested.

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Antitrust suit defendants didn't conspire: Attorney

By MIKE SCHACHNER

NEW YORK—It would have been virtually impossible for the insurance industry defendants named in the massive antitrust litigation filed by 19 state attorneys general to conspire to restrict the availability of coverage and the use of the occurrence-based commercial general liability insurance form, an industry attorney contends.

In conspiracy cases, concentration of power must fall within a small group so enforcement of the plan is possible, explained William E. Bailey, chief counsel to the Insurance Information Institute and

The industry is 'too fragmented, too diverse' to have conspired, says Mr. Bailey.

chairman of Boston-based Legal Management Systems Inc.

"The largest insurer in the world has only 8.6% of the U.S. market," said Mr. Bailey, explaining the diversity of the industry.

"I'm appalled by this accusa-

tion," he said during the annual convention of the Professional Insurance Wholesalers Assn. of New York Inc. held earlier this month in New York.

Eighteen state attorneys general have filed suit in U.S. District Court in San Francisco charging that the insurance industry defendants conspired to restrict availability of coverage in the mid-1980s; eliminate the occurrence-based commercial general liability policy forms; and exclude all pollution coverage from the CGL forms (BI, June 27; June 20; March 28).

The suits, which have been consolidated, name four major U.S. insurers, several U.S. reinsurers, the Insurance Services Office Inc., the Reinsurance Assn. of America, Lloyd's of London managing agencies, British reinsurers and reinsurance brokers.

Another antitrust suit filed in state court in Texas is similar to the consolidated litigation pending in U.S. District Court in San Francisco, but the Texas suit contains broader allegations of wrongdoing (BI, Nov. 7).

Mr. Bailey rebutted the allegation in the lawsuits that the defendants coerced the industry to deprive consumers, such as day-care centers and municipalities, of insurance products at reasonable rates.

He said the insurance industry is "too fragmented, too diverse" to allow 31 individual parties to force similar action among 3,500 insurers. "It's fallacious to say this," Mr. Bailey said.

He also assailed the attorneys general's allegation that ISO took part in the alleged conspiracy. "It's the worst allegation of them all," he said, noting that ISO is a non-profit information gatherer and data disseminator. "ISO doesn't drive or dictate, but advises. ISO doesn't draft language; it takes language given to it by the insurance companies," he said.

"The lawsuits are designed to break up the conglomeration of insurers and reinsurers. The attorneys general don't understand the business. They want things to be different, like the automobile industry, where they (auto companies) compete against each other.

"But insurance has a commonality. There are interchangeable parts so we can do business with each other," Mr. Bailey said.

"The attorneys general's suits are but one piece of a systematic attack on the way in which we, the insurance industry, conduct our business," Mr. Bailey said.

The suits are an extension of the public's opinion that the insurance industry is greedy, overly profitable, self-interested and anti-consumer, he said.

Mr. Bailey summed up the lawsuits as a "battle between us and the public interest groups who have developed such an antipathy for us."

According to Mr. Bailey, the nation's insurance buyers should decide what kind of insurance system they want.

The system can be operated by privately capitalized companies, as it is now, or by a public entity that uses a strict no-fault compensation system.

"I can't imagine anything worse than going to a state-run insurance agency and trying to get someone to discuss my claim. It would be like asking the IRS for help," Mr. Bailey quipped.

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In commercial insurance, we now have special

programs designed specifically for association members such as veterinarians, mobile home dealers, auto repair shop owners and dry cleaners.

And our Excess and Special Risk Department provides extensive excess property and casualty layers for customers with high exposure limits.

In short, we're putting our customers first to build relationships that last. If this makes sense to you, perhaps we're the kind of company you should keep.



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National Union

Continued from page 2

ers in California, it does not change the fact that National Union must respond to the Village Escrow claim.

Nor does the decertification order prevent policyholder attorneys outside California from citing Judge Johnson's decision in their briefs.

"Lawyers outside California do use decertified California decisions," pointed out Eugene Anderson, an attorney with Anderson, Russell, Kill & Olick in New York. "Even decertified decisions are straws in the wind."

But, insurers nationwide are pleased that the adverse decision has been pulled off the books, according to National Union attorney R. Gaylord Smith of Lewis, D'Amato, Brisbois & Bisgaard in Los Angeles.

He said the Supreme Court's decision to decertify the National Union case "restores the efficacy of the claims-made form in California, which was seriously threatened by the appellate court decision."

"Because the volume of death penalty cases (in California) precludes the court from ruling on every civil case, the court uses decertification as a tool to police appellate court decisions with which it may disagree," Mr. Smith explained.

"Decertification is a tool used by the court with increasing frequency" noted Village Escrow attorney Terence C. McGaughey of Tremaine, Shank, Stroud & Robbins in Los Angeles. "The decision indicates the Supreme Court has a problem with part or all of the appellate court opinion."

The decision also may indicate that this Supreme Court is more conservative, according to attorneys.

But, Mr. Smith maintained that "the ruling seems conservative only because we have had such liberal courts in the past."

At least one attorney is asking the court to rescind the decertification order, attorneys say. But Mr. Smith said the chances of the Supreme Court rescinding its decertification order are "virtually nil."

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Intere acquired

Continued from page 2

owned broker in Atlanta that specializes in facultative reinsurance; London-based reinsurance broker J.H. Minet Reinsurance Ltd.; and Minet Burne & Roche, Minet's reinsurance brokerage affiliate in Australia for the last three years.

All of Minet's reinsurance brokerage units—including Intere—will remain autonomous and keep their separate names, Mr. Chapple said.

Meanwhile, Intere will be able to tap into Minet's major international retail network, according to Mr. Gordon. For example, through Minet Intere may gain business from Lloyd's underwriters, European or Australian insurers looking for reinsurance in the U.S. market.

Intere will continue to specialize as an intermediary for treaty reinsurance, particularly for all property, casualty, marine and aviation risks.

Minet and Intere have been in serious negotiations since September, according to Mr. Gordon.

Although both parties have agreed to the purchase, the transaction will not be completed for another six to eight weeks, he added.

Mr. Gordon stressed that Intere was not looking for a buyer because its estimated gross revenues dropped 12.8% to \$20.5 million in 1987 from estimated revenues of \$23 million to \$24 million in 1986 (BI, Oct. 31), or because the intermediary's revenues are expected to fall again this year.

"Minet wants to develop its reinsurance business," he said. "This interested us."

"If this situation did not make sense, then we would go on as in the past. . . . We have been around a long time and we know what to do" when revenues are down.

When St. Paul bought Minet, some critics questioned whether an insurance company should own a Lloyd's broker. However, Mr. Gordon said he is not concerned that Intere will be ultimately owned by an underwriter.

"St. Paul has entered into diversification in its long-range plans," said Mr. Gordon, stressing that Intere will report directly to Minet and not to St. Paul.

"It is up to the public to determine whether it is good or bad" to be owned by an insurance company, he said.

After the merger, Mr. Gordon will remain chairman and chief executive officer of Intere, and Daniel R. Colletto, who recently was appointed executive vp, will become president and chief operating officer.

Among other Intere management changes: President Wallace E. Winter will become vice chairman; Senior Vp Michael G. Woll will become executive vp-administration; Senior Vp Thomas F. McGrath III will become executive vp of marine/aviation/international/non-marine and eastern division; and Senior Vp Brian Keegan will become executive vp of central, west and south divisions.

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Jackson loses bid for Lloyd's Council seat

By STACY SHAPIRO
and CAROLYN ALDRED

London

LONDON—Prominent Lloyd's of London underwriter Robin A.G. Jackson will not be among the three working Lloyd's members who will fill seats on the Council of Lloyd's next year.

In addition, the council will have to elect a new junior deputy chairman since Alan Parry, who currently holds the office, did not seek re-election.

However, the council is expected to re-elect Chairman Murray Lawrence when it votes on Dec. 7. Senior Deputy Chairman David Coleridge also is expected to be re-elected.

Working members elected to the council earlier this month include:

- Colin Murray, chairman of Lloyd's underwriting agency R.J. Kiln & Co. He received 2,581 votes.
- John Greig, chairman of Lloyd's broker Greig, Fester Ltd. He received 2,469 votes.

- Anthony Gordon Hines, director of Lloyd's underwriting agency Crow Underwriting Agency Ltd. He received 2,081 votes.

Mr. Jackson, a director of Merrett Holdings P.L.C. and one of the leading underwriters of U.S. liability risks in the London market, is retiring this year as underwriter for non-marine syndicate 799, which will be split into three syndicates (*BI*, Aug. 29). Mr. Jackson, who is one of the defendants' named in the antitrust suits filed by U.S. state attorneys general, has been an outspoken critic of the U.S. legal system and other problems affecting insurers.

Some working members in the market say Mr. Jackson wasn't elected because he isn't liked and is too opinionated. However, other members including Mr. Parry disagree, saying that the three men who won the election had good reasons for victory.

Mr. Murray and Mr. Greig won re-election to the council. And, Mr. Hines, who has run for election to the council previously, will be the only aviation underwriter on the council.

This is also the first time Mr. Jackson has sought election to the council, said Mr. Parry, adding that Mr. Jackson only lost by 425 votes.

"I don't think it has anything to do (with Mr. Jackson being unlikely)," said Mr. Parry. "A lot of people think he could make a great contribution to the council."

Another theory voiced by working members who did not wish to be named is that Mr. Jackson lost votes because Lloyd's marine underwriters did not want Mr. Jackson and Stephen Merrett, chairman of Merrett Holdings, on the council at the same time. Mr. Merrett has held a seat on the council since January.

Mr. Jackson would not comment on the election. However, he said it is "unlikely" that he will run for the council again, since he is expected to retire from the market in two years.

Two non-working members also were elected to fill council vacancies:

- Mary Doreen Archer, wife of author Jeffrey Archer and a Lloyd's member since 1977.

Ms. Archer will be the second woman to serve on the Lloyd's Council.

- Sir Gerrard Charles Peat, a partner with accountant Peat Marwick McLintock in London and a member since 1973.

Among the non-working members who were not elected was American Phil C. Gallagher, president of broker Gallagher-Cole Associates in Miami.

Outhwaite ruling

Lloyd's of London underwriter Richard Outhwaite is appealing a second arbitration ruling that he must pay claims stemming from an unlimited run-off reinsurance policy he wrote for a fellow Lloyd's underwriter.

Arbitration umpire Simon Tucker ruled earlier this month that Mr. Outhwaite's syndicate 317/661 cannot void an unlimited run-off reinsurance contract with syndicate 179/884, which is underwritten by Ron Hampton and managed by Anton Underwriting Agencies Ltd.

Claims from the policy currently

total about \$12 million.

While Mr. Outhwaite will appeal the latest arbitration ruling against the syndicate, Mr. Outhwaite will not appeal last month's arbitration decision that Mr. Outhwaite must pay claims—estimated to total about \$50 million—stemming from an unlimited run-off reinsurance policy ceded by Lloyd's underwriter Michael Cockell (*BI*, Oct. 24), a spokesman for RHM Outhwaite (Underwriting Agencies) Ltd. said.

Shortly after the ruling was released, the spokesman noted that newly appointed Outhwaite Chairman Lord Havers, the former head of Britain's judiciary, and leading

London insurance lawyer Stephen Mitchell, an Outhwaite director, were "going through the decision with a fine-tooth comb."

The decisions are the first two arbitration rulings on run-off reinsurance contracts Mr. Outhwaite is disputing. He is not paying claims on the policies because he says that the ceding underwriters did not disclose adequate information regarding tens of millions of dollars of U.S. asbestos and pollution losses.

Mr. Outhwaite currently is disputing at least eight other run-off reinsurance contracts written in 1981 and 1982, of which four are scheduled for arbitration, said the spokesman.

"It is disappointing to have lost both arbitrations so far," said the spokesman, adding that the next

arbitration likely will be concluded early next year.

Although liability for the Hampton and Cockell syndicates' claims are fully reserved in syndicate 317/661's latest accounts, "adjustment to the reserves may be required for future years," because the two contracts did not contain aggregate limits, said a statement released by the Outhwaite agency.

Reserves established by the Outhwaite agency last year to meet outstanding liabilities for the 1982 underwriting year total 263.3 million pounds (\$497.6 million at year-end 1987 exchange rate). While the agency has reinsurance arrangements such as time-and-distance policies and other assets to meet most of the required reserves, 85.4 million pounds (\$153.7

Continued on next page



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IN THE DARK**

Continued from previous page

million at current exchange rate) must be paid by the syndicate's 1,614 members from 1982.

Mr. Outhwaite has called on members to pay 20.5 million pounds (\$36.9 million) of the loss this year and has warned members to expect future cash calls at regular intervals into the 1990s (BI, Aug. 29).

Merrett syndicate changes

Lloyd's of London's largest marine syndicate 418/417 has finalized its reorganization into three separate sub-units, each of which will have its own syndicate number.

Syndicate 418/417, managed by Merrett Underwriting Agency Management Ltd., announced in August that it would be subdivided for underwriting and administrative purposes into the three divisions (BI, Aug. 29; Aug. 22).

Merrett announced last week that although syndicate 418 will remain the general umbrella name for the group and Stephen Merrett will remain group underwriter, each unit will have its own syndicate number beginning with 1989 renewals:

- Syndicate 1131/1132, underwritten by Mr. Merrett and Barnabas Hurst-Bannister.
- Syndicate 1133/1134, underwritten by Tim Jonas.
- Syndicate 1136/1135, underwritten by Dennis

Purkiss.

Syndicate 418/417 will cease to use its numbers for underwriting purposes, confirmed Merrett Managing Director Kenneth Randall. However, syndicate 418/417 will be the vehicle for members to join the three sub-units and for accounting purposes.

Altogether, syndicate 418/417 has 1988 capacity of 287.3 million pounds (\$522.9 million), while the combined capacity of the three sub-units is expected to drop to between 240 million pounds (\$436.8 million) and 250 million pounds (\$455 million) in 1989, according to Mr. Randall.

Merrett hopes to close syndicate 418/417's 1985 accounts by the beginning of next year, "but we can't guarantee it," said Mr. Randall.

The syndicate was left open last year while Merrett resolved several runoff reinsurance contracts underwritten by the syndicate.

Meanwhile, Merrett also announced the formation of a U.S.-based company called Merrett Underwriting Services Inc.

The company will include U.S. operations already owned by Merrett like loss adjuster Robert Bishop (New York) Ltd. and joint ventures with the claims administrator and risk management consultant Caronia Corp. of Jericho, N.Y. Charles Caronia, president of Caronia, has been appointed chief executive of Merrett Underwriting Services. ■

Datebook

DEC. 1. Directors and Officers Liability seminar in London, sponsored by Insurance & Reinsurance Research Group Ltd.; 190 pounds (\$336) plus VAT. Caroline Atkinson, Insurance & Reinsurance Research Group Ltd., Bridge House, 181 Queen Victoria St., London, England EC4V 4DD; phone: 01-236-2175; fax: 01-489-1487.

DEC. 1. CAOHC Approved Recertification Course in Occupational Hearing Conservation in Kansas City, Mo., sponsored by Impact Hearing Conservation Inc.; \$150. Impact Hearing Conservation Inc., 406 W. 34th St., Suite 400, Kansas City, Mo. 64111; 800-346-2139; 816-531-4848.

DEC. 1. Pollution Control & Legal Compliance seminar in London, sponsored by Insurance & Reinsurance Research Group Ltd.; 155 pounds (\$274) plus VAT. Joy Bambrugh, Insurance & Reinsurance Research Group Ltd., Bridge House, 181 Queen Victoria St., London, England EC4V 4DD; phone: 01-236-2175; fax: 01-489-1487.

DEC. 1-2. Managing Risk Communications seminar in Wilmington, Del., sponsored by E.I. du Pont de Nemours & Co.; \$925; \$795 each for two or more registrants from same company. Also Jan. 25-26 in New Orleans; Feb. 15-16 in

Denver; March 30-31 in Houston; and April 26-27 in Philadelphia. Du Pont, Room X51430, P.O. Box 4500, Greenville, Del. 19807; 800-532-7233; 302-999-6982 within Delaware.

DEC. 1-2. Occupational Health Nursing Principles and Certification Review course in Schaumburg, Ill., sponsored by Fireman's Fund Risk Management Services Inc.'s Occupational Health Consulting & Ergonomics division; \$295. Also Jan. 12-13 in Atlanta; Feb. 9-10 in Torrance, Calif.; Feb. 23-24 in Denver; March 9-10 in Cambridge, Mass.; and March 30-31 in Arlington, Va. Annette B. Haag, Director, Occupational Health Consulting, Fireman's Fund Risk Management Services Inc., P.O. Box 777, Novato, Calif. 94998-9002; 415-899-2423.

DEC. 1-3. Hazardous Wastes, Superfund, and Toxic Substances course in Washington, sponsored by the American Law Institute-American Bar Assn. Committee on Continuing Professional Education; \$400; \$50 for coursebook. \$135. Registrar, American Law Institute-American Bar Assn., 4025 Chestnut St., Philadelphia, Pa. 19104; 800-253-6397; 215-243-1661 within Pennsylvania.

DEC. 1-3. Fundamentals of Bankruptcy Law seminar in Scottsdale, Ariz., sponsored by the American Law Institute-American Bar Assn. Committee on Continuing Professional Education; \$400. Registrar, American Law Institute-American Bar Assn., 4025 Chestnut St., Philadelphia, Pa. 19104; 800-253-6397; 215-243-1661 within Pennsylvania.

DEC. 4-6. Changing Relationships: Business, Organized Labor and HMOs workshop in Washington, sponsored by the Group Health Assn. of America; \$560 for GHAA members; \$660 for non-members. Registrar, GHAA, 1129 20th St. N.W., Suite 600, Washington, D.C. 20073-0612; 202-778-3228.

DEC. 5. Section 89 of the Internal Revenue Code workshop in Boston, co-sponsored by Buck Consultants Inc. and Employee Benefit Education Associates; \$195. Patricia J. Ibbs, Principal, PJI Benefits, Suite 1000, 2290 Peachtree Road N.E., Atlanta, Ga. 30326; 404-264-6552.

DEC. 5-6. Barbados Captive Conference in St. Philip, Barbados, sponsored by the Tillinghast division of Towers, Perrin, Forster & Crosby Inc.; \$675; \$825 Canadian. Conference Director, Tillinghast/TPF&C, Financial Centre, 695 E. Main St., Suite 600, Stamford, Conn. 06901-2138; 203-326-5400.

DEC. 5-7. Fundamentals of Insurance course in Charlotte, N.C., sponsored by the Risk & Insurance Management Society Inc.; \$540 for RIMS members; \$640 for non-members. Risk & Insurance Management Society, 205 E. 42nd St., Suite 1504, New York, N.Y. 10017; 212-286-9292.

DEC. 6. Directors and Officers Liability and HMO Act Amendments workshop in Boston, co-sponsored by the Society of Chartered Property & Casualty Underwriters; \$130 for Society of CPCU members; \$160 for non-members. Mari Jennings, Professional Services Coordinator, Society of Chartered Property & Casualty Underwriters, Kahler Hall, 720 Providence Road, CB#9, Malvern, Pa. 19355; 215-251-2741.

DEC. 6. Retiree Medical Benefits, COBRA and HMO Act Amendments workshop in Boston, co-sponsored by Buck Consultants Inc. and Employee Benefit Education Associates; \$195. Patricia J. Ibbs, Principal, PJI Benefits, Suite 1000, 3390 Peachtree Road N.E., Atlanta, Ga. 30326; 404-364-6552.

DEC. 6-7. Health Care Purchasing-From Principle to Practice: Successful Strategies for Cost Containment seminar in Des Moines, Iowa, sponsored by the Health Policy Corporation of Iowa; \$150. Kathy Van Gundy, HPCI, 601 Locust, Suite 330, Des Moines, Iowa 50309; 515-244-1211.

DEC. 7. Society of Insurance Accountants' Quarterly Meeting in New York City; \$30 for SIA members; \$60 for non-members (includes membership fee). Robert Bauer, Society of Insurance Accountants, P.O. Box 61, Hollowville, N.Y. 12530; 518-851-9780.

DEC. 7. Investment Strategy for Lloyd's Syndicates seminar in London, sponsored by Insurance & Reinsurance Research Group Ltd.; 190 pounds (\$336) plus VAT. Caroline Atkinson, Insurance & Reinsurance Research Group Ltd., Bridge House, 181 Queen Victoria St., London, England EC4V 4DD; phone: 01-236-2175; fax: 01-489-1487.

DEC. 7-9. Techniques of Risk Management course in Atlanta, sponsored by the Risk & Insurance Management Society Inc.; \$540 for RIMS members; \$640 for non-members. Risk & Insurance Management Society, 205 E. 42nd St., Suite 1504, New York, N.Y. 10017; 212-286-9292.

DEC. 7-9. Managed Care: Risk, Challenge and Opportunity conference in Los Angeles, sponsored by The National Health Lawyers Assn.; \$440 for NHLA members; \$490 for non-members. NHLA, 1620 I St. N.W., Suite 900, Washington, D.C. 20006; 202-833-1100.

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Regulation

Continued from page 3

years. These alternatives are growing, according to Mr. Greene, because the regulatory environment suits policyholders and owners.

"They can avoid the oppression of the guaranty funds and other social responsibilities," he said.

Mr. Corcoran contended that regulation provides insurers with a tool that offers a competitive edge. "If regulation does its job, it should cut down on confusion and should, effectively, cut down on frivolous litigation," said Mr. Corcoran.

"We have to make sure the companies are solvent," he said. "We have to make sure the companies who sell the products will be there so the victims don't become wards of the state."

However, Mr. Corcoran also indicated that he would entertain a dialogue on a two-tiered system of regulation for commercial vs. personal lines insurance.

"We agree that certain things don't belong in the guaranty funds," he said. "They're not intended for credit enhancement," he added.

Panelists representing brokers, insurers and commercial insurance buyers generally advocated less insurance regulation.

"Answers don't come from lawyers, legislators or regulators responding to irate consumers," said Robert V. Hatcher, chairman of Johnson & Higgins in New York. "Answers come from helping those who will change the system to de-

velop a clearer understanding of how the industry works."

Mr. Hatcher acknowledged that the regulatory system has been improved during the past decade.

Mr. Hatcher cited sophisticated captive laws, which permit buyers to insure their own risks, and exemptions for certain commercial accounts to attain coverage from non-admitted insurers as a couple of vital strides.



Mr. Sinnott

Jack Sinnott, president of Marsh & McLennan Worldwide in New York, offered two precepts that frame M&M's attitude toward regulation. He said M&M supports any philosophy that allows creativity and innovation and it looks unfavorably on any law that limits options or makes the risk transfer mechanism unnecessarily complicated or unfairly expensive.

Jon Harkavy, general counsel and director of government affairs for the Risk & Insurance Management Society Inc. in New York, commented that New York's recently adopted flex rating system may not result in the desired stability in rates.

Commercial insurance buyers will seek alternatives if desired rate decreases are rejected while insurers will succeed in obtaining a higher price for their coverage if rate increases are rejected, perhaps by restricting coverage.

And, after the meeting, Mr. Harkavy commented that he does not agree that large commercial accounts should be exempt from guaranty fund protection. He noted that the guaranty funds need the financial support generated by commercial lines underwriting. To take protection away from commercial accounts would be "taxation without indemnification," he said.

William M. McCormick, chairman and chief executive officer of Fireman's Fund Insurance Cos. in Novato, Calif., suggested that insurance regulators could impose new accounting rules on insurers to make financial statements more accurate.

But, Mr. McCormick blamed the U.S. tort system for the insurance industry's problems.

"There are some fundamental forces occurring in our society that are causing insurance to be a major public issue," he said.

Mr. McCormick referred to a "25-year macro trend" of a new tort liability system that no longer adjudicates negligence but dispenses people's money. "It's a switch from 'I'm responsible for my life' to 'Everybody else in this country is responsible for my problems.'"

Mr. McCormick said the liability cost side of the insurance equation has been compounding at two to three times the rate of inflation.

The U.S. liability system is the most expensive in the world, Mr. McCormick said, citing a book by Peter Huber, "Liability: The Legal Revolution and its Consequences," which places direct liability costs incurred by individuals, businesses and municipalities at \$80 billion annually. That is equivalent to the total profits of the nation's top 200 companies, according to Mr. Huber.

And, Mr. Huber's book reports indirect, or hidden, liability costs as high as \$300 billion annually.

"It's referred to as a hidden tax. But it isn't just insurance costs, as most consumers see it. It's the fact when you buy a stepladder, one third of the cost of the stepladder is liability. The cost of liability in a car is more than the cost of the steel. The cost of liability in a football helmet is more than the cost of making the

football helmet. It more than doubles the price," Mr. McCormick said.

"The nation needs to understand and analyze overall liability costs, he said. But, if society wants the system to continue as is, the insurance industry can handle it because it simply spreads the risk.

Mr. McCormick also assailed the antitrust litigation filed by state attorneys general, which alleges the insurance industry conspired during the liability insurance crisis of the mid-1980s to eliminate the occurrence version of the commercial general liability policy form and pollution coverage.

Noting that Fireman's Fund is not a defendant in the action pending in federal court in San Francisco, Mr. McCormick called the allegations silly. Fireman's Fund is, however, a defendant in the state court suit pending in Texas.

Mr. McCormick equated the attorneys general's allegation that the Insurance Services Office Inc. changed standardized general liability forms to hurt consumers to "pulling the wrong tooth."

Neither antitrust nor ISO are issues, he said. "The issue is liability costs are going up."

"The antitrust lawsuit and Prop. 103 are not ice breakers," observed John J. Hampton, professor of finance at The College of Insurance in New York, contending that some sort of "ice breaker" is needed to find a cure for the liability crisis.

George Sampson, chief of the antitrust enforcement section of the New York Attorney General's Office and one of the assistant attorneys general litigating the antitrust suit, disagreed with Mr. McCormick's assessment.

"ISO operates as a monopoly. It's the single form-promulgation organization in America," Mr. Sampson said. And, because it has no consumers and brokers sitting on its board, ISO is only susceptible to criticism after-the-fact, he said.

"ISO wields tremendous power that in many cases goes unchecked," Mr. Sampson said.

The suit asks the court to appoint to ISO's board of directors "public interest" members and to make them the majority of ISO's board.

Mr. Harkavy, responding to a question, said he would not advocate RIMS seeking representation on the ISO board.

"The policy language tends to be construed against the drafter of the policy," said Mr. Harkavy, explaining why he would not push for consumer representation on ISO's board.

"However, I think it would be important to know how these forms are promulgated," added Mr. Harkavy.

Both Mr. Hatcher and Mr. Sinnott said brokers are not in the business of underwriting and so there is no need for broker representation on ISO's board.

A member of the audience also pointed out that there is no legal precedent in antitrust law for appointing outside people to the board of a private company.

But Mr. Sampson contends that in antitrust cases if violations are found, the court can make changes it deems necessary to ensure that similar violations do not reoccur.

"Courts in antitrust cases have broad authority to fit the remedy to the violation," he said. "It's up to the individual judge."

According to Mr. Sampson, until ISO is changed to better represent more than insurers, there will continue to be problems.

"Brokers must understand that the whole process of speaking up has to start earlier. It's almost too late to get involved when decisions are made, forms are presented for regulation and the industry has said: 'This is the way it is going to be,'" said Mr. Sampson.

"The heart of the case is that antitrust laws do not countenance all types of group behavior and there is a line over which insurers and reinsurers cannot cross without violating antitrust laws," he said.

Several panelists pointed out the dramatic growth in alternative risk financing facilities. Currently, some 30% to 35% of commercial risk financing costs are in alternative facilities, they said.

The commercial property/casualty insurance industry writes about \$100 billion in annual premiums.

Commenting on the growth of alternative facilities, Mr. Harkavy said: "This is happening during an open, competitive time. Imagine what is going to happen when the hard market hits."

Mr. Harkavy suggested that the growth of the alternative market might be a means for insurers to stabilize the market cycle. Alternative facilities provide insurer and policyholder with a shared stake in the outcome, he explained.

"The policyholder is in essence saying, 'Listen, I recognize you need a steady sense of profit and we need service and stability,'" said Mr. Harkavy. "I think this is a very promising trend."

Brokers, too, want off the merry-go-round, said Mr. Harkavy. He foresees a transfer from commission-based business to fee-based business.

"I think brokers should welcome this," he said. "I think it's a long-due recognition that their commissions come not from the vagaries and fluctuations of the marketplace, but true value added. And I think the fee-based system which these alternative facilities represent is well-received by the brokerage community."

Mr. McCormick said alternative facilities have grown because traditional multiline insurers have stopped writing certain types of insurance when they consider the risks too large.

"We wrote that type of business during the '20s, '30s, '40s, '50s, '60s and '70s, and now we are paying for it in the '80s and '90s," he said.

Mr. McCormick warned those involved in captives and pools to get a good grip on the length of the tail on the business they are underwriting.

M&M's Mr. Sinnott said the goals for the future are to get off the roller coaster of insurance cycles and establish stability. He predicted that the soft market will continue through 1989 and into 1990. "Beyond that we're just not certain," he said.

Because primary insurers now are less dependent on reinsurance than in the past, the next hard market should not be as severe, according to Mr. Sinnott. He also said brokers have teamed up with corporate policyholders to create powerful new entities such as A.C.E. Insurance Co. Ltd. and X.L. Insurance Co. Ltd.

In addition, Mr. Sinnott said, plans exist for additional facilities that were not needed because the market became competitive again. When the market tightens, these facilities could be set up quickly.

Responding to the claim that the industry has learned from past mistakes and will not return to cash-flow or market-share underwriting, Mr. Harkavy said, "I don't believe anyone in this room believes that."

"Some believe the next hard market will hit in '90 or '91. I say '92 because I have great faith in this industry. It seems to have a love for extended hari-kari rather than to get it over quickly," Mr. Harkavy said.

Mr. Hatcher said the biggest issue at hand is addressing the overwhelming doubts surrounding the insurance industry's credibility. The industry has done a poor job of positioning insurance as a dependable risk transfer vehicle, he said. "And this comes at a time when practices are at an all-time high of unpredictability."

The forum was moderated by Kathryn J. McIntyre, associate publisher and editor of *Business Insurance*.



Mr. McCormick

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THE FAST TRACK TO A COMEBACK

TPA of America sells 2 units to Harrington

Los Angeles-based benefits administrator TPA of America Inc. is selling two of its subsidiaries to Harrington Services Corp., an employee benefit consultant and plan administrator in Columbus, Ohio.

TPA of America is selling American Benefit Plan Administrators Inc. and Mass Insurance Consultants & Administrators Inc. for \$15 million and securities representing 25% of the equity of Harrington at the time of the sale. The company plans to disclose the full value of this transaction next week in a proxy statement.

TPA of America is ranked by *Business Insurance* as the nation's fifth-largest claims administrator. It paid about \$650 million in claims for about 328 self-insurers in 1987 (*BI*, Jan. 25).

Last month, the TPA's insurance unit—First Transcontinental Life Insurance Corp. of Milwaukee—was liquidated by the Wisconsin Insurance Department (*BI*, Oct. 24). At that time, TPA of America announced that it would sell the two subsidiaries.

The sale is "part of the company's overall restructuring plan," said David R. Adamoli, chief financial officer.

The sale is subject to approval by TPA of America shareholders and certain legal conditions. If all conditions are met, the sale could be completed by February 1989.

Blues launches TPA

Recognizing that more and more employers are self-insuring their benefit plans, Blue Cross & Blue Shield of New Jersey has launched a third-party administration unit.

Markets

The new subsidiary, Total Plan Administrators Inc., provides claims processing services as well as utilization review services.

The company is able to process claims for companies that have traditional health care coverage or managed care programs involving preferred provider organizations and health maintenance organization or flexible benefit plans.

Total Plan Administrators also provides detailed utilization review reports so employers can see how health care benefits are being used.

For more information, contact Terence L. Byrd, executive vp and chief operating officer, Total Plan Administrators Inc., 14 Commerce Drive, Cranford, N.J. 07016; 201-272-1616.

Kellison opens firm

Stephen Kellison, formerly executive director of the American Academy of Actuaries, has opened his own actuarial consulting firm.

In addition to offering actuarial consulting services, The Kellison Co. also specializes in legislative and regulatory consulting.

"I am building on the kinds of things I did at the Academy," said Mr. Kellison.

The Kellison Co. also offers management consulting services and will host educational seminars and programs.

Mr. Kellison served as executive director of the American Academy of Actuaries for 12 years, having

opened the organization's Washington office in 1976.

For more information, contact Mr. Kellison at The Kellison Co., 1900 L St. N.W., Suite 500, Washington, D.C. 20036; 202-785-0494.

Continental expands

New York-based Continental Corp. has created a new Mid-Atlantic region that will encompass Delaware, Maryland, Pennsylvania, Virginia, West Virginia and the District of Columbia.

William Bender, currently Continental's resident vp in New York, has been named Mid-Atlantic regional vp and manager.

The new regional office will be based in York, Pa.

For more information, contact Gillian Sterling, Continental Corp., 180 Maiden Lane, New York, N.Y. 10038; 212-440-7714.

Norwest agency

Norwest Corp., parent company of Minneapolis-based Norwest Insurance Inc., has launched an in-

urance agency that will specialize in commercial lines.

Norwest Commercial Insurance Agency will offer a full line of commercial insurance products.

The agency will operate as a subsidiary of Norwest Insurance Inc., which markets all types of personal and commercial insurance.

James C. Schneider has been named president of Norwest Commercial Insurance Agency. Previously, Mr. Schneider was vp at Johnson & Higgins in Minneapolis.

For more information, contact Mr. Schneider at Norwest Commercial Insurance Agency, 401 Second Ave. S., Minneapolis, Minn. 55479; 612-667-2163.

Mergers/acquisitions

New York-based Guy Carpenter & Co. Inc. has acquired a majority interest in Munich, West Germany-based Gradmann & Holler Reinsurance Brokers.

Richmond, Va.-based Hilb, Rogal & Hamilton Co., the nation's 12th-largest broker, has acquired Foss, Cates, Hudson & Sims Agency Inc. of Houston and Victoria, Texas.

Burns & Wilcox Ltd. of Southfield, Mich., has acquired the Bos-

ton office of Alexander Howden North America.

Irvine, Calif.-based Consolidated Care Corp., a managed care corporation, has acquired Wake & Associates, a rehabilitation services provider in Denver.

New offices

American Re-Insurance Co. has relocated its offices to American Re Plaza, 555 College Road E, Princeton, N.J. 08543-5241; 609-243-4200.

Jardine Group Services Corp., a unit of Jardine Emett & Chandler, has opened a satellite office at 1055 Thomas Jefferson St. N.W., Suite 500, Washington, D.C. 20007; 202-298-0416. William J. Thomas, formerly director and vp-marketing for Bertholon & Rowland Corp. in New York, will head the new office as vp.

Johnson & Higgins has opened a new office at 877 W. Main St., Suite 707, Boise, Idaho 83702; 208-338-1006. Vp Richard Ioset will manage the new office.

Allendale Mutual Insurance Co. has opened a new office at Corporate Woods, Building 12, 10975 Benson, Suite 370, Overland Park, Kan. 66210; 913-451-8060. ■

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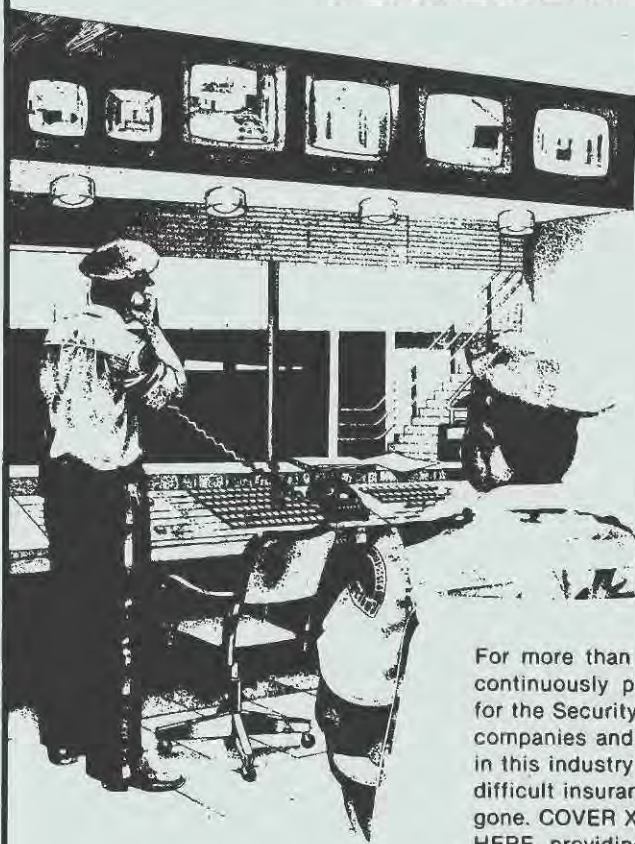
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Excise tax refund

Continued from page 3

\$23 million—will be paid as fees to brokers for their help in refunding the money, said Mr. Harding.

The nine insurers receiving the bulk of the refunds—47%—are: Sun Alliance & London Insurance P.L.C.; The Orion Insurance Co. P.L.C.; Commercial Union Assurance Co. P.L.C.; Walbrook Insurance Co. Ltd.; Terra Nova Insurance Co. Ltd.; Unionamerica Insurance Co. Ltd.; English & American Insurance Co. Ltd.; St. Katherine Insurance Co. P.L.C.; and The Yasuda Fire & Marine Insurance Co. (U.K.) Ltd.

In its lawsuit, Columbia, a defunct river barge and towing operation in Cincinnati, had charged that because it purchased insurance from U.K. insurers it was "owed relief" under the 1980 tax treaty that produced the refund.

Columbia also claimed that the tax that was paid by British insurers was, in fact, paid by policyholders and should therefore be refunded to policyholders.

Columbia also sought "relief" from the insurers under the Racketeer Influenced and Corrupt Organizations act.

But the appeals court dismissed all three of Columbia's charges. The court said that Columbia, as a purchaser of insurance from British insurers, "cannot claim to be a victim of such double taxation."

Columbia did not file any claim for direct relief with the

'Indeed, if Congress had intended to extend this multimillion-dollar benefit only to United States insureds, it could have accomplished that result without an international treaty,' the court says.

IRS within three years of the treaty, which it should have done if it was owed any tax refund, the court said. The treaty had provided a special statute of limitations for U.K. insurers, requiring them to file for their refunds on or before Dec. 31, 1983.

"The conclusion is inevitable that Columbia has no treaty right to the FET refunds at issue herein," said the court.

Besides, the tax treaty eliminated the tax on insurance premiums paid to foreign insurers, said the court. "It is inconceivable that either the treaty signatories or the ratifying senators intended the refund provisions of the treaty to be a \$150 million bonanza to United States companies or individuals simply because they purchased insurance from U.K. insurers," said the court. "Indeed, if Congress had intended to extend this multimillion-dollar benefit only to United States

insureds, it could have accomplished that result without an international treaty."

The court also rejected Columbia's argument that the tax was paid by it and not the foreign insurers.

"When the tax was included in the premium charged, the burden was borne by the insurer; when it was added as a separate item to the premium charged, the burden was borne by the insured," the court said.

But Columbia cannot show that the tax was charged separately or that the company "had ownership or possessory rights in the unidentified monies paid out of IRS general funds to the U.K. insurers," the court said.

"We hold (that) Columbia has no right to refunds paid to the U.K. insurers," the court said. "Concluding, as we do, that the U.K. insurers were entitled to the FET refunds they received, we see no need to discuss Columbia's tortious attempts to allege that U.K. insurers secured such refunds in an unlawful manner. In short, no RICO violation was alleged."

It is not known yet whether Columbia will seek review from the U.S. Supreme Court, said Stephen Winston, a partner with Philadelphia law firm Berger & Montague, who represented Columbia.

The U.K. insurers were represented by White & Case in New York, while Refett was represented by LeBoeuf, Lamb, Leiby & MacRae in New York.

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Texas work comp

Continued from page 3
 earner is one of the highest in the nation, he said.

However, high wage earners in Texas recover a much lower percentage of their wages under the Texas law, according to Mr. Huff.

He emphasized that "the main problem is that the substantial dollars spent are to a great extent going to the less seriously injured, including many with no permanent, physical disability."

Sen. Tejada, who is a member of the state's Select Committee on Workers Compensation, agrees with Texas Gov. Bill Clements' assertion that the state's workers compensation system is broken and says that the 75-year-old system is overdue for a revision.

"We haven't touched it probably in the last 50 years. And if we have, it's just been one Band-Aid over the other," he said.

Repairing the system calls for cooperation among several groups, according to Sen. Tejada.

But, in recent years, there has been "a lot of finger-pointing" among employees, employers, attorneys, the medical profession and insurance companies, he said.

"For many, many years we've all been pointing fingers at each other trying to pin the blame on one group or the other. But in order to bring about real reform, all parties involved need to face the issue squarely and do their part to return the system to its original purpose" of compensating injured workers, Sen. Tejada said.

The senator's committee in January will make recommendations to the Texas Legislature on how to improve the state's workers compensation system. A study completed by the committee's staff in October made several recommendations and the committee will decide which of those will be formalized and drafted into a workers comp reform bill.

Recommendations in the study call for, among other things:

- Penalizing employers and workers exhibiting unsafe behavior. For example, workers comp benefits might be reduced for workers who disregard safety regulations and increased in cases when an employer has been found negligent.

- Increasing utilization and effectiveness of safety programs. The committee points to a need for clarifying the statutory duty of insurers to provide safety services to small employers and calls for more resources for the state's Health Department, which would enable the agency to broaden its safety consultation program.

- Increasing utilization of vocational rehabilitation by increasing the resources of the Texas Rehabilitation Commission and devising methods of referring cases to the commission more quickly.

- Changing the average weekly wage calculation to determine a more accurate wage upon which benefits will be based.

- Modifying or eliminating the trial de novo system, which allows an injured worker to appeal a decision by the Industrial Accident Board to a court jury, which is not allowed to consider the IAB's ruling in its decision. The study says injuries in de novo trials "cannot respond quickly to the problems that may arise in a compensation claim, particularly those involving medical care and temporary disability issues."

The trial de novo issue is one of the thorniest in the debate over reform of the Texas workers compensation system. While some believe the right to a trial de novo should be modified or eliminated, trial lawyers in the state want to keep that feature.

Sen. Tejada pointed out that "one suggestion has been to institute some changes to make the

terms of arbitration at the IAB level more binding in some cases."

In addition, many employers, legislators and insurers say that the lump sum payment to plaintiffs' attorneys of 25% of settlements in a de novo trial are too high.

"Many feel that the worker is not getting what is due to him, particularly once that 25% is taken," the senator said.

However, some attorneys say the fee is too low, he said.

But Margaret M. Maisel, a partner in the San Antonio law firm of Tinsman & Houser and director of the San Antonio Trial Lawyers Assn., is adamant that trial de novo should be left alone.

In the panel discussion after the senator's speech, Ms. Maisel said, "I think that the cornerstone of any democracy is a jury trial, and I simply am not willing to give that up."

Ms. Maisel said she does believe that the Texas system is even bro-

ken.

There is no need to "start from scratch," she asserted. "I think that those states that have done that, for instance Florida and Louisiana, have seen that not only have they not had a decrease in their premiums, but in fact their premiums have escalated higher than what we have had here in Texas," she said.

"Trying to turn the system upside down is not the solution," Ms. Maisel said.

One area where most critics of the Texas system find agreement is the area of workplace safety.

"We have a real problem with safety in the workplace in Texas," Sen. Tejada said. "This is corroborated by the fact that the fatality rate in Texas ranks 12th in the nation."

Contributing to the problem is the declining number of Occupational Safety and Health Administration inspectors assigned to Texas, according to the senator.

"We may have to think about levying fines against employers who have chronically unsafe work environments," Sen. Tejada said. "We certainly need to reinforce the utilization and effectiveness of safety programs."

Nick Heustis, vp-workers compensation for the Austin-based Texas Assn. of Business, agreed during the panel discussion that "there's no question that the major cause of (high) workers comp costs is a poor safety record in Texas."

Mr. Heustis said employers "need to take a much more serious attitude toward selecting, training and equipping their employees so they can provide the tasks they're being compensated for in a safe and productive manner."

"Likewise, employees need to understand that the most valuable issue in workers compensation is the work that they have available to them, that truly—if costs don't come under control—it will affect jobs," he said.

Ms. Maisel of the San Antonio Trial Lawyers Assn. said she thinks "it is clear that something has to be done about the safety problems in this state. It makes good sense that if you have less accidents, premiums are going to go down."

Ms. Maisel agreed with Mr. Heustis that there are major employers in Texas with good safety records.

But, "that isn't our problem," she stressed. "Our problem is the smaller employers who simply do not have the time and resources to dedicate to safety."

Also on the panel were Brad B. Hall, chairman of the orthopedics department of St. Luke's Lutheran Hospital in San Antonio; and Joe Meador, a principal in the San Antonio firm of Meador & Samaniego.

Paul A. "Pete" Synnott Jr., executive vp of the Society of Chartered Property & Casualty Underwriters, moderated the panel. ■

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Texas comp insurers to tough it out

AUSTIN, Texas—Many workers compensation insurers in Texas expect to continue writing the same amount of workers comp business as in the past although the rate increase they were granted is only half the amount they sought.

The Texas State Board of Insurance earlier this month granted workers comp insurers in the state an 18.7% rate increase, a little more than half the 36.7% increase requested by insurers. The rate hike means employers will pay \$700 million more in workers comp premiums, or a total of about \$4.35 billion, in 1989 than they will pay this year (BI, Nov. 21).

The state's office of Consumer Protection asked that the board grant only a 10.9% hike.

The rate hike, effective Jan. 1, is the third consecutive annual increase granted to workers comp insurers in Texas. However, all the increases have fallen far below what insurers felt they needed to realize a profit in the state.

In 1987, the National Council on Compensation Insurance sought a 31.3% increase but was granted only a 17.9% increase. This year, insurers were allowed to raise rates another 25% although they had requested a 43.2% increase (BI, Nov. 30, 1987).

"I think most companies felt (the rate increase) had to get over 20% to make it a viable market," said Wayne Stratton, regional vp of the Alliance of American Insurers' Southwest Region in Austin.

However, the increase was so close to that figure that he suspects "most companies feel that with the possibility of major (workers comp) law reform from the Legislature, this is enough to keep them hanging on."

Reform of the workers compensation system is the top priority for next year's meeting of the Texas Legislature (see story, page 3).

Among the insurers that expect to continue writing workers comp business in the state is Casualty Insurance Co. of Texas in Dallas. The insurer will make no changes in the amount of work comp business it writes in the state, according to Wayne Fisher, president of the special operations group at parent company Continental Corp. of New York.

"The company did \$20 million in business in Texas last year, and we intend for that business to continue and increase in 1989," Mr. Fisher said. Casualty Insurance, which began operating last year and writes only Texas workers compensation insurance, plans to open another office in San Antonio in the next four or

five months, he added.

Mr. Fisher said the rate increase was "in line with what we had hoped for."

However, he said Continental may make some changes in the amount of Texas workers comp business it writes through agents and brokers. That business is separate from the business written by Casualty Insurance.

"We are reassessing that position" and will decide in a few weeks what changes, if any, will be made in the business generated by agents and brokers, he said.

Continental last year wrote \$78 million in gross workers comp premiums in Texas.

Employers Casualty Co. of Dallas, one of the largest underwriters of workers comp insurance in the state, also does not plan any changes in the amount of workers comp coverage it writes in the state.

The insurer probably will not alter the amount of workers comp business it writes in the state because of the rate hike, according to Bill Huff, executive vp and general counsel at Employers Casualty. "But we haven't made any decisions," he said.

"I don't think it will cause us to increase or decrease" the amount of business written, he added.

In 1987, the group wrote around \$250 million in workers comp premiums and chalked up a combined ratio of 111.2%.

Mr. Huff said the 18.7% increase was about what he expected. "I don't think we could have expected any more. It was politically difficult for the board to vote that increase."

Some insurers are not yet sure what action, if any, they will take.

A spokesman for Travelers Corp. of Hartford, Conn., said the rate hike was inadequate but that the insurer has not made any plans to change the amount of business it writes in Texas. "We're reviewing the situation," he said.

"We're still looking at it, trying to assess the situation," said a spokeswoman for Zurich-American Insurance Co. in Schaumburg, Ill.

The largest underwriter of workers compensation coverage in the state is the Texas Workers Compensation Assigned Risk Pool, which provides insurance for employers that are turned down by commercial insurers. The pool in 1987 wrote \$471 million in premiums and is expected to write \$526 million this year.

—By Michael Bradford

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Proposition 103

Continued from page 3

And, the Insurance Department plans to hire 300 additional employees to handle the new duties, a spokesman said. The new employees, which will include rate analysts, attorneys and financial analysts, will represent a 60% increase to the current staff of 515.

Operating expenses for the department, including salaries and additional equipment, will add \$18 million to the department's 1988-89 budget, the spokesman said. The department had been budgeted to spend \$33 million prior to approval of Proposition 103.

Because the expenses include some one-time expenditures, such as for computer equipment, the ongoing costs will be somewhat less than \$18 million, he said.

At the hearing, several legislators ripped into the insurance industry, saying they were "disgusted" by the use of "tricks of the trade" to evade rollback provisions of Proposition 103.

"Some companies have used some tricks of the trade that I don't find funny," said state Sen. Alan Robbins, D-Los Angeles.

Mr. Robbins categorized insurers as in the state as either "good guys"—insurers that have continued business as usual following approval of Proposition 103—or "bad guys"—insurers that have stopped writing new business or renewing policies or have taken other actions to circumvent the effect of the initiative.

Californians are tired of being "run over by the insurance industry," said Sen. David Roberti, D-Los Angeles, the Senate president pro tem. "The worst part is the people voted and you still run over them."

Pending the state Supreme Court review of Proposition 103 and possible modification of the law by the court, the proposition "is the law," he added.

To give insurers additional incentive to comply with the new law, several legislators are drafting bills that would penalize insurers that refuse to renew business governed by the law if it survives its legal challenges.

One bill scheduled to be introduced next week would levy fines against insurers that decline to renew policies between Nov. 11, 1988, and a date yet to be determined in 1989, according to Sen. Robbins, who is sponsoring the bill. The penalties could range from 25% to 50% of premiums insurers would have charged policyholders, he said.

Insurers also would be forced to renew the coverage or reimburse policyholders for any difference if the policyholders obtain more expensive insurance from another insurer, he said.

The bill, to be called S.B. 103 after Proposition 103, is scheduled to be introduced on Dec. 5, followed by an insurance committee hearing on Jan. 11 and a vote by the full Senate on Jan. 18, Sen. Robbins said.

Sen. Dan Boatwright, D-Concord, said he may propose a bill that would mandate all property/casualty insurers in the state to write auto insurance.

He said insurers should not be able to choose to write only profitable lines of insurance, like homeowners coverage, and decline to write other lines.

"You can't take the good and leave the bad," Sen. Boatwright told insurers. "I think we ought to pick a date and say you can't write any insurance unless you comply with Proposition 103 and write auto insurance in California," Sen. Boatwright said.

Several other legislators said they would co-sponsor legislation that would force insurers to write auto insurance in addition to other, more profitable lines.

Sen. Robbins said 14 bills on insurance reform have been killed by the industry's heavy lobbying effort, but that the lobby is now powerless.

"The Legislature is not going to sit idly by," he said.

S.B. 103 will emerge from the insurance committee and eventually become law, unlike other insurance reform bills that have routinely died in committee, Sen. Robbins predicted. "I don't think you are going to be able to block it," he asserted.

Sen. Roberti agreed that insurers are likely to lose their clout in Sacramento. "You can lobby, because that's the democratic process, but that bill will make it out of the committee," Sen. Roberti said.

But, insurers have not lost all of their support in the Legislature: Sen. Ed Davis, R-Valencia, said he would oppose any measure that would impose cost controls

or insurers or force them to write certain lines.

"I will never vote for any price control or anything that forces anyone to do business," Sen. Davis said.

At the hearing, lawmakers vilified insurers for, among other reasons, not presenting hard evidence showing how the mandated insurance charge rollbacks under the new law would financially ruin them while taking measures to avoid complying with the law.

Noting that the new law grants rate relief to insurers that can demonstrate they would be forced into insolvency if they complied with the law, Assemblywoman Maxine Waters, D-Los Angeles, challenged insurers to produce that financial documentation.

Assemblywoman Waters, noting that the insurance committee was still seeking details about finances of California insurers, said: "I'm not convinced that the information we want from you is forthcoming."

Insurers have not given the state Insurance Department or the public with information that assures everyone understands the insurers' financial concerns, she said. "The information is fuzzy and not well understood by people," she said.

But, some insurers early last week attempted to clarify the picture for the department in applications they filed seeking relief from the new law. The applications from the 11 insurers vary from one-page letters to several with "reams of supporting material," said Reid McClaran, department staff attorney.

However, the department will not consider the requests until the Supreme Court lifts its stay of the law's immediate effective date, he said.

Among other insurers taking severe measures to avoid complying with the law is Travelers Corp. of Hartford, Conn., which is pulling out of the state.

While the company remains confident that the state Supreme Court will invalidate Proposition 103, it "can't entertain the risk" that the court would uphold the initiative, said Ronald E. Foley, senior vp.

"We don't want to leave California," he said, noting that the company wrote about \$1.35 billion in gross premiums for all lines of business in the state in 1987.

State lawmakers at the hearing also were concerned with the state's personal auto insurance market, since Proposition 103 grew out of voters' displeasure with auto insurance rates in the state.

Lawmakers were particularly critical of State Farm Insurance Cos. of Bloomington, Ill., which has announced it will transfer all new auto policyholders to a subsidiary that charges higher rates. New applicants will pay 20% to 60% higher premiums under the strategy, according to a State Farm spokesman.

The Insurance Department has announced it would seek to block the move.

However, State Farm was acting only to protect its current policyholders and guard against further losses, said Laura Sullivan, vp and counsel of State Farm Mutual Automobile Insurance Co.

State Farm had an increasing underwriting loss on California auto insurance since 1984, including a \$207 million underwriting loss in 1987, she said.

But Sen. Roberti said he was not impressed by the company's position. He said State Farm has shown "an egregious amount of contempt" for voters by transferring new auto insurance applicants to the subsidiary that charges higher rates.

But John Martin, president of the personal lines division of Aetna Life & Casualty Co. of Hartford, Conn., insisted that insurers are not making huge profits off high auto insurance premiums. Mr. Martin emphasized that costs for auto insurance are rising more rapidly in California than in the rest of the country.

Aetna lost more than \$12 million in auto insurance for the past four years in California, he said.

"Bottom line, there is no exorbitant profit. The facts are there is no profit at all," Mr. Martin said.

However, Aetna, like many other insurers, is continuing to renew current policies and write new business in California, Mr. Martin pointed out.

"We are not going to be run out of the state. We are not going to turn our backs on the nearly half of the electorate that when offered a free lunch, said 'No,'" Mr. Martin said, referring to the voters who voted against Proposition 103.

The committee is scheduled to conduct another hearing Dec. 13-14 in Los Angeles. ■

Ohio lawmaker eyes Prop. 103

By KARI BERMAN

CLEVELAND—California's controversial Proposition 103 is heading east.

An Ohio state representative plans to introduce legislation based on the voter-approved proposition that would mandate at least 20% reductions in "insurance charges" across many lines of property/casualty insurance.

The Ohio bill also would mandate an additional 20% rollback on private auto insurance charges for "good drivers," according to Rep. Ronald M. Mottl, D-Parma, who is in the process of drafting the legislation.

However, Ohio's insurance com-

missioner opposes the legislation.

Rep. Mottl, who plans to introduce his proposal when the state Legislature reconvenes in January, said the bill would mandate:

- A 20% rollback for one year of all property/casualty insurance charges. However, the representative says he has not determined which date insurers would have to use as a base for the reductions.
- An additional 20% reduction to auto insurance buyers with good driving records, bringing their total reduction to 40%.
- The election instead of the appointment of the state insurance commissioner.

The representative, however, said his staff has not yet developed

language dealing with many of the questions raised in California about Proposition 103. For example:

- What is the definition of "charges"? Are charges filed rates or actual premiums charged? And how should the rollbacks be figured when a policyholder's exposure has changed since the date on which the rollbacks are based?
- Would the law apply to surplus lines insurers?
- Would the law apply to insurers that write coverage for members of purchasing groups?
- Would the law apply to risk retention groups fronted by insurers?

Continued on next page

Update

Piper Alpha settlements near

Continued from page 2

out an agreement on claimants' rights to further compensation from third parties, but the details of this provision will not be revealed until the steering committee meets with the lawyers for the families not represented on the committee.

Occidental already has made an interim payment of 10,000 pounds (\$18,060) to each of the 62 workers who survived the July 6 explosion in the North Sea (*BI*, Nov. 14); payments of around five times victims' salaries to their families within 10 days of the disaster; and a 1 million pound (\$1.8 million) donation to the Piper Alpha disaster fund in Aberdeen.

Florida hikes work comp rates

TALLAHASSEE, Fla.—Employers in Florida will be paying around \$432 million in additional premiums for workers compensation insurance next year.

The Florida Insurance Department earlier this month granted workers comp insurers in the state a 28.8% rate increase effective Jan. 1.

Insurers had requested a 47.7% rate increase. The rate hike means Florida employers will pay more than \$1.93 billion in work comp premiums next year, up from about \$1.5 billion this year, said Jim Watford, an department actuary.

A spokeswoman for the Insurance Department said the lower rate was granted because insurers:

- Did not adequately recognize the effects of investment income.
- Requested allowances for expense costs that were not in line with industry averages that show such costs have decreased.
- Sought compensation for overpayment of claims, which should be borne by the insurance company and not the policyholder.
- Overstated loss projections.

Mr. Watford said Florida workers comp insurers reported a 146% combined ratio on business written in the state in 1987, which translated into an underwriting loss of \$525 million.

The recent rate increase follows a 13.7% jump in 1988.

IBP settles dispute with OSHA

WASHINGTON—IBP Inc., the nation's largest meatpacker, will pay the federal government \$975,000—less than one-fifth of a proposed \$5.7 million fine—to settle alleged violations of federal safety and health violations.

The settlement, signed last week, is the third-largest ever negotiated by the Occupational Safety and Health Administration.

OSHA had cited the Dakota City, Neb., meatpacker in 1987 and 1988 for allegedly underreporting injuries and illnesses and for ignoring cumulative trauma disorders among its Dakota City workforce (*BI*, July 27, 1987). Cumulative trauma disorder—caused by repeated hand, wrist and arm motions in a job task—is the No. 1 injury in the meatpacking industry.

Under terms of the settlement, IBP agreed to:

- Evaluate OSHA's recommendations for reducing carpal tunnel syndrome and other cumulative trauma disorders at the Dakota City and 14 other IBP facilities.
- Implement a comprehensive education program for managers, supervisors, engineers, union representatives and employees on the range, causes and means of preventing carpal tunnel syndrome.
- Install a medical management program addressing carpal tunnel syndrome at all its plants. This will include early detection of symptoms and conservative treatment of them; physical therapy; and analyzing jobs that workers with carpal tunnel syndrome might be assigned to while they are recovering.
- Bring its procedures for recording illnesses and injuries into accord with federal requirements within six months.
- End its contest of OSHA's citations, without admitting any wrongdoing.

Accountant ordered to pay

CHICAGO—Accountant Touche Ross & Co. Inc. must pay the Congregation of the Passion, Holy Cross Province, a Roman Catholic religious order, \$3.9 million for failing to notify the order of significant investment portfolio losses, a Cook County Circuit Court jury ruled last week.

The order employed Touche Ross in 1972 to review its annual financial statements and monitor the growth of its U.S. securities portfolio, which was being invested in arbitrage trading by Cramford Newall, a San Francisco-based independent investment advisor, said Thomas P. Ward of the Chicago law firm of McBride, Baker & Coles, which represents the order.

The jury found that Touche Ross was negligent in not taking into account the significant swings inherent in arbitrage trading when evaluating the portfolio and in allowing the order's financial reports to portray the securities at an inaccurately high value, according to Mr. Ward.

Leon Gold, Touch Ross' general counsel in New York, said the firm will appeal but would not comment on its insurance.

Briefly noted

Denver-based **Manville Corp.** reports that the cost for its six-year bankruptcy will total about \$118 million in fees and expenses for lawyers, investment bankers and accountants. . . **Sedgwick Group P.L.C.** Chief Executive David Rowland will take over as the group's chairman when current Chairman Carel Mosselmans retires in April 1989. . . **Maxicare Health Plans Inc.** will pay \$250,000 to settle an AIDS-discrimination suit filed by the San Francisco District Attorney's Office, against one of its affiliates. The settlement also includes an injunction prohibiting the 65,000-member HMO in suburban San Francisco from refusing or canceling memberships to people with AIDS, AIDS-related complex or people who have tested positive for the virus that causes AIDS.

Summary of major property/casualty insurers' nine-month results

(All amounts in thousands of dollars)
(Ranked by change in aftertax operating income)

Rank 1988	Corporate			Property/casualty operations										
	Consolidated revenues 1988	Aftertax ¹ operating income 1988	Percent increase (decline) 1987-1988	Combined ¹ ratio 1988	Combined ¹ ratio 1987	Net premiums written 1988	Percent increase (decrease) 1987-1988	Pretax underwriting income (loss) 1988	Percent increase (decline) 1987-1988	Pretax investment income 1988	Percent increase (decrease) 1987-1988	Policyholders surplus 1988	Percent increase (decrease) 1987-1988	
1	Ohio Casualty Corp.	1,182,887	93,565	29.4	101.0 ²	102.4 ²	1,032,435 ²	(1.3)	(19,592)	25.8	127,345	10.1	444,172	20.9
2	American International Group	9,750,200	850,151	26.0	99.4	99.6	6,494,010	11.7	48,041	768.6	610,468	23.6	2,450,784	19.0
3	General Re Corp.	2,101,663	381,518	15.8	99.2 ²	100.1 ²	1,385,113	(20.4)	(960)	74.8	398,376	12.1	2,177,405	(3.9)
4	Hartford Steam Boiler	333,241	45,949	15.2	84.2	85.6	211,666	(1.8)	34,420	13.5	26,128	7.2	254,197	5.2
5	Crum & Forster Inc.	3,214,700	238,400	12.0	108.7	108.1	2,564,300	1.3	(211,700)	0.2	404,500	12.4	1,324,700	3.0
6	Chubb Corp.	2,965,200	279,200	8.8	99.1	97.4	2,074,000	3.1	26,200	(53.3)	273,900	35.1	1,320,500	(2.4)
7	The St. Paul Cos. Inc.	2,646,963	261,642	7.7	103.8 ²	105.2 ²	1,955,826	(2.8)	(67,899)	21.0	396,216	8.8	1,308,481	7.1
8	Hartford Insurance Group	7,644,519	271,988	4.5	103.5	102.9	4,876,423	(1.8)	(211,964)	(17.9)	548,552	17.3	2,490,636	0.4
9	SAFECO Corp.	2,230,821	166,112	(0.8)	101.0	99.9	1,149,823	6.1	(11,348)	(1,892.7)	161,043	22.5	803,522	1.9
10	Old Republic Int'l Corp.	807,179	69,300	(4.6)	104.4 ²	105.5 ²	437,843 ²	(5.2)	(14,918) ²	21.8	93,268 ²	18.7	563,317	14.5
11	CNA Financial Corp.	6,039,000	284,300	(4.7)	107.3 ²	111.5 ²	3,944,000 ²	12.9	(334,800) ²	21.2	636,800 ²	15.0	2,568,000	31.2
12	Fremont General Corp.	311,156	19,041	(5.8)	103.8	104.6	210,574	1.6	(8,063)	15.0	31,579	23.4	90,059	26.5
13	Kemper Corp.	2,904,908	144,973	(6.6)	103.5 ²	104.8 ²	579,319	4.5	(37,211)	(27.3)	61,764	7.8	496,480	2.3
14	USF&G Corp.	4,109,911	226,263	(20.8)	104.9 ²	104.2 ²	2,982,130 ²	4.3	(152,953)	(79.9)	463,351	1.7	1,420,400	2.0
15	Reliance Ins. Co. & subs.	2,670,648	107,825	(23.4)	102.3 ²	102.0 ²	1,278,262	14.4	(45,428)	(59.4)	148,139	6.4	N/A	N/A
16	Aetna Life & Casualty Co.	17,973,900	470,600	(26.4)	110.4	106.0	5,114,800	2.0	(527,000)	(85.2)	668,700	9.9	2,009,377	(8.3)
17	Sentry Insurance Cos. ²	986,387	33,914	(27.0)	104.3	103.7	874,710	3.7	(49,371)	(30.8)	100,093	12.1	530,646	10.0
18	Continental Corp.	4,316,300	175,600	(28.4)	106.1 ²	103.2 ²	3,851,900 ²	—	(252,700)	(112.0)	458,600	7.2	1,572,973	(11.0)
19	The Home Group Inc.	2,148,700	64,100	(33.5)	108.8	110.8	1,621,000	5.5	(140,800)	12.1	261,600	(5.9)	828,800	5.4
20	Fireman's Fund Ins. Cos.	2,702,929	175,731	(33.8)	108.4	116.8	2,196,342	(18.8)	(193,182)	57.0	336,807	2.7	1,318,176	(10.0)
21	Lincoln National Corp.	5,079,100	114,200	(34.6)	100.1	97.8	1,701,000	7.8	(6,900)	(123.2)	203,400	11.7	1,243,300	11.4
22	CIGNA Corp.	13,059,500	287,100	(35.6)	107.8	105.3	4,511,700	4.8	(351,900)	(53.7)	596,900	4.4	2,175,000	14.3
23	Travelers Corp.	14,941,300	192,200	(41.8)	105.5	103.4	4,012,300	(1.3)	(181,300)	(56.4)	464,100	15.4	1,613,700	(13.5)
24	Royal Group (U.S. subs.) ²	N/A	(99,600)	(205.4)	120.7	102.1	1,702,800	—	(324,100)	(976.7)	210,000	6.0	N/A	N/A
—	Nationalwide Mutual Ins. Co. ²	N/A	N/A	N/A	104.6	106.8	4,159,189	(3.1)	(173,073)	30.0	463,844	10.8	2,668,897	1.8
—	Commercial Union Ins. (U.S.) ²	N/A	N/A	N/A	105.8	105.9	919,700	10.4	(66,700)	(1.1)	109,500	(4.8)	547,300	(2.3)
—	Liberty Mutual Ins. Co. ²	N/A	N/A	N/A	111.7	110.7	5,189,172	3.0	(337,975)	15.8	673,949	16.6	N/A	N/A
Cumulative		110,121,112	4,854,072	(12.8)	105.7	105.0	67,030,337	1.8	(3,612,976)	(15.7)	8,928,922	11.3	32,215,822	2.6

¹ After dividends. ² Statutory. N/A—Company did not provide data

Insurers' results

Continued from page 1
• Underwriting losses increased 15.7% to \$3.6 billion. While the

nine-month figure is an improvement from the 17% increase in underwriting losses in the first half, it contrasts with the 35.9% increase in underwriting profits in the first

nine months of last year.

• The combined ratio was relatively flat at 105.7%, compared with a 105.5% combined ratio in the first half and a 105% combined ratio in the first nine months of 1987.

• Policyholder surplus increased 2.6% to \$32.2 billion. This compares with a 3.7% increase in the first half and a 24.7% increase in the first nine months of 1987.

• Of the 24 companies that reported operating income to *Business Insurance*, 16 reported that earnings had dropped compared with the first nine months of 1987.

BI's survey no longer includes American General Corp., which

has announced plans to sell its property/casualty insurance business. American General now reports that segment of its business as a discontinued operation.

Declining premium volume, especially in property insurance lines, has "begun to take its toll" by delivering less cash flow, which has hurt investment income, said Herbert E. Goodfriend, an analyst with Prudential/Bache Securities in New York, who added that competition is increasing in casualty lines as well.

Contributing to the situation, he said, were deteriorating loss ratios caused by catastrophes including Hurricane Gilbert and the Piper

Alpha oil rig disaster (BI, Nov. 14; July 11).

Companies that are refusing to write some business because of competitive prices saw their expense ratios rise, Mr. Goodfriend said. They also reported continuing deterioration in personal lines and in workers compensation results, he said.

The nine-month results were a "little bit worse than expected," said Michael A. Lewis, first vp for Dean Witter Reynolds in New York. "The earnings weren't quite up to what I was looking for," he said, attributing the poor performance in part to reserve additions

Continued on next page

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Ohio proposal

Continued from previous page

"We are putting it together as quickly as possible and we anticipate having a final draft within the next two weeks," Rep. Mottl estimated.

In an effort to word the Ohio legislation more coherently than Proposition 103, Rep. Mottl has enlisted the aid of consumer activist Robert Hunter, president of the National Insurance Consumer Organization in Alexandria, Va.

And, as regulators feared following California's election of Proposition 103, Ohio will be one of many states drafting this type of legislation in the near future, Mr. Hunter said.

As in California, residents of Ohio and other states are angrily responding to high premiums for personal auto insurance and calling for reductions in insurance charges across all lines of insurance, he explained.

"Ohio is one of several states that is interested in adopting (Proposition) 103 or applicable parts of it for themselves," Mr. Hunter said.

Because of a high rate of car theft in northeast Ohio, specifically in Cleveland and Akron, auto insurance premiums for residents of these areas are up to three times greater than for other Ohioans.

"We have a pocket of Ohio that is getting raped by insurers and legislative steps similar to those outlined in Proposition 103 have to be initiated," said a spokesman for Rep. Mottl. Rep. Mottl and his staff point out that the Ohio insurance lobby is one of the strongest in the nation and acknowledge that getting the bill ratified will be difficult.

However, if the bill fails in the Legislature, the issue

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Continued from previous page by some insurers.

Meanwhile, the fourth quarter—with more weather-related losses expected—could be even tougher for insurers, he said.

Overall, 1988 "still should be a very decent year," said Mr. Lewis. In 1989, however, there will be a "much sharper fallout" as prices continue to erode, he warned.

Insurers that focus on "Main Street" commercial lines business performed relatively worse than more specialized firms like American International Group Inc., General Re Corp. and The Hartford Steam Boiler Inspection & Insurance Co., commented Udayan D. Ghose, an analyst with Shearson Lehman Hutton in New York.

"I think what we're going to see is some real differentiation in the results based on market position and the products written," said Mr. Ghose.

Observers agree that the insurance industry is in a downturn.

"The decline in prices and in profits is probably going to continue for some time until it becomes so painful that companies start dropping out, as they had before, both through insolvency or their fear of insolvency," said Barbara Stewart, president of Stewart Economics in New York.

"We perceive that the last cyclical recovery period has clearly peaked out. We are into the next cyclical downturn now," said Edwin J. Goss, chairman and chief executive officer of Indianapolis-based American States Insurance Co., the principal property/casualty subsidiary of Lincoln National Corp.

Mr. Goss added, however, that "we don't see any major surprises. Competition is more intense, including price competition, and premium levels for us are stable to down but not down dramatically in the aggregate."

He predicted that the industry's combined ratio will deteriorate to 106% this year and to about 109% next year. American States' combined ratio, which was 99.9% after nine months of 1988, will rise to about 100% by year-end and to 103% to 104% next year, Mr. Goss said.

Lincoln National Corp.'s 100.1% combined ratio for the nine months for its property/casualty operations also reflects its reinsurance operation, National Reinsurance Corp.

"I think the fourth quarter will be more of the same," said David Seifer, vp with the First Boston Corp., based in New York. As for next year, "the property/casualty side is going to be difficult."

The fourth quarter will be used by insurers for "corrective surgery" to assure themselves of reserve adequacy so that they can enter 1989 in a "solid state," said Mr. Goodfriend, noting as well that there is a growing realization by insurers that they will face significantly higher tax liabilities next year, when the full impact of the Tax Reform Act of 1986 is felt.

While the tax act is going to affect insurers this year, it will have an even greater impact

next year, said Ms. Morrissey. She pointed in particular to the alternative minimum tax, a provision of the tax act that was intended to assure that all corporations with income pay some tax.

Previously, she said, insurers' underwriting losses could be used to offset taxable income generated by their investment portfolios.

While underwriting losses are expected to increase next year, the AMT will limit how many of these losses can be offset by a tax benefit. As a result, insurers who start "playing with their portfolio" could find themselves taxed "even harder," said Ms. Morrissey.

"Sometime during this cyclical downturn most of the companies are going to become very aware of the negative impacts of the new tax law, and they are going to be substantial, and that impact will have a moderating impact on the cyclical downturn," said Mr. Goss, who noted that Lincoln National will have to pay an additional \$130 million over the next five years because of tax reform.

"That's a very big number, and other companies are going to be similarly impacted," he said.

The 1986 tax law "hurts cash flow and ultimately hurts earnings," and should have an effect on turning rates around sooner, said Gloria Vogel, associate director for Bear, Stearns & Co. Inc. in New York.

"I think it will bring a measure of price stability and an increase fairly shortly," said Gordon Luce, assistant manager at Brown Bros. Harriman & Co. in New York.

"I think the tax act is going to have a devastating impact, much more so than the industry realizes," and will trigger a turn in the market, according to Robert Branche of the Branche Research Group in Morrisville, Pa.

Tax reform's impact on insurers' earnings "has not been fully effected yet," said Mr. Ghose.

The tax increase will impact the amount of money available for investments and that "takes a while to filter" down to earnings, said Mr. Ghose.

"The bulk of the tax increase has not really dampened earnings yet," he said. "The accounting impact will be felt over the next couple of years."

However, there is no question that the tax act's impact is "enormous," said a spokesman for The Home Group Inc. in New York. By year-end, "the effect of that law is going to be felt, and understood much more so" than it is now, he said.

Industry observers last week generally agreed that California's Proposition 103—which among other things calls for most property/casualty insurance "charges" in California to be reduced to 20% lower than November 1987 prices—is unlikely to be implemented in its current form. However, it remains a concern.

"Our people feel that the rate rollback

provision will be declared unconstitutional. The other provisions, though, will be left intact," said George Yonker, assistant controller at SAFECO Corp.

Among other things, Proposition 103 ends insurers' exemption from state antitrust laws, allows state-chartered banks to sell insurance and calls for the election of the state insurance commissioner, who is currently appointed by the governor (BI, Nov. 21; Nov. 14).

Mr. Yonker said he cannot predict the impact of Proposition 103 on insurers' earnings. "It's a little too early to know that," he said.

"There are so many unanswered questions right now, we're still struggling with" the potential impact of Proposition 103 on earnings, said a spokeswoman for Fireman's Fund Corp. Fireman's Fund is among a group of insurers that has filed a suit challenging the constitutionality of Proposition 103.

"California is a cloud that may spread" and put pressure on premium volume, cash flow and investment income, said Mr. Seifer.

"It raises all kinds of uncertainties in other states," said Ms. Stewart.

On the other hand, Mr. Luce of Brown Bros. Harriman said: "I think the California situation is going to be such a mess it's not that likely to spread to other states."

If Proposition 103 does lead to a forced rollback in rates, it "will have a distinctly negative impact on the industry," said Mr. Lewis, adding that could be seen "as one other nail in the coffin" and lead to the cycle running its course.

"It's possible this may be enough to turn the cycle around," agreed Bear Stearns' Ms. Vogel.

Some insurers say they expect Proposition 103 to have little effect on their own operations.

"Politically, it's obviously a large problem," said the CIGNA spokesman. He added, however, that although the proposition applies to all types of commercial insurance "clearly the more immediate issue" is for personal automobile insurers and the 9,000 vehicles in California insured by CIGNA represent only 0.4% of the market.

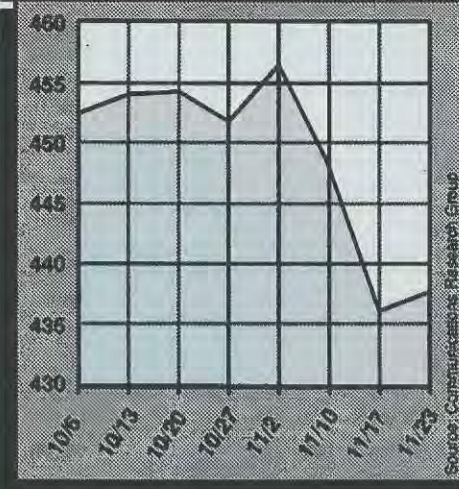
"We write classes of business that for the most part are really outside Proposition 103's guidelines," said an AIG spokesman.

Insurers point out as well that prices for many lines of commercial property/casualty insurance are already 20% lower than November 1987 prices.

A spokesman for USF&G Corp., which is no longer writing new business in the state, said that much of the commercial business it writes in California falls outside Proposition 103's guidelines because of rate cuts in the past year.

Still, "right now there's no way to put a good face on" Proposition 103, said American States' Mr. Goss. "It's a problem, and how much of a problem depends on what the courts do."

BI Insurance Index



Insurance industry stocks rebounded slightly early last week as the Business Insurance stock index rose 0.9 points to 437.6 on Nov. 23, up from 436.7 on Nov. 18. The largest advances were reported by Tokio Marine & Fire Insurance Co., up 6.8%; Harleysville Group Inc., 6.7%; Hilb, Rogal & Hamilton Co., up 5.6%; Fremont General Corp., up 5.5%; and Zenith National Insurance Co., up 5.0%. The largest declines were reported by: Forum Re Group (Bermuda) Ltd., down 28.6%; Kansas City Life Insurance Co., down 9.0%; Phoenix Re Corp., down 5.0%; Hancock Insurance Co., down 2.8%; and Belvedere Corp., down 2.8%. The most active insurance stock were: USF&G Corp., 3.3 million shares traded; Sears, Roebuck & Co. (Allstate Insurance Co.), 2.3 million shares traded; and Farmers Group Inc., 2.2 million shares traded. The Business Insurance index, which gained 0.2%, did not perform as well as other market averages: The Standard & Poor's 500 index rose 2.0%; the Dow Jones 30 Industrials rose 1.9%; and the New York Stock Exchange composite rose 1.5%.

British Issues

Nov. 21 Companies	Price	P/E	Div.	Yield	High-Low
	pence		pence	%	pence
Comm Union	324	10.5	25.2	7.8	324-320
Genl Accident	828	8.2	58.0	7.0	829-826
Genl Royal Exch	182	9.8	13.1	7.2	183-179
Royal	369	12.1	30.0	8.1	377-364
Sun Alliance	998	7.6	54.7	5.5	1008-996

Brokers	Price	P/E	Div.	Yield	High-Low
	pence		pence	%	pence
Bradstock	203	11.0	8.0	3.9	203-201
CE Heath	433	13.7	34.5	8.0	439-430
Hogg Robinson	157	13.3	8.0	5.1	158-156
Lloyd Thompson	205	16.1	8.0	3.9	205-205
PWS Holdings	151	21.6	6.0	3.4	151-151
Sedgwick Grp	216	18.0	16.0	7.4	217-212
Steel Brl Jones	213	19.0	13.3	6.3	216-213
Willis Faber	221	12.3	16.0	7.2	222-217

Source: Philip Olsen/Alan Clifton, Insurance Industry Specialists Kitcat & Aitken Stockbrokers, London

BI Industry Stock Report

NOVEMBER 23, 1988

11/18/88 THRU 11/23/88

	Weekly Price	Year to Date % change	Annual High	Annual Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value	Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value																						
BROKERS																																											
Alexander & Alexander Svcs	NYSE	24.88	1.0	40.2	28.13	17.75	166	1.00	4.0	17.0	3.71	6.71																															
Corroon & Black Corp	NYSE	29.63	0.9	4.9	34.75	28.00	26	1.08	3.6	4.5	5.43	5.46																															
Gallagher Arthur J & Co.	NYSE	17.88	0.7	11.8	19.13	13.88	34	0.48	2.7	12.3	5.16	3.47																															
Hill Frank B. & Co	NYSE	2.75	0.0	-4.5	5.50	2.50	73	0.00	0.0	12.3	0.00	N/A																															
Hilb, Rogal & Hamilton	OTC	14.25	5.6	46.2	14.50	9.75	6	0.00	0.0	12.3	0.00	N/A																															
Marsh & McLennan Cos Inc.	NYSE	57.00	1.5	15.2	59.63	45.25	196	2.50	4.4	13.9	6.74	8.46																															
Poe & Assoc Inc	OTC	8.25	0.0	17.9	9.25	6.75	2	0.40	4.8	12.7	0.27	30.56																															
BROKERS AVERAGE																							1.4	18.8					2.8	12.0													
CONGLOMERATES & HOLDING COMPANIES																																											
Berkley W.R. Corp	OTC	29.50	0.9	22.9	30.00	23.50	149	0.36	1.2	6.4	17.63	1.67																															
Berkshire Hathaway Inc DEL	OTC	4750.00	1.1	61.0	5000.00	2755.00	37	0.00	0.0	19.1	77.66	1.92																															
ITT (Hartford Group)	NYSE	49.25	2.9	9.4	54.88	43.25	827	1.48	3.0	6.2	52.23	0.94																															
Sears Roebuck & Co (Allstate)	NYSE	40.00	-1.2	18.9	46.13	32.25	2340	2.00	5.0	10.4	34.74	1.15																															
CONGLOMERATES AVERAGE																							0.9	28.1					2.3	10.5													
INSURERS & REINSURERS																																											
Aetna Life & Cas Co	NYSE	48.25	1.0	6.6	52.50	39.50	505	2.76	5.7	7.9	53.56	0.90																															
American General Corp	NYSE	30.88	-0.4	-2.7	36.38	27.50	464	1.40	4.5	7.8	28.04	1.10																															
Amer Heritage Life Inv	NYSE	25.50	-1.9	5.2	27.00	24.00	4	1.08	4.2	10.8	20.98	1.22																															
Amer Indly Finl Corp	OTC	10.25	2.5	13.9	12.00	8.25	7	0.56	5.5	18.0	15.26	0.67																															
American Int'l Group	NYSE	63.38	0.6	5.6	68.75	49.00	664	0.40	0.6	9.3	33.56	1.89																															
Aon Corp.	NYSE	27.00	0.0	18.0	28.75	21.88	331	1.28	4.7	8.9	15.13	1.78																															
Argonaut Group	OTC	43.50	-0.6	46.2	49.00	29.50	66	0.00	0.0	6.0	29.19	1.49																															
AVEMCO Corp	NYSE	23.50	-1.6	19.7	28.75	17.88	50	0.34	1.4	10.9	7.74	3.04																															
Belvedere Corp.	AMEX	4.50	-2.8	2.7	6.00	4.00	4	0.04	0.9	6.6	7.87	0.57																															
Chandler Insurance	OTC	8.50	0.0	74.2	10.25	4.25	21	0.00	0.0	4.1	7.18	1.18																															
Chubb Corp	NYSE	55.38	2.6	-0.9	63.38	51.25	182	2.16	3.9	6.3	46.13	1.20																															
CIGNA Corp	NYSE	47.25	1.3	7.7	55.38	42.75	273	2.96	6.3	8.8	49.19	0.96																															
CNA Fin'l Corp	NYSE	57.75	2.2	3.8	66.13	51.00	143	0.00	0.0	9.1	46.40	1.24																															
Continental Corp	NYSE	35.00	1.8	-9.7	41.63	33.75	214	2.50	7.4	11.2	42.10	0.83																															
Durham Corp	OTC	32.25	0.8	50.0	36.75	21.50	22	0.92	2.9	37.5	26.00	1.24																															
Farmers Group Inc	OTC	73.25	0.9	82.0	73.38	40.50	2221	1.44	2.0	17.2	22.02	3.33																															
Firemans Fd Corp	NYSE	28.75	-2.1	10.6	33.50	25.75	130	0.50	1.7	125.0	26.17	1.10																															
Forum Re (Bermuda)	OTC	1.25	-28.6	-63.0	2.00	0.63	53	0.00	0.0	3.5	2.58	0.48																															
Fremont Gen Corp	OTC	12.13	5.5	26.0	13.50	8.75	269	0.60	4.9	8.2	16.24	0.75																															
General Re Corp	NYSE	54.75	1.9	-2.0	59.38	45.50	536	1.20	2.2	11.1	26.21	2.09																															
Home Group Inc	NYSE	11.00	-1.2	-7.4	14.38	10.75	151	0.20	1.8	2.7	17.76	0.62																															
Hanover Ins Co	OTC	25.75	-2.8	10.8	27.75	20.50	60	0.36	1.4	4.9	25.10	1.03																															
Harleysville Group Inc.	OTC	17.75	6.7	35.3	17.88	13.38	51	0.48	2.7	7.0	16.65	1.07																															
Hartford Steam Boiler Insp	OTC	31.00	-1.6	34.8	32.75	22.50	186	1.20	3.9	10.6	10.65	2.91																															
Kans City Life Ins	OTC	35.50	-9.0	35.2	39.25	25.25	63	0.00	0.0	10.6	29.60	1.20																															
Kemper Corp	OTC	24.25	4.3	18.3	27.50	20.75	497	0.72	3.0	7.7	26.50	0.92																															
Lawrence Ins. Group	AMEX	9.63	-1.2	114.0	11.63	4.50	0	0.24	2.5	21.4	2.90	3.92																															
Liberty Corp S C	NYSE	37.75	-1.0	6.3	47.25	34.50	8	0.80	2.1	13.1	17.40	2.17																															
Lincoln Natl Corp	NYSE	46.00	-0.3	14.6	53.50	40.25	93	2.48	5.4	11.9	36.62	1.26			</																												

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